

**Improving
The
Discharge Planning
Process
In New York State**

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1. OVERVIEW

The hospital discharge experience for many New Yorkers and their families is a process filled with unknowns and uncertainty. The April 2015 *Hospital Compare* data revealed that, for patients being discharged from an acute care facility, only 47% of New Yorkers and 52% nationally reported that they were given information about what to do during their recovery at home¹. A small study completed by the Department of Medicine at North Shore University Hospital in Manhasset, New York and a larger study completed by the New York State Health Foundation each concluded that a lack of patient and caregiver understanding and awareness of the discharge plan is directly linked to hospital readmissions and impedes the patient's and family's ability to follow the discharge plan.^{2,3}

The purpose of this document is to identify barriers and challenges to providing high quality, consistent discharge planning. Options presented in this document will inform decisions on ways to improve the current discharge planning process with the goal of dramatically improving the discharge experience for New York residents and their families and increasing the percentage of New Yorkers that self-report understanding their discharge plan at time of discharge by 20%.

The Joint Commission, a national accrediting body that is responsible for accreditation and certification of health care organizations and programs, including hospitals, states that approximately 80% of adverse medical events occur during the transition from one care setting to another, whether during the transition from hospital to home or other care setting.⁴ The New York State Health Foundation cites the fragmentation of the discharge plan, medication management failures, and the lack of key information within the plan as primary reasons for the failure of the discharge plan and the readmission of the patient to the hospital.⁵

The New York State Health Foundation further suggests that a more comprehensive and intensive discharge planning process would not only improve the discharge planning process for New Yorkers and their families, but would also help to reduce preventable avoidable hospital readmissions by 25%.⁶ Recent data indicates that 18% of Medicare patients return to the hospital within 30-days of their hospital discharge.⁷ Kaiser Health News estimates that approximately 2 million patients are readmitted to the hospital each year, costing approximately \$26 billion dollars.⁸ \$17 billion of this is directly tied to preventable avoidable readmissions.⁹

2. CONCLUSION

A lack of a standardized process in the discharge planning system has led to inconsistencies, which may lead to poor patient outcomes, including avoidable hospital re-admissions. Care Transition Models as well as other innovative models have shown promise in improving the discharge planning process. Additions and or enhancements to current discharge planning regulations will assist in the assurance that patients

discharged from an acute care setting receive comprehensive and appropriate discharge planning services.

There continues to be inconsistency in discharge planning protocols. The state of New York has begun taking the needed steps forward to achieve this change, however, there is still a considerable amount of work that needs to be done in order to continue the change and sustain it. It is uncertain how New York State's recently passed Caregiver Advise, Record and Enable (CARE) Act will impact patient satisfaction with the percentage of patients who self-report the understanding of their discharge plan at time of discharge.

The following pages offer a discussion of identified discharge planning barriers in New York State, along with the activities that New York is currently engaged in to improve the discharge planning process. Recommendations for further action and activities for further exploration are also discussed.

3. CURRENT ENVIRONMENT

In 2011, Medicare imposed financial penalties on individual hospital rates for patients who were readmitted within 30-days for the same initial admitting diagnosis.¹⁰ To date, 80% of New York State (NYS) hospitals have been financially penalized for high re-admission rates.¹¹ This data indicates that hospital re-admission rates are a high priority issue. In an effort to avoid financial penalties hospitals have begun admitting patients who have returned within 30-days under observation status. The use of observation status has increased 69 percent over five years for the senior population.¹²

NYS has taken progressive steps to improve the discharge experience for its residents and their families. In addition to the Informal Caregiving Initiative mentioned in the 2015 State of the State Address, the CARE Act¹³ was signed into law in October 2015. The CARE Act focuses on the early identification and engagement of the caregiver in the discharge process. While this law takes proactive steps to address the issue of caregiver involvement in the discharge planning process, there remains considerable work ahead to fully improve issues identified in this paper.

Discharge planning practices are currently regulated by both the State (See Appendix A) and the Federal Government. In order to meet the Conditions of Participation (CoP) for Medicare and Medicaid, hospitals must adhere to both sets of regulations (See Appendix B). Under both State and Federal regulations, hospitals must have:

- A discharge planning process with corresponding policies and procedures,
- Designated discharge planning staff,
- A discharge plan documented in each patient's medical record,
- Documentation that the discharge plan was discussed with the patient and/or their designated representative,
- Documentation that post-discharge services were arranged or made reasonably available,

- Documentation that the patient and/or designated representative was provided with a written copy of the discharge plan.

In addition to the similarities between state and federal regulations, New York State has enacted Public Health Law Article 28 - §2805-v Observation Services, which requires hospitals to notify patients verbally and in writing if they are being assigned as observation status and are not admitted to the hospital. This law requires that patients be notified no later than 24-hours after the assignment of observation status. New York State has recently amended Public Health Law Article 28 to mandate that patients designated as observation status receive discharge planning services. Patients classified as observation status have traditionally been excluded from receiving discharge planning services. While these laws are unquestionably relevant and necessary, value could be added by expanding them to provide clearer direction that reflects best practices that have been established in recent years.

Medicare and Medicaid Discharge Planning Regulations do not reflect current advances in clinical practice. In May 2013, the Centers for Medicare and Medicaid (CMS) issued interpretive guidance¹⁴ on the regulations that include suggested best practices. There is, however, no standardized evaluation tool or core data set in New York State used by discharge planners to identify patients at high risk for needing post - hospitalization care or to determine a patient's need for continuing care.

Fragmented communication and coordination across the health care continuum, inadequate patient education, delays in Medicaid eligibility determination, and insufficient community support each may lead to a decline in health status post discharge, as well as costly, preventable readmissions.

With the goal of improving the quality of care and efficiency in which healthcare is provided to New Yorkers, the State has developed a comprehensive technological infrastructure that provides access to electronic health records and personal health records for providers. The Statewide Health Information Network for New York (SHIN-NY) is an "information highway" that allows clinicians and consumers to make timely, fact-based decisions that will reduce medical errors, duplicative tests and will improve care coordination and the quality of care.

The SHIN-NY is comprised of Regional Health Information Organizations (RHIOs). RHIOs are a "type of health information exchange organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community". These initiatives are key to improved communication between services providers and improved care provided to New Yorkers.

The Patient Review Instrument (PRI), the assessment tool used to determine the patient's eligibility for a Residential Health Care Facility (RHCF) level of care, does not include an assessment of the post discharge environment, social functioning, or supports. In addition to the PRI, individuals being assessed for RHCF level of care must also be screened for mental illness, intellectual disability and/or developmental disability using the Preadmission Screen Resident Review (PASRR). The PASSR is used to

determine that individuals with serious mental illness and developmental disabilities are placed in the most appropriate and integrated setting possible that will best meet their needs. The first part of the PASSR tool, the Level 1 Screen, used to identify a possible mental illness and/or intellectual/ developmental disability, may not be sensitive enough to adequately identify those having a PASRR condition. The 2014 Preadmission Screen Resident Review (PASRR) National Report¹⁵ prepared by CMS, rated New York State's Level 1 Screen in the third Quartile for comprehensiveness and determined that those with a serious mental illness are being under identified¹⁶. An under identification of those with serious mental illness and developmental disabilities puts these individuals at high-risk for placement in institutions that may not be able to address their specialized needs.

A lack of knowledge about available care transition support programs, community resources, non-medical supports, and the availability of caregivers, can all contribute to likelihood of patients being discharged to a higher level of care.

In practice, the discharge planning process still tends to be viewed as a singular, isolated event. This culture needs to shift to a more fluid, collaborative model, incorporating best practices.

4. BARRIERS TO EFFECTIVE HOSPITAL DISCHARGES

A discharge planning process that is collaborative and reflects the continuum of care is needed to assure positive health outcomes. Barriers, if not addressed, can lead to costly readmissions. Care coordination between the acute care setting, the patient, the primary provider, and the subsequent care setting are key elements to support successful discharges. Current regulations are very broad, leaving ample room for variation in implementation. There has been considerable advancement in best practices related to care transitions in recent years, but no incentive for implementing them.

4.1 Lack of standardized evaluation and assessment tools across the continuum of care

Currently, New York State does not mandate the use of a standard comprehensive evaluation or an assessment tool to identify discharge needs. There is no way to consistently screen and stratify higher risk patients. This lack of a standardized tool that can trigger additional assessments for specialized needs contributes to an inefficient system where varied assessment scales are used to determine the patient's care needs.

Mental illness, intellectual disabilities or related conditions have special protections in Medicaid law that require screening to assure that the patient is being placed in the most integrated setting.

For example, the PRI and PASRR are completed in acute-care settings to determine the patient's level of care when nursing home or long-term support services are anticipated. According to the 2014 PASSR study, the PASSR does not adequately assess mental health, intellectual or developmental deficits or

cognitive impairment related to the ability of the patient to be discharged to the community.

Screening and assessment tools and processes do not identify all the information that is required to construct a patient-centered discharge plan. Inconsistency in completing a screening tool, or lack of sensitivity of a screening tool such as the PASRR, may not accurately identify all individuals who might have a PASRR disability.

NYS currently uses the Uniform Assessment System for New York (UAS-NY) tool to determine level of care and to develop care plans for individuals in the community. The tool triggers additional evaluation questions based on an algorithm. There is no comparable tool in use in the acute care setting. A comparable comprehensive tool would create greater consistency across the continuum of care.

4.2 Inadequate patient education

Patients and caregivers often report that they feel isolated from the discharge planning process and may be hesitant to ask for clarification when they don't understand something¹⁷. This can lead to anxiety about moving from the supportive environment of the hospital to a community setting. Discharge planners sometimes inaccurately assume that the patient and/or caregiver have the necessary tools and knowledge to carry out the plan of care because they are not actively engaged and do not question the plan. Hospital stays, particularly lengthy ones, can foster dependency.

Lack of understanding of red flags¹⁸ and who to call with questions or concerns can lead to unnecessary utilization of higher level medical services, such as emergency department visits. Lower hospital readmission rates are associated with greater satisfaction with nurse and staff communication.

There is also particular need for patient education regarding post-discharge medication. Patients may experience confusion or uncertainty about what medications they should take once they arrive home. Doses or manufacturers may be different than pre-admission medication. Patients may get confused when the same drug, but made by a different manufacturer is prescribed. The medication may look different, leading the patient to think they are different medications, so the patient may take both. Medication reconciliation is crucial in order to avoid potentially hazardous reactions to improper use of medication.

4.3 Language barriers

Language barriers should be taken into account when assessing a patient's understanding of a discharge plan. According to the U.S. Census Bureau, approximately 60 million people in the U.S. speak English "less than very well." Therefore, miscommunications between hospital staff and Limited English Proficient (LEP) patients may lead to misdiagnoses, dangerous mistakes and

subsequent readmissions. For example, a person who speaks some English but only reads Spanish could misinterpret prescription instructions stating to take a medicine “once daily,” since the word “once” in Spanish means eleven. Current regulations require hospitals to have interpreter services available for non-English speaking patients. In spite of regulations, hospitals often use telephonic-based vendors or non-certified, bilingual staff to provide translation services, in addition to formal translation services. Therefore, important information may still get lost in translation. However, the Department of Health proposed in the state regulatory agenda to “add regulations and develop rates for the payment of Language Assistance services provided by hospitals to inpatients.”¹⁹

4.4 Lack of coordination and fragmented communication

The current discharge process is usually fast paced and confusing for patients and caregivers, leading to complicated transitions and fragmented care. Discharge planners are often not notified of a patient discharge until the day before or the day of discharge, diminishing their ability to implement an adequate discharge plan. The need for adequate discharge timing notification is vital to a successful and timely discharge.

Early identification of barriers to discharge and potential risk factors is essential to starting the discharge planning process early and crucial to identifying individuals who should be referred for a more comprehensive assessment. Identification of prior services, supports, as well as potential risk factors and barriers to discharge must be taken into account when developing a discharge plan. Barriers include: language, literacy, low income, social isolation, lack of informal caregiver support, multiple chronic conditions, and cognitive impairment. Communication within the interdisciplinary team regarding identified risk factors reinforces the need for adequate discharge timing notification.

Attention needs to be given to assessing the environment to which the patient will be discharged. This assessment should include the impact of the current illness upon activities of daily living, the availability of informal caregivers and any physical barriers, such as stairs or accessible bathrooms.

Communication between the patient and multiple providers both within and outside the acute care setting are vulnerable to breakdown. A lack of coordination and communication between disciplines and the patient could lead to the failure of the discharge plan. Often times the member of the medical team most familiar with the patient is not the individual who writes the discharge order, leading to the omission of key components of the discharge plan.

It is not clear where the responsibility for post-discharge interventions lies. Care coordination between the acute care setting, the patient, and the primary provider is a key element to ensure that the patient will discharge to the community successfully.

Primary care providers (PCP) and other specialists are not always made aware that one of their patients has been admitted to the hospital. Discharge information is not always sent to the PCP in a timely manner once the patient has been discharged. The window in which discharge summaries must be completed under current Medicare regulations (482.24 (c) (2) (viii)) is within 30 days of discharge. The Joint Commission standard (RC 01.03.01) leaves the timeframe up to individual hospitals, as long as it does not exceed 30 days.

Delayed or poor communication between the acute care setting and the PCP causes a fragmentation of care coordination. Lack of a timely discharge summary, containing critical information regarding the hospital course of treatment, at the time of the post-hospital follow-up visit has been shown to increase the risk of re-admission.

Patients without a PCP are at the greatest risk for failure of a discharge plan, lacking the essential medical resources needed to support a successful transition. They are frequently unable to access home and community based services beyond what has been arranged for them in the hospital, since most home and community-based services require a physician's order.

Patients new to a provider may not know to indicate that the requested appointment is for a hospital follow-up visit. Many outpatient practices will give priority to scheduling a hospital follow-up visit. Follow-up care is one of the critical concepts in care transition models and has been found to improve clinical outcomes and reduce readmissions.

4.5 Observation status

Observation status, provides a short period of time (less than 48 hours) for hospital physicians to determine whether a patient requires admission. This designation helps hospitals to defer possible financial penalties imposed by Medicare for patients readmitted with 30-days for the same diagnosis. Services are considered outpatient and covered under Medicare Part B, which may impose higher co-pays for the patient. To the patient, services may be indistinguishable from an inpatient admission. This classification poses challenges for the Medicare patient who may not understand that they are not technically admitted and thus incur higher out-of-pocket expenses. In addition, due to the outpatient classification, hospital discharge planning regulations did not apply, leading to inconsistencies in post observation transition planning.

Observation status may also impact the Medicare patient needing post-hospital rehabilitation services in a skilled nursing facility (SNF). Medicare pays for full coverage for the first 20 days only if the patient was admitted to a hospital for the previous three days. Time a patient spends in a hospital under observation status would not meet the Medicare criteria for the three-day admission, thus the patient would be responsible for the cost of the nursing facility care.

Regulatory authority regarding observation status is primarily dictated by CMS (Medicare) leaving aspects of observation status outside of State control. On November 4, 2015²⁰, regulations within State authority regarding observation status were amended to reflect the following: “the hospital, in conjunction with the discharge planning program of the hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post observation treatment or services but not in need of inpatient hospital care”. The enhancement of this regulation will provide a previously exempt population with access to discharge planning services.

4.6 Lack of knowledge of available community resources

A major barrier to discharging individuals from hospital settings back to the community is the lack of information about community alternatives and inaccurate beliefs about who can be supported in the community.

NY Connects, which provides information and assistance on long term services and supports (LTSS), was established by New York State Office for the Aging (NYSOFA) in 2006. In 2007, NY Connects was statutorily mandated through section 203(8) of the New York State Elder Law.

And yet a 2014 survey in which 169 discharge planners across the state were surveyed by New York State Department of Health (NYSDOH), in collaboration with the Health Care Association of New York State (HANYS) revealed that most respondents were not familiar with the NY Connects program.

Responders also reported that they primarily used information collected through their own research, internet searches, or written information to determine available resources for referrals to services. Many stated that they maintained on-line resources or directories on an individual basis and do not use a public database for information on LTSS. Most respondents noted that a searchable database of LTSS would be the most useful tool for a discharge planner.

4.7 Insufficient community support

Insufficient community supports can delay a discharge. The lack of available community supports including informal supports, personal care aides or home health aides, can significantly impact a patient’s ability to be discharged in a timely manner. This is a challenge particularly in rural areas where community services are sparse. Insufficient community support, capacity and lack of adequate transportation have a significant impact on the transition to increasing home and community-based services.

Payment sources for certain non-medical care are scarce and difficult to arrange. Non-medical wrap-around supports to formal care may mean the difference between a patient being admitted to a long term care facility and being able to be discharged to the community. Challenges particularly exist for the arrangement of

transportation to and from medical appointments, and for the pick-up of medications and groceries. Patients often have the responsibility, but lack the knowledge to arrange the necessary services. Patients sometimes simply forego these needed services, placing themselves at a high-risk for re-admission to the hospital.

New York State relies on the thousands of unpaid, informal caregivers to provide or supplement care at home. Services to provide respite and education for the large number of informal caregivers are underfunded. Information on available services and resources for caregivers is available, but not widely publicized. The lack of availability or underutilization of services has a huge impact on caregivers, emotionally, functionally and financially.

4.8 Insufficient reimbursement for care transitions

Care transitions programs have shown a great impact on reducing readmissions for high risk patients. Lack of on-going reimbursement incentives to support care transitions programs as a discrete service, in addition to the high cost for the evidence based programs, may deter hospitals from engaging in these programs.

Care transition programs require investment, both within the hospital and other organizations 'downstream' (nursing homes, home care organizations, primary care). Current financial incentives reward readmissions over investment in care transition programs. The hospital will not get reimbursed for these investments or for care transition activities; neither will any organizations involved. Although organizations such as home care agencies may gain (because they are often key actors in organizing a smooth and cost-effective discharge program), such organizations may lack the appropriate staff and/or financial capabilities to organize an integrated, inter-organizational care pathway. Under these circumstances, few hospitals may be willing to invest in care transition programs that may reduce the hospitals overall income.

Through Section 3026 of the Affordable Care Act (ACA), CMS established funding for a 5-year period beginning January 1, 2011, to promote community-based care transitions programs (CCTP) in hospitals that were at high risk for readmissions.

Funded programs would test models that would:

- Improve care transitions for high risk Medicare beneficiaries that would improve transitions from the hospital to other care settings;
- Improve quality of care;
- Reduce re-admissions for high risk Medicare beneficiaries; and
- Document measureable savings to the Medicare program.

4.9 Delays in Medicaid eligibility determination

Delays in processing Medicaid Eligibility Determinations can prevent a hospital discharge planner from being able to arrange services and supports needed at

discharge and may dictate whether a person remains in a community setting or enters a nursing facility.

Medicaid applications from individuals seeking long term care are often complex and may take a long time to process. Eligibility determinations can take up to 45 days to process and can be hampered by an inability to retrieve required documentation for processing.

Local Departments of Social Services (LDSS) often bump up against capacity issues. Staffing levels may be inadequate to process applications in a timely manner due to high caseloads or lack of staff to do necessary follow up on incomplete applications, contribute to determination delays past the required time frames.

5. BEST PRACTICES

Use of best practices and key interventions to improve care transitions have been shown to improve clinical outcomes, increase patient satisfaction, improve quality of care, and reduce re-admissions²¹. Discharge planning processes should identify patients at high risk for re-admission or complex discharges early on in the admission and include an assessment of patient discharge needs and readiness for discharge, availability of community services, a check of planned arrangements at discharge and a post-discharge follow-up (See Appendix C).

5.1 Comprehensive evaluation

A comprehensive, patient centered approach to discharge planning promotes collaboration and informed decision making, and facilitates a trusting relationship between the patient and the discharge planning team. Engaging the patient and caregivers early in the hospital course²², allows time to gather information regarding the patient's environment and level of functioning and supports prior to admission, as well as risk factors that may affect their ability to perform self-care functions post discharge. Assessing the patient's medical, physical, cognitive, economic, and emotional strengths and abilities, as well as their available support system is crucial in evaluating their post- hospital needs. It can be an opportunity to engage the patient in the planning process.

In support of the goals of the Olmstead Decision²³ to promote a person-centered approach to care, a discussion about patient/caregiver expectations and goals of care provides insight into informal resources that may be available to assist with the post discharge transition. It is imperative to verify that the informal supports are willing and able to assume the responsibilities required.

5.2 Standardized assessment tool

Use of standardized assessment tools that include compatible domains across the continuum of care can improve care coordination and improve clinical outcomes.

Communicating core data elements across providers and care settings adds to consistency of care and contributes to a seamless health system and should be included in discharge summaries.²⁴

5.3 Advanced directives

The Medical Orders for Life-Sustaining Treatment (MOLST) form is a document that can be used across the continuum of care. The MOLST form is a 4-page document which indicates the patient's goal for care, including resuscitation and life-sustaining measures. The document is hot-pink in color to signify that the patient has advanced directives in place. The MOLST is meant to travel with the patient across care settings to ensure consistency in the delivery of care.²⁵

Patient Education provides an opportunity for hospital staff, the patient, and the caregiver to assess self-management skills. The Teach-back method allows patients and caregivers to practice skills in a safe environment, provides an opportunity to ask questions, and increases knowledge retention. It reinforces patient/caregiver understanding of the post discharge care instructions, including how to recognize warning signs that may require follow-up, along with information on how to respond and who to contact. Validating understanding of the discharge instructions helps to boost confidence, allay concern and increase patient satisfaction²⁶.

5.4 Coordination and accountability

Hand off of information, whether it be between staff during the hospital stay, or between the hospital and subsequent setting, provides coordinated communication and improves clinical outcomes.

Identification of a PCP or other clinicians who will assume care once the patient is discharged, and the timely availability of critical information bridges that transition of responsibility and accountability for care. Communication between physicians encourages collaboration between care settings and assures that all members of the medical team regardless of setting have up to date and accurate information regarding the patient.

Assistance should be available to the patient in scheduling follow-up appointments prior to discharge²⁷. Appointment details including, the provider's name, address, phone number, and appointment date/time should be included on the discharge instructions.

For discharges with service referrals, follow-up calls to patients should occur within three days after discharge to assure the home care visit and/or supportive services, e.g. home delivered meals, were made as scheduled. The follow-up call also serves to reinforce the need to follow-up with: physician visits; diagnostic tests; and adherence to medication regime until the community-based provider can be seen.

A patient at home without the supportive environment like that of a hospital may have heightened fears or misunderstanding of the discharge plan. Such a call will indicate both the level of understanding and level of compliance with the plan.

5.5 Information technology

Health information technology, implemented in a patient-centered way, has vast potential to help successful care coordination outcomes and tracking. Information Technology (IT) can be used to enhance the care coordination process through real time availability of information, as well as enabling performance assessment and quality improvement²⁸.

5.6 Medication reconciliation

Medication errors are a major contributor to re-admissions²⁹. The use of a stratified process for triggering a pharmaceutical review prior to discharge will identify possible contraindication of medications prescribed by multiple providers³⁰.

Prior to discharge a review of the patient's medications should occur. The review should include, what post-discharge medications are prescribed, with clear instructions on what has changed from pre-admission medications, and a verification of the patient/caregiver's understanding of the instructions on how to administer it. The facility's discharge medication instructions should match what is on the pharmacy's label and/or instructions, and should include both the trade and generic name of the medication. If necessary, arrange a medication review from a home care provider or PCP to check for contraindications between discharge medications and those at home.

5.7 Medicaid eligibility determination

Other states have been successful in addressing the barrier of long wait times for Medicaid eligibility determinations by expediting the eligibility determination process or through presumptive eligibility.

Presumptive Medicaid eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible and to initiate services before the official determination has been made by the eligibility staff³¹.

The expedited or rapid eligibility determination process addresses the factors that are most likely to cause delays - fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing home and community based services, helps the individual or family member complete the application and attach sufficient documentation. Expedited processes reduce the time it takes to complete a financial application using the normal channels. Staff responsible for

making the decision does not change. The expedited process has reduced the average time required to make decisions from 37 days to 17 days³²

In the states where presumptive Medicaid eligibility or a rapid/expedited Medicaid process exist, Home and Community-Based Services (HCBS) are initiated before the final eligibility decision is made. Various studies show that states that have assumed the risk of paying for services prior to final eligibility determination, have been incorrect about eligibility in less than 1% of cases³³. Federal law does not allow reimbursement to states for Medicaid services provided to HCBS applicants who are later determined not eligible for Medicaid. Some states have set up special funds (i.e. from savings realized by keeping individuals out of nursing homes and earlier discharges from hospitals), used their general funds, or took money from block grants to pay for the services provided.

5.8 Care transition programs

Care transitions models have shown a significant reduction in 30-day readmissions and associated cost savings. Common practices across most care transitions programs include a dedicated resource to provide “bridge” support between the hospital and community setting, multidisciplinary communication, standardized plans, procedure and forms, standardized training for transition staff and timely follow up. Post discharge follow up and medication reconciliation are integral components of care transitions models. (See Appendix D)

Through Section 3026 of the Affordable Care Act³⁴ (ACA), CMS established funding for a 5-year period beginning January 1, 2011 to promote community-based care transitions programs (CCTP) in hospitals that were at high-risk for readmissions.³⁵

Funded care transition programs tested models that would:

- Improve care transitions for high risk Medicare beneficiaries that would improve transitions from the hospital to other care settings
- Improve quality of care
- Reduce readmissions for high risk Medicare beneficiaries

Financial penalties that Medicare imposes on readmissions have led to increases in the use of care transitions programs to reduce these readmissions. This has most likely significantly contributed to the overall downward trend in readmissions that has become visible in recent years.³⁶

6. CURRENT ACTIVITIES ADDRESSING IDENTIFIED BARRIERS

6.1 Delivery System Reform Incentive Payment Program (DSRIP) and Value Based Payment (VBP) Reform

New York State is undertaking a major Medicaid Reform effort to restructure the health care delivery system with the goal of reducing avoidable hospital use by twenty five percent over five years through the Delivery System Reform Incentive Payment Program.

Some of the DSRIP projects address barriers mentioned in Section 4, such as care transitions interventions, transitional supportive housing services, outreach and linkage to Health Homes and observation units.

DSRIP helps providers to work together and redesign care pathways to reduce readmissions by a certain percentage, and providers stand to lose DSRIP dollars if they do not meet these targets. Yet as mentioned previously, the current payment system within Medicaid will still penalize providers that aim to implement discharge planning and the reduction of readmissions. For some organizations, these negative consequences may actually be more significant than the potential DSRIP income.

Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period. Discharge planning and care coordination activities could be reimbursed, and the value-destroying care patterns (avoidable readmission and Emergency Department visits) do not simply return when the DSRIP dollars stop flowing.

The New York State Medicaid VBP Roadmap, which was approved by CMS in July 2015, aims to do just this. It describes a menu of options that providers and MCOs can choose from, including: bundled payments for chronic conditions and maternity care, integrated primary care, total care for the total population (Medicaid Accountable Care Organizations (ACOs)), and total care for special need subpopulations (condition-specific ACOs, mapping the range of care of the existing special need plans: HIV/AIDS, Health and Recovery Plan (HARP), Managed Long Term Care (MLTC), and forthcoming, the Developmentally Disabled population).

The State's Medicaid payment reform goals move away from the current situation where increasing the value of care delivered has a *negative* impact on the financial sustainability of providers towards a situation where the delivery of high-value care can result in *higher* margins. *All* the individual VBP arrangements are designed to incentivize the investment in discharge planning and reduction of readmissions.

6.2 Language barriers

New York State regulations require that non-English speaking patients be afforded interpreter services so that services be delivered in a respectful manner compatible with his/her cultural and religious beliefs, practices and preferred language.³⁷ In

addition, there is a proposed regulatory agenda to “add regulations and develop rates for the payment of Language Assistance services provided by hospitals to inpatients.”³⁸

6.3 Care transitions programs

Care transitions programs have demonstrated the effectiveness in reducing preventable readmissions. There are a number of projects in New York State, both evidence-based and demonstration projects that are showing promising success (Appendix D).

Through Section 3026 of the Affordable Care Act (ACA), CMS established funding for a 5-year period beginning January 1, 2011 to promote community-based care transitions programs (CCTP) in hospitals that were at high-risk for readmissions.

Funded care transition programs tested models that would:

- Improve care transitions for high risk Medicare beneficiaries that would improve transitions from the hospital to other care settings
- Improve quality of care
- Reduce readmissions for high risk Medicare beneficiaries

Financial penalties that Medicare imposes on readmissions have led to increases in the use of care transitions programs to reduce these readmissions. This has most likely significantly contributed to the overall downward trend in readmissions that has become visible in recent years.

6.4 Observation status

In October 2013, Governor Cuomo signed into law (NYS Public Health Law Article 28 – Hospitals PHL Section 2805-w³⁹) an act to amend Public Health Law, requiring hospitals to notify patients verbally and in writing if they are placed in observation status. Hospitals are required to provide patients with the implications associated with this status⁴⁰.

Effective November 4, 2015 state regulations governing observation status were amended to include discharge planning services for patients that are not classified as an inpatient status.

6.5 Available community resources

A collaboration between local Area Agencies on Aging and the LDSS, the NY Connects is a locally based "No Wrong Door" (NWD) system that provides one stop access to free, objective, comprehensive information and assistance for

people of all ages needing long term services and supports. The program links individuals of all ages to long term services and supports regardless of payment source, whether it be private pay, public or a combination of both. The program also maintains a comprehensive statewide web-based resource directory on long term services and supports.

As part of the NWD structural change required of Balancing Incentive Program (BIP), the NY Connects program is being expanded statewide to offer streamlined, coordinated access for all disability populations seeking information about long term services and supports. Through a collaboration with NYSDOH, NYSOFA, Office for People with Developmental Disability (OPWDD) and Office of Mental Health (OMH), NY's NWD will include screening, comprehensive information and assistance in connecting to services. The web-based NWD Screen will be housed within the state's UAS platform.

Scheduled for summer and fall 2015, NYSDOH will provide education for discharge planners and related professionals involved in the discharge planning process to decrease bias toward institutional care. NYSDOH will raise awareness of available HCBS for Medicaid eligible individuals and resources that support community living, including NY Connects.

The training includes information on New York State's health care reform activities and the Olmstead Decision priorities of supporting individuals in the community. It also will address how NY Connects can improve the discharge planning process by assisting discharge planners in identifying community resources.

6.6 Caregivers

Caregivers are often overwhelmed by the responsibility placed upon them in providing care and support following a discharge from a health care facility. Their role is often overlooked in the discharge planning process. Governor Cuomo, in his 2015 State of the State⁴¹ address, identified a Caregiver Support Initiative that aims to identify and provide training and support to informal caregivers prior to their loved ones being discharged from a hospital. This initiative targets support to the more than 3 million informal caregivers in NYS who, through provision of their informal support, augment, delay, or prevent individuals from requiring services through the formal care system.

The Caregiver Advise, Record and Enable (CARE) Act amends Public Health Law requiring hospitals to allow a patient and/or designated representative to appoint an identified caregiver. Hospitals will be required to:

- Document the identification of the appointed caregiver in the patient's medical chart;
- Contact the identified caregiver and provide the caregiver with an opportunity to meet with the hospital in regards to the patient's discharge plan and plan of care prior to the patient's discharge;

- Offer and provide training as requested to the caregiver on after-care tasks that the patient will require post discharge.

To expand access to non-institutional LTSS for caregivers and their Medicaid-eligible loved ones, one time Balancing Incentive Program (BIP) funding has been provided to NYSOFA to increase offerings and access to non-institutional LTSS.

6.7 Medicaid eligibility determination

Financial eligibility for Medicaid must be made within 45 days and disability determination must be made within 90 days. New York State currently has protocols in place that expedite the Medicaid eligibility process if certain criteria are met.⁴²

NYCRR 18 Social Services, Section 360-3.7 Presumptive eligibility allows for a 60 day presumptive Medicaid eligibility for any person from the date of transfer from a general hospital to a certified home health agency or long term Home Health Care program who meet certain criteria:

- The applicant is receiving acute care in such hospital;
- A physician certified that the applicant no longer requires acute hospital care, but still requires medical care;
- The applicant does not have insurance coverage for said care and cannot afford to pay out of pocket;
- It appears that the applicant is eligible for Medicaid; and
- It appears the amount expended to provide said service is less than the amount for continued acute hospital care.

The Medicaid Reference Guild (MRG) states that when an application is being made for presumptive eligibility, the local district determines that the applicant meets specified criteria, makes an eligibility determination by reviewing the application package and notifies the applicant of his/her presumptive eligibility determination within five working days of the receipt of the presumptive eligibility application package or by the discharge date if that date is later.⁴³

97 ADM-10 specifies that social services districts must process an application for presumptive Medicaid eligibility in accordance with procedures outlined in this Administrative Directive (ADM). Social services districts are required to make training available or to provide training to appropriate providers involved in the presumptive eligibility process.⁴⁴

In addition to these processes, New York State plans to operationalize hospital presumptive eligibility under the ACA through the Health Plan Marketplace within the next several years. The Hospital Presumptive Eligibility (HPE) program became effective January 1, 2014. That rule specifies that hospitals qualified under the

state plan or hospitals with a Medicaid 1115 demonstration waiver will have the option as qualified entities to make presumptive eligibility (PE) determinations.⁴⁵ Medicaid must be provided during a presumptive eligibility period to individuals who are determined by a qualified hospital.

7. RECOMMENDATIONS TO ADDRESS IDENTIFIED BARRIERS

The following are recommendations to assist in moving the discharge planning improvement process forward. The goal is to improve the discharge experience for New York residents and their families and increasing the percentage of patients who self-report understanding their discharge plan at time of discharge by 20%.

7.1 Evaluation of processes and tools used to identify discharge needs and develop appropriate protocols

A study conducted by the University of Pennsylvania School Of Nursing⁴⁶ identified 10 screening criteria that correlated to high risk on transition from the hospital to home. If two or more of the criteria exist, discharge planning needs to begin immediately. Those criteria are:

- Age 80 or older
- Moderate to severe functional deficits
- Active behavioral and/or psychiatric health issue
- Four or more active co-existing health conditions
- Six or more prescribed medications
- Two or more hospitalizations within the past 6 months
- A hospitalization within the past 30 days
- Inadequate support system
- Low health literacy
- Documented history of non-adherence to therapeutic regimen

Use of a standardized screening process to identify high risk individuals in need of more intensive discharge planning would lower the risk of re-hospitalization and/or institutionalization for these individuals.

As a next step, a scope of work will be developed to engage an outside vendor to conduct an evaluation of discharge planning processes and tools and to provide recommendations for the development and feasibility of a comprehensive discharge planning tool to be used throughout the State.

7.2 Revision of discharge planning regulations

A proposal is being developed by the Department to bring 10 NYCRR 405.9, NYS' hospital discharge planning requirements, into alignment with Medicare's CoP as they relate to hospital discharge planning. Included in this proposal is a

recommendation to develop the minimum elements, as appropriate, for all acute care discharge summaries.

- Admission and Discharge Diagnosis
- Procedures during Hospitalization
- History of Present Illness
- Allergies and Medications on Admission
- Past Medical History
- Past Surgical History
- Social/Family History
- Admission Review of Systems
- Physical Exam at time of discharge
- Lab, Imaging and Pathology results
- Hospital Course
- Patient Condition upon Discharge
- Dietary Instructions
- Discharge Medications, including what medications were discontinued
- Follow-Up appointment instructions and pending lab results
- Special Instructions, i.e. wounds care, home nursing, etc.

As a next step, the department is drafting a proposal to amend current state discharge planning regulations.

NOTE: On November 3, 2015, the Department of Health and Human Services issued a proposed rule, revising the discharge planning requirements for Medicare and Medicaid participation for hospitals, inpatient rehabilitation facilities, critical access hospitals, and home health agencies. Therefore, the decision to pursue the above recommendation will be delayed until a final rule is established.

7.3 Evaluation of presumptive Medicaid eligibility efficacy in New York State

A study is necessary to determine if implementing presumptive Medicaid eligibility for long term services and supports will:

- Provide a safety net to ensure appropriate access to care by potentially eligible individuals thus providing complete access to health care services promptly;
- Make it possible for individuals to receive community care more quickly;
- Eliminate or lessen costly non-acute hospitalization while individuals are waiting for Medicaid eligibility determination.

As a next step, a scope of work will be developed to engage an outside vendor to conduct an evaluation of presumptive eligibility and its efficacy for New York State.

8. OTHER RECOMMENDATIONS

The following recommendations outline areas of discharge planning that require further exploration and attention. The recommendations below require input from other areas at both the State and Federal level.

8.1 Develop a public awareness campaign and educational materials

Develop a public awareness campaign and educational materials to increase awareness of patient rights and encourage participation in the discharge planning process.

Current proposed legislation is aimed at support and training for caregivers. Educational materials, training, and support need to be developed for self-directing patients and/or patients without a caregiver or support.

Collaborate with Healthcare Association of New York State (HANYNS) to encourage the use of instructions sheets and checklists to reduce skipping key steps and encourage patient participation in the discharge planning process. These tools should be included in admission packets, made available on hospital websites, and used in the discharge planning process.

8.2 Discharge planning requirements for observation status

A proposed bill in the House of Representatives, H.R. 1571, Improving Access to Medicare Coverage Act of 2015 (formerly H.R. 1179), would amend title XVIII of the Social Security Act to count outpatient observation services days toward satisfying the 3-day inpatient hospital stay requirement for coverage of skilled nursing facility services under Medicare. The bill is currently in the congressional committee, which will consider it before it can be sent to the House or Senate as a whole.

Amend New York State regulations, with input from hospitals, to require that patients classified as observation status receive a modified level of discharge planning.

In addition, conduct an audit to determine compliance with Public Health Law 2805-w, requiring hospitals to notify a patient orally and in writing that they are being assigned as observation status.

8.3 Implementation of care transitions models and value-based payment

A method for implementing care transition models tied to value-based payments is being explored through discussions with staff from the New York State Department of Health.

The introduction of VBP in NYS Medicaid is intended to strongly incentivize discharge planning and the reduction of readmissions. It is therefore recommended that the other activities foreseen to stimulate discharge planning are presented and organized in the context of this statewide effort.

9. APPENDIX A: STATE DISCHARGE PLANNING REGULATIONS⁴⁷

The governing body shall establish and implement written admission and discharge policies to protect the health and safety of the patients and shall not assign or delegate the functions of admission and discharge to any referral agency and shall not permit the splitting or sharing of fees between a referring agency and the hospital.

- A complete and permanent record shall be maintained of all patients admitted, including but not limited to the date and time of admission, name and address, date of birth, the next of kin or sponsor, veteran status (insofar as these are obtainable), the admitting diagnosis, condition, the name of the referring practitioner, the hospital attending practitioner or service, and as to discharge, the date and time, condition and principal diagnosis.

- The hospital shall adopt and make public the following admission notices to be provided to all patients receiving inpatient hospital care. Medicare patients shall be given the notice set forth in subparagraph (i) and all other inpatients shall be given the notice set forth in subparagraph (ii) of this paragraph.
 - (i) Hospital Admission Notice for Medicare Patients
 - You have the following rights under the New York State law:
 - Before you are discharged, you must receive a written Discharge Plan. You or your representative have the right to be involved in your discharge planning.
 - Your written Discharge Plan must describe the arrangements for any future health care that you may need after discharge. You may not be discharged until the services required in your written Discharge Plan are secured or determined to be reasonably available.
 - If you do not agree with the Discharge Plan or believe the services are not reasonably available, you may call the New York State Health Department to investigate your complaint and the safety of your discharge. The hospital must provide you with the Health Department's telephone number if you ask for it.
 - For important information about your rights as a Medicare patient, see the "IMPORTANT MESSAGE FROM MEDICARE," which you must receive when admitted to a hospital.

 - (ii) Hospital Admission Notice
 - An Important Message Regarding Your Rights as a Hospital Inpatient
 - Your Rights While a Hospital Patient
 - You have the right to receive all of the hospital care that you need for the treatment of your illness or injury. Your discharge date is determined only by YOUR health care needs, not by your DRG category or your insurance.
 - You have the right to be fully informed about decisions affecting your care and your insurance coverage. ASK

QUESTIONS. You have the right to designate a representative to act on your behalf.

- You have the right to know about your medical condition. Talk to your doctor about your condition and your health care needs. If you have questions or concerns about hospital services, your discharge date or your discharge plan, consult your doctor or a hospital representative (such as the nurse, social worker, or discharge planner).
- Before you are discharged you must receive a written DISCHARGE NOTICE and a written DISCHARGE PLAN. You and/or your representative have the right to be involved in your discharge planning.
- You have the right to appeal the written discharge plan or notice you receive from the hospital.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

- Be sure you have received the written notice of discharge that the hospital must give you. You need this discharge notice in order to appeal.
- This notice will say who to call and how to appeal. To avoid extra charges you must call to appeal by 12 noon of the day after you receive the notice. If you miss this time you may still appeal. However, you may have to pay for your continued stay in the hospital, if you lose your appeal.

Discharge Notice

- In addition to the right to appeal, you have the right to:
 - Receive a written discharge plan that describes the arrangements for any future health care you may need after discharge. You may not be discharged until the services required in your written discharge plan are secured or determined by the hospital to be reasonably available. You also have the right to appeal this discharge plan.

Discharge:

The hospital shall ensure that each patient has a discharge plan which meets the patient's post-hospital needs. No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient.

A staff member shall be designated to coordinate the required reporting to the New York State Central Register of Child Abuse and Maltreatment and the hospital's actions taken with respect to such cases in accordance with procedures set forth in article 6, title 6 of the State Social Services Law.

The hospital shall ensure:

- (i) that discharge planning staff have available current information regarding home care programs, institutional health care providers, and other support services within the hospital's primary service area, including their range of services, admission and discharge policies and payment criteria;

- (ii) the utilization of written criteria as part of a screening system for the early identification of those patients who may require post-hospital care planning and services. Such criteria shall reflect the hospital's experience with patients requiring post-hospital care and shall be reviewed and updated annually;
- (iii) that upon the admission of each patient, information is obtained as required to assist in identifying those patients who may require post-hospital care planning;
- (iv) that each patient is screened as soon as possible following admission in accordance with the written criteria described in subparagraph (ii) of this paragraph and that this screening is (v) that each patient identified through the screening system as potentially in need of post-hospital care is assessed by those health professionals whose services are appropriate to the needs of the patient to determine the patient's post-hospital care needs. Such assessment shall include an evaluation of the extent to which the patient or patient's personal support system can provide or arrange to provide for identified care needs while the patient continues to reside in his/her personal residence;
- (vi) that for each patient determined to need assistance with post-hospital care, the health professionals whose services are medically necessary, together with the patient and the patient's family/representative shall develop an individualized comprehensive discharge plan consistent with medical discharge orders and identified patient needs;
- (vii) that each patient determined to need assistance with post-hospital care and the patient's family/representative receive verbal and written information regarding the range of services in the patient's community which have the capability of assisting the patient and the patient's family/representative in implementing the patient's individualized discharge plan which is appropriate to the patient's level of care needs;
- (viii) that the patient and the patient's family/representative shall have the opportunity to participate in decisions regarding the selection of post-hospital care consistent with and subject to any limitations of Federal and State laws. Planning for post-hospital care shall not be limited to placement in residential health care facilities for persons assessed to need that level of care, but shall include consideration of non-inpatient services such as home care, long-term home health care, hospice, day care and respite care;
- (ix) that when residential health care facility placement is indicated, the patient and the patient's family/representative shall be afforded the opportunity, consistent with and subject to any limitation of Federal and State laws, to participate in the selection of the residential health care facilities to which applications for admission are made.
- (x) that contact with appropriate providers of health care and services is made as soon as possible, but no later than the day of assignment of alternate level of care status and that each patient's record contains

a record of all such contacts including date of contact and provider response as well as a copy of any standard assessment form, including but not limited to any hospital/community patient review instrument as contained in section 400.13 of this Title and any home health assessment, completed by the hospital for purposes of post-hospital care;

(xi) that relevant discharge planning information is available for the utilization review committee; and

(xii) the development and implementation of written criteria for use in the hospital emergency service indicating the circumstances in which discharge planning services shall be provided for a person who is in need of post emergency care and services but not in need of inpatient hospital care.

The hospital shall establish and implement written policies and procedures governing the admissions and discharge process which ensure compliance with State and Federal antidiscrimination laws which apply to the operator. Discharge planners shall inform each patient and his/her family of the admission policies of the residential health care facilities to which they are referred.

The requirements of this subdivision relating to a patient's family/representative participating in the discharge planning process and in receiving an explanation of the reason for a patient's transfer or discharge shall not apply in the following circumstances:

- (i) when a competent adult patient objects to such participation by, or to an explanation regarding transfer or discharge being given to, any family/representative. Any such objections shall be noted in the patient's medical record; or
- (ii) when the hospital has made a reasonable effort to contact a patient's family/representative in order to provide an opportunity to participate in the discharge planning process or to explain the reason for transfer or discharge, and the hospital is unable to locate a responsible family member/representative, or, if located, such individual refuses to participate. The reasons a patient's family/representative did not participate in the discharge planning process or did not receive an explanation of the reason for a patient's transfer or discharge shall be noted in the patient's medical record. A reasonable effort shall include, but not be limited to, attempts to contact a patient's family/representative by telephone, telegram and/or mail.

The hospital shall ensure that no person presented for medical care shall be removed, transferred or discharged from a hospital based upon source of payment. Each removal, transfer or discharge shall be carried out after a written order made by a physician that, in his/her judgment, such removal, transfer or discharge will not create a medical hazard to the person or that such removal, transfer or discharge is considered to be in the person's best interest despite the potential hazard of movement. Such a removal, transfer or discharge shall be made only after explaining the need for removal,

transfer or discharge to the patient and to the patient's family/representative and prior notification to the medical facility expected to receive the patient.

- (i) The hospital shall maintain a record of all removals, discharges and transfers from the hospital, including the date and time of the hospital reception or admission, name, sex, age, address, presumptive diagnosis, treatment provided, clinical condition, reason for removal, transfer or discharge and destination. A copy of such information shall accompany any person transferred or discharged to a health care facility or a certified or licensed home care services agency and, where applicable, become a part of the person's medical record.
- (ii) Patients discharged from the hospital by their attending practitioner shall not be permitted to remain in the hospital without the consent of the chief executive officer of the hospital except in accordance with provisions of subdivision (g) of this section.
- (iii) In the absence of a written order of an attending practitioner discharging a patient, with respect to a patient who insists upon discharging himself from the hospital, the hospital shall obtain, where practicable, a written release from the patient absolving the hospital and the patient's attending practitioner of liability and damages resulting from such discharge.

Unless otherwise provided by law, the hospital shall ensure that a minor shall be discharged only in the custody of his parent, a member of his immediate family or his legal guardian or custodian, unless such parent or guardian shall otherwise direct.

The hospital shall develop and implement written policies and procedures pertaining to the review and communication of laboratory and diagnostic test/service results ordered for a patient while admitted or receiving emergency services to the patient. If the patient lacks medical decision-making capacity, the communication shall be to the patient's medical decision-maker. The results shall also be provided to the patient's primary care provider, if known. Such policies and procedures shall be reviewed and updated as necessary and at a minimum shall include:

- (iii) provisions to include in the discharge plan information regarding the patient's completed and pending laboratory and other diagnostic test/service results, medications, diagnoses, and follow-up care and to review such information with the patient or, if the patient is not legally capable of making decisions, the patient's parent, legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations;
- (iv) a requirement that patients may not be discharged from the hospital or the emergency room until any tests that could reasonably be expected to yield "critical value" results – results that suggest a life-threatening or otherwise significant condition such that it requires immediate medical attention – are reviewed by a physician, physician assistant (PA) and/or nurse practitioner (NP);
- (v) a requirement that before a patient is discharged, any critical laboratory test results are communicated to the patient or, if the patient is not legally capable of making decisions, the patient's parent,

- legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations;
- (vi) a requirement that all information be presented to the patient or if the patient is not legally capable of making decisions, the patient's parent, legal guardian or health care agent, or surrogate, as appropriate, subject to all applicable confidentiality laws and regulations, in a manner that reasonably assures that the patient, their parents or other medical decision makers understand the health information provided in order to make appropriate health decisions.

Hospital inpatient discharge review program:

(1) A hospital inpatient discharge review program applicable to all patients other than beneficiaries of title XVIII of the Federal Social Security Act (Medicare) shall be established in accordance with this subdivision. No hospital inpatient subject to the provisions of this subdivision may be discharged on the basis that inpatient hospital service in a general hospital is no longer medically necessary and that an appropriate discharge plan has been established unless a written notice of such determinations and a copy of the discharge plan have been provided to the patient or the appointed personal representative of the patient. The patient or the appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the discharge plan and receive a copy of both signed documents. Every hospital shall use the common notice set forth in paragraph (9) of this subdivision. The patient, or the appointed personal representative of the patient may request a review of such determinations by the appropriate independent professional review agent or review agent in accordance with paragraph (4) of this subdivision. Notwithstanding that the patient discharge review process provided in accordance with Federal law and regulation shall apply to beneficiaries of title XVIII of the Federal Social Security Act (Medicare), a written copy of the discharge plan, and discharge notice shall be provided to the beneficiary or the appointed personal representative of the beneficiary. The beneficiary or the appointed personal representative of the beneficiary shall have the opportunity to sign the documents and receive a copy of the signed documents.

(2) (i) For patients eligible for payments by state governmental agencies for hospital inpatient services as the patient's primary payor an independent professional review agent shall mean the commissioner or his designee. In conducting hospital inpatient discharge reviews in accordance with this paragraph, the commissioner may utilize the services of department personnel or other authorized representatives, including a review agent approved in accordance with subparagraph (ii) of this paragraph.

- (ii) For patients who are not beneficiaries of title XVIII of the Federal Social Security Act (Medicare) nor eligible for payments by state governmental agencies as the patient's primary payor, an independent professional review agent shall mean a third-party payor of hospital services or other corporation approved by the commissioner in writing for purposes of conducting hospital inpatient discharge reviews in accordance with this subdivision. For a third-

party payor of hospital services or other corporation to be approved as an independent professional review agent in accordance with this subparagraph, such third-party payor or other corporation must meet the following approval criteria:

(a) the review agent shall employ or otherwise secure the services of adequate medical personnel qualified to determine the necessity of continued inpatient hospital services and the appropriateness of hospital discharge plans;

(b) the review agent shall demonstrate the ability to render review decisions in a timely manner as provided in this subdivision;

(c) the review agent shall agree to provide ready access by the commissioner to all data, records and information it collects and maintains concerning its review activities under this subdivision;

(d) the review agent shall agree to provide to the commissioner such data, information and reports as the commissioner determines necessary to evaluate the review process provided pursuant to this subdivision;

(e) the review agent shall provide assurances that review personnel shall not have a conflict of interest in conducting a discharge review for a patient based on hospital or professional affiliation; and

(f) the review agent meets such other performance and efficiency criteria regarding the conduct of reviews pursuant to this subdivision established by the commissioner.

- The commissioner may withdraw approval of an independent professional review agent where such review agent fails to continue to meet approval criteria established pursuant to this subparagraph.

(iii) Each hospital shall enter into contracts with one or more independent professional review agents approved by the commissioner in accordance with subparagraph (ii) of this paragraph for purposes of conducting hospital inpatient discharge reviews in accordance with this subdivision for patients, including uncompensated care patients, who are not beneficiaries of title XVIII of the Federal Social Security Act (Medicare) nor eligible for payments by State governmental agencies as the patient's primary payor; provided, however, a payor of hospital service authorized under article 43 of the State Insurance Law or certified as health maintenance organizations under article 44 of the Public Health Law, may designate the review agent for their subscribers or beneficiaries or enrolled members and shall reimburse such designated review agent for costs of the discharge review program.

(3) (i) If a hospital and the attending physician agree that inpatient hospital service in a hospital is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the Federal Social Security Act (Medicare), and an appropriate discharge plan has been established for such patient, at that

time the hospital shall provide the patient or the appointed personal representative of the patient with a written discharge notice and a copy of the discharge plan, meeting the requirements of paragraph (1) of this subdivision.

- (ii) If a hospital has determined that inpatient hospital service in a hospital is no longer medically necessary for a patient, other than a beneficiary of title XVIII of the Federal Social Security Act (Medicare), and an appropriate discharge plan has been established for such patient but the attending physician has not agreed with the hospital's determinations, the hospital may request by telephone a review of the validity of the hospital's determinations by the appropriate independent professional review agent. Such review agent shall conduct a review of the hospital's determinations and prior to the conclusion of the review shall provide an opportunity to the treating physician and an appropriate representative of the hospital to confer and provide information which may include the patient's clinical records if requested by the review agent. Such review agent shall notify the hospital of the results of its review not later than one working day after the date the review agent has received the request, the records required to conduct such review, and the date of such conferring and receipt of an additional information requested. The hospital shall provide notice to the attending physician of the results of the review. If the review agent concurs with the hospital's determinations, the hospital shall provide the patient or his appointed personal representative with a written notice of such determinations and notice that the patient shall be financially responsible for continued stay, and with a copy of the proposed discharge plan. The patient or the appointed personal representative of the patient shall have the opportunity to sign the notice and a copy of the proposed discharge plan and receive a copy of both signed documents. Every hospital shall use the notice set forth in paragraph (10) of this subdivision which shall indicate the determinations made, shall state the reasons therefor and that the patient's attending physician has disagreed, and shall state that the patient or the appointed personal representative of the patient may request a review of such determinations by the appropriate review agent.

(4) A patient in a hospital, or the appointed personal representative of the patient, who receives a written notice in accordance with subparagraph (3)(i) or (3)(ii) of this subdivision, may request a review by the appropriate review agent of the determinations set forth in such notice related to medical necessity of continued inpatient hospital service, the appropriateness of the discharge plan and the availability of required continuing health care services.

- (i) If a patient while still hospitalized or while no longer an inpatient, or the appointed personal representative of such patient, requests a review by the appropriate review agent, the hospital shall promptly provide to the review agent the records required to review the determinations. Such request for a patient no longer an inpatient shall take place no later than 30 days after receipt of a notice provided in accordance with paragraph (3) of this subdivision or seven days after

receipt of a complete bill for all inpatient services rendered, whichever is later. The review agent shall conduct a review of such determinations, and shall provide the treating physician and an appropriate representative of the hospital with an opportunity to confer and provide information prior to the conclusion of the review. The review agent shall provide written notice to the patient, or the appointed personal representative of the patient, and the hospital of the results of the review within three working days of receipt of the requests for review and the records required to review the determinations. The hospital shall provide notice to the attending physician of the results of the review.

- (ii) If a patient while still an inpatient in the hospital, or the appointed personal representative of the patient, requests a review by the appropriate review agent not later than noon of the first working day after the date the patient, or the appointed personal representative of the patient, receives the written notice, the hospital shall provide to the appropriate review agent the records required to review the determinations by the close of business of such working day. The appropriate review agent shall conduct a review of such determinations and provide written notice to the patient, or the appointed representative of the patient, and the hospital of the results of the review not later than one full working day after the date the review agent has received the request for review and such records. The hospital shall provide notice to the attending physician of the results of the review.

(5) If the appropriate review agent, upon any review conducted pursuant to subparagraph (3)(ii) or pursuant to paragraph (4) of this subdivision does not concur in the determinations, continued stay in a hospital shall be deemed necessary and appropriate for the patient for purposes of payment for such continued stay.

(6) If a patient eligible for payment for inpatient hospital services under the case-based payment per discharge system or the appointed personal representative of the patient, requests a review by the appropriate review agent in accordance with subparagraph (4)(ii) of this subdivision, the hospital may not demand or request any payment for additional inpatient hospital services provided to such patient subsequent to the proposed time of discharge and prior to noon of the day after the date the patient or the appointed personal representative of the patient receives notice of the results of the review by the review agent except deductibles, copayments, or other charges that would be authorized for a patient for whom inpatient hospital services in a hospital continue to be necessary and appropriate.

(7) In any review conducted pursuant to subparagraph (3)(ii) or pursuant to paragraph (4) of this subdivision, the review agent shall solicit the views of the patient involved, or the appointed personal representative of the patient, and the attending physician.

(8) Each patient, or the appointed personal representative of the patient, provided a notice by a hospital in accordance with paragraph (3) of this subdivision shall be provided at such time by the hospital with a notice of

such patient's right to request a discharge review in accordance with this subdivision. The patient or the appointed personal representative of the patient shall have the opportunity to sign this form and receive a copy of the signed form.

(9) Notice that inpatient hospital service is no longer medically necessary. For purposes of subparagraph (i) of paragraph (3) of this subdivision, the hospital shall utilize the following notices:

- (i) The following form shall be used for patients covered under the case payment system:

Date: / /

READ THIS LETTER CAREFULLY-IT CONCERNS YOUR PRIVATE INSURANCE BENEFITS OR MEDICAID BENEFITS OR IF YOU ARE UNINSURED

PATIENT NAME: _____ PRIMARY PAYOR AT DISCHARGE:

ATT. PHYS: _____ MR #: _____ ADM. DATE:

Dear Patient:

Your doctor and the hospital have determined that you no longer require care in the hospital and will be ready for discharge on:

_____/_____/_____
Day of Week Date

IF YOU AGREE with this decision, you will be discharged. Be sure you have already received your written discharge plan which describes the arrangements for any future health care you may need.

IF YOU DO NOT AGREE and think you are not medically ready for discharge or feel that your discharge plan will not meet your health care needs, you or your representative may request a review. Contact the review agent indicated on the reverse side of this letter if you would like a review of the discharge decision.

IF YOU WOULD LIKE A REVIEW, you should immediately, but not later than noon of (Day and Date) call the telephone number checked off on the reverse side of this page.

IF YOU CANNOT REQUEST THE REVIEW YOURSELF, and you do not have a family member or friend to help you, you may ask the hospital representative at extension, who will request the review for you.

IF YOU REQUEST A REVIEW, the following will happen:

1. The review agent will ask you or your representative why you or your representative think you need to stay in the hospital and also will ask your name, admission date and telephone number where you or your representative can be reached.
2. After speaking with you or your representative and your doctor and after reviewing your medical record, the review agent will make a decision which will be given to you in writing.

3. While this review is being conducted, you will not have to pay for any additional hospital days until you have received the review agent's decision.

IF THE REVIEW AGENT AGREES WITH THE DISCHARGE DECISION, you will be financially responsible for your continued stay after noon of the day after you or your representative has been notified of the review agent's decision.

IF THE REVIEW AGENT AGREES THAT YOU STILL NEED TO BE IN THE HOSPITAL: for Medicaid patients, Medicaid benefits will continue to cover your stay; for private health insurance patients, coverage for your continued stay is limited to the scope of your private health insurance policy.

NOTE: If you miss the noon deadline mentioned on the first page of this notice, you may still request a review. However, if the review agent disagrees with you, you will be financially responsible for the days of care beginning with the proposed discharge date.

If you would like a review of your hospital stay after you have been discharged, you may request a review by the review agent within thirty (30) days of the receipt of this notice or seven days after receipt of a complete bill from the hospital, whichever is later, by writing to the review agent.

I have received this notice on behalf of myself as the patient or as the representative of the patient:

____/____/____

Date

Signature Time

Relationship

- (ii) The following form shall be used for patients covered under a per diem reimbursement system:

DISCHARGE NOTICE

____/____/____
Date

READ THIS LETTER CAREFULLY-IT CONCERNS YOUR PRIVATE INSURANCE BENEFITS OR MEDICAID BENEFITS OR IF YOU ARE UNINSURED

PATIENT NAME: PRIMARY PAYOR AT DISCHARGE:

ATT. PHYS: MR #: ADM. DATE: //

Dear Patient:

Your doctor and the hospital have determined that you no longer require care in the hospital and will be ready for discharge on:

____/____/____
Day of Week Date

IF YOU AGREE with this decision, you will be discharged. Be sure you have already received your written discharge plan which describes the arrangements for any health care you may need when you leave the hospital.

IF YOU DO NOT AGREE and think you are not medically ready for discharge or feel that your discharge plan will not meet your health care needs, you or your representative may request a review of the discharge decision by contacting your review agent indicated on the reverse side of this page.

IMPORTANT NOTICE ABOUT THE PAYMENT FOR YOUR CARE

o If your hospital care is covered by private health insurance, you may be charged directly while you remain in the hospital while the discharge review is being conducted. Whether you have to pay during this period will depend on your private health insurance benefits and if the review agent agrees with you that you need to stay in the hospital.

o If your hospital care is covered under the Medicaid program, Medicaid will pay for the days you remain in the hospital while the discharge review is being conducted.

IF YOU WOULD LIKE A REVIEW, you should immediately, but not later than noon of (Day and Date) call the telephone number checked off on the reverse side of this page.

IF YOU CANNOT REQUEST THE REVIEW YOURSELF, and you do not have a family member or friend to help you, you may ask the hospital representative at extension, who will request the review for you.

IF YOU REQUEST A REVIEW, the following will happen:

1. The review agent will ask you or your representative why you or your representative think you need to stay in the hospital and also will ask your name, admission date and telephone number where you or your representative can be reached.
2. After speaking with you or your representative and your doctor and after reviewing your medical record, the review agent will make a decision which will be given to you in writing.

IF THE REVIEW AGENT AGREES WITH THE DISCHARGE DECISION, you will be financially responsible for your continued stay after noon of the day you or your representative has been notified of the review agent's decision.

IF THE REVIEW AGENT AGREES THAT YOU STILL NEED TO BE IN THE HOSPITAL: for Medicaid patients, Medicaid benefits will continue to cover your stay; for private health insurance patients, coverage for your continued stay is limited to the scope of your private health insurance policy.

NOTE: If you miss the noon deadline mentioned on the first page of this notice, you may still request a review. However, if the review agent disagrees with you, you will be financially responsible for the days of care beginning with the proposed discharge date.

If you would like a review of your hospital stay after you have been discharged, you may request a review by the review agent within thirty (30) days of the receipt of this notice or seven days after receipt of a complete bill from the hospital, whichever is later, by writing to the review agent.

I have received this notice on behalf of myself as the patient or as the representative of the patient:

_____/_____/_____
Signature Date Time

Relationship

10. APPENDIX B: FEDERAL DISCHARGE PLANNING REGULATIONS⁴⁸

Subject: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning (*Effective 5/17/13*)

- (1) §482.43 Condition of Participation: Discharge Planning
 - a. The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.
 - b. The hospital is required to specify in writing its discharge planning policies and procedures. The policies and procedures must address all of the requirements of 42 CFR 482.43(a) – 482.43(e). The hospital must take steps to assure that its discharge planning policies and procedures are implemented consistently.

- (2) §482.43(a) Standard: Identification of Patients in Need of Discharge Planning:
 - a. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.
 - b. If a hospital does not voluntarily adopt a policy of developing a discharge plan for every inpatient, then the hospital must evaluate all inpatients to identify those patients for whom the lack of an adequate discharge plan is likely to result in an adverse impact on the patient's health.
 - c. For hospitals that do not develop a discharge plan for every inpatient, the hospital's discharge planning policies and procedures must document the criteria and screening process it uses to identify patients likely to need discharge planning, including the evidence or basis for the criteria and process. They must also identify which staff are responsible for carrying out the evaluation to identify patients likely to need discharge planning.
 - d. The regulation requires that the identification of patients must be made at an early stage of the patient's hospitalization. This is necessary in order to allow sufficient time to complete discharge planning evaluations and develop appropriate discharge plans, for those patients who need them. (See §482.43((b)(5)) Ideally the identification process will be completed when the patient is admitted as an inpatient, or shortly thereafter. However, no citations will be made if the identification of patients likely to need discharge planning is completed at least 48 hours in advance of the patient's discharge and there is no evidence that the patient's discharge was delayed due to the hospital's failure to complete an appropriate discharge planning evaluation on a timely basis or that the patient was placed unnecessarily in a setting other than where he/she was admitted from primarily due to a delay in discharge planning.
 - e. If the patient's stay is for less than 48 hours, hospitals must nevertheless ensure that they are screened so that, if needed, the discharge planning process is completed before the patient's discharge.
 - f. Changes in the patient's condition may warrant development of a discharge plan for a patient not identified during the initial screening process. The hospital's discharge planning policies and procedures must address how the staff responsible for discharge planning will be made aware of changes in a patient's condition that require a discharge planning evaluation.
 - g. In the event that a patient is transferred to another hospital, any pertinent information concerning the identification of the patient's post-hospital needs should be in the

patient's medical record that is transferred with the patient. The receiving hospital then becomes responsible for the discharge planning process for the patient.

- (3) §482.43(b) Standard: Discharge Planning Evaluation
- a. The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
 - b. The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.
 - c. The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

Interpretive Guidelines:

§482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)

For every inpatient identified under the process required at §482.43(a) as at potential risk of adverse health consequences without a discharge plan, a discharge planning evaluation must be completed by the hospital. In addition, an evaluation must also be completed if the patient, or the patient's representative, or the patient's attending physician requests one. Unless the hospital has adopted a voluntary policy of developing an evaluation for every inpatient, the hospital must also have a process for making patients, including the patient's representative, and attending physicians aware that they may request a discharge planning evaluation, and that the hospital will perform an evaluation upon request. Hospitals must perform the evaluation upon request, regardless of whether the patient meets the hospital's screening criteria for an evaluation.

§482.43(b)(4)

Requires that the evaluation include assessment of the patient's capacity for self-care or, alternatively, to be cared for by others in the environment, i.e., the setting, from which the patient was admitted to the hospital. In general, the goal upon discharge is for a patient to be able to return to the setting in which they were living prior to admission. This may be the patient's home in the community or residence in a nursing home. In the case of transfer from another hospital, generally the preferred goal is to return the patient to the setting from which he/she presented to the transferring hospital.

The evaluation must consider what the patient's care needs will be immediately upon discharge, and whether those needs are expected to remain constant or lessen over time. If the patient was admitted from his/her private residence, the evaluation must include an assessment of whether the patient is capable of addressing his/her care needs through self-care. The evaluation must include assessment of whether the patient will require specialized medical equipment or permanent physical modifications to the home, and the feasibility of acquiring the equipment or the modifications being made. If the patient is not able to provide some or all of the required self-care, the evaluation must also address whether the patient has family or friends available who are willing and able to provide the required care at the times it will be needed, or who could, if willing, be trained by the hospital sufficiently to provide the required care.

§482.43(b)(3)

Requires the evaluation to consider the patient's likelihood of needing post-hospital services and the availability of such services.

If neither the patient nor the patient's family or informal caregiver(s) are able to address all of the required care needs, then the evaluation must determine whether there are community-based services that are available to meet the patient's needs while allowing the patient to continue living at home. For Example:

- Home health, attendant care, and other community-based services;
- Hospice or palliative care;
- Respiratory therapy;
- Rehabilitation services (PT, OT, Speech, etc.);
- End Stage Renal Dialysis services;
- Pharmaceuticals and related supplies;
- Nutritional consultation/supplemental diets; and/or
- Medical equipment and related supplies.

However, services may also include those that are not traditional health care services, but which may be essential to a patient's ongoing ability to live in the community, including, but not limited to:

- Home and physical environment modifications;
- Transportation services;
- Meal services; and/or
- Household services, such as housekeeping, shopping, etc.

Some of the information related to needed services will emerge from the required evaluation of the patient's ability to receive care in the home, either as self-care or provided by someone else. All patients, even those with a high capability for self-care, are likely to require some follow-up ambulatory health care services, e.g., a post-discharge appointment with their surgeon, specialist or primary care physician, or a series of appointments for physical or occupational therapy. Some patients might have more complex care needs which nevertheless may still be met in the home setting, depending on the specific clinical needs and the services available in the patient's community.

If the result of the evaluation is that the patient cannot receive required care if he/she returns to home, then an assessment must be made of options for transfer to another inpatient or residential health care facility that can address the patient's needs, including other types of hospitals, such as rehabilitation hospitals; skilled nursing facilities; assisted living facilities; nursing homes; or inpatient hospice facilities.

If prior to the hospital admission the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the evaluation must address whether that facility has the capability to provide the post-hospital care required by the patient. The post-discharge care requirements may be different than the care that was previously provided. This requires dialogue and cooperation between hospitals and post-hospital care facilities in the area served by the hospital, as well as with the physicians who provide care to patients in either or both of these settings.

Long term care facilities often express concern that hospitals discharge patients to their facilities with care needs that exceed their care capabilities, necessitating

sending the patient to the emergency department for care and possible readmission. On the other hand, hospitals often express concern that long term care facilities send patients to the emergency department with ambulatory care-sensitive conditions, i.e., conditions that either do not require an acute level of care, or which could have been prevented from escalating to an acute level had appropriate primary care been provided in a timely manner.

- While hospitals cannot address these concerns in isolation, they are expected to be knowledgeable about the care capabilities of area long term care facilities and to factor this knowledge into the discharge planning evaluation.

Hospitals are expected to have knowledge of the capabilities and capacities of not only of long term care facilities, but also of the various types of service providers in the area where most of the patients it serves receive post-hospital care, in order to develop a discharge plan that not only meets the patient's needs in theory, but also can be implemented. This includes knowledge of community services, as well as familiarity with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients.

If the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient.

Once the determination has been made that services will be necessary post-discharge, the team must then determine availability of those services or identify comparable substitutions. Included in the evaluation is coordination with insurers and other payer's, including the State Medicaid agency, as necessary to ensure resources prescribed are approved and available.

The ability to pay out of pocket for services must also be discussed with the family or other support persons. Although hospitals are not expected to have definitive knowledge of the terms of any given patient's insurance coverage or eligibility for community-based services, or for Medicaid coverage, they are expected to have a general awareness of these matters and their impact on the patient's post-discharge needs and prospects for recovery.

- For example, if the patient is a Medicare beneficiary, the hospital is expected to be aware of Medicare coverage requirements for home health care or admission to a rehabilitation hospital, a skilled nursing facility, or a long term care hospital, etc. and to make the beneficiary aware that they may have to pay out of pocket for services not meeting the coverage requirements.

Similarly, for Medicaid, they should know coverage options for home health, attendant care, and long term care services or have contacts at the State Medicaid agency that can assist with these issues. As noted above, hospitals are also expected to have knowledge of community resources to assist in arranging services.

The hospital CoP governing patients' rights at §482.13(b) provides that "The patient has the right to participate in the development and implementation of his or her plan of care." (CMS views discharge planning as part of the patient's plan of care). "The patient or his/her representative (as allowed under State law) has

the right to make informed decisions regarding his/her care” and “The patient’s rights include...being involved in care planning and treatment.” Accordingly, hospitals are expected to engage the patient, or the patient’s representative, actively in the development of the discharge evaluation, not only as a source of information required for the assessment of self-care capabilities, but also to incorporate the patient’s goals and preferences as much as possible into the evaluation. A patient’s goals and preferences may be, in the hospital’s view, unrealistic. Identifying divergent hospital and patient assessments of what is realistic enables a discussion of these differences and may result in an assessment and subsequent development of a discharge plan that has a better chance of successful implementation.

- (4) §482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

Interpretive Guidelines:

§482.43(b)(2)

The patient’s discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriate qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be considered a registered nurse or a social worker. The hospital’s written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the evaluation. The qualifications must include such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect the patient’s functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills. All personnel performing or supervising discharge planning evaluations, including registered nurses and social workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient’s expected post-discharge care needs can be met. It is acceptable for a hospital to include new staff who may not have had previous discharge planning experience, but who are being trained to perform discharge planning duties and whose work is reviewed by qualified personnel.

- (5) §482.43(b)(5) - The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

Interpretive Guidelines:

§482.43(b)(5)

After a patient has been identified as needing an evaluation, or after a request for an evaluation has been made by the physician, patient and/or patient’s representative, the evaluation must be completed timely. This means there must be sufficient time after completion to allow arrangements for post-hospital care to be made, without having to delay the patient’s

discharge in order to do so, or requiring the patient to transfer to a different setting from where he/she was admitted from primarily due to the delay in making appropriate arrangements. The comparatively short average length of stay of a short term acute care hospital inpatient necessitates prompt attention to patients' discharge planning needs in that type of hospital. Failure to complete the evaluation in a timely manner could make it more difficult to implement the patient's final discharge plan, and/or may cause an unnecessary delay in the patient's discharge from the hospital. While other types of hospitals with a longer average length of stay may be able to complete the evaluation at a later point after admission, they too must complete it on a timely basis to avoid delays in discharge.

Where a team approach is utilized by the hospital in developing the discharge planning evaluation, there must be a process to promote efficient collaboration among team members to complete the evaluation in a timely manner. Changes in patient condition throughout the hospitalization warrant adjustments to the discharge plan.

- (6) §482.43(b)(6) - The hospital must :
- a. discuss the results of the evaluation with the patient or individual acting on his or her behalf
 - b. include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan

Interpretive Guidelines:

§482.43(b)(6)

The results of the discharge planning evaluation must be discussed with the patient or the patient's representative. Documentation of this communication must be included in the medical record, including if the patient rejects the results of the evaluation. It is not necessary for the hospital to obtain a signature from the patient (or the patient's representative, as applicable) documenting the discussion.

The patient or the patient's representative must be actively engaged in the development of the plan, so that the discussion of the evaluation results represents a continuation of this active engagement. It would not be appropriate for a hospital to conduct an evaluation without the participation of the patient or the patient's representative, and then present the results of the evaluation to the patient as a finished product, since this would place the patient in a passive position that is not consistent with the requirements of the patient's rights CoP at §482.13(b).

The hospital must include the discharge planning evaluation in the patient's medical record in order for it to guide the development of the patient's discharge plan. Timely placement of the evaluation in the medical record facilitates communication among members of the patient's healthcare team who should participate in a multidisciplinary process to develop and implement the discharge plan. The evaluation and subsequent planning process may be a continuous one and hospitals may choose not to divide the process into distinct documents. The key requirement is that the evaluation

results are included in the patient's medical record and are used in the development of the features of the discharge plan.

- (7) 482.43(c) Standard: Discharge Plan - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

Interpretive Guidelines:

§482.43(c)(1)

The discharge plan that is based on the findings of the discharge planning evaluation must be developed by a registered nurse, social worker, or other appropriate qualified personnel, or by a person who is supervised by such personnel. State law governs the qualifications required to be considered a registered nurse or a social worker. The hospital's written discharge planning policies and procedures must specify the qualifications for personnel other than registered nurses or social workers who develop or supervise the development of the plan.

The qualifications should include such factors as previous experience in discharge planning, knowledge of clinical and social factors that affect the patient's functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs, and assessment skills. All personnel performing or supervising development of discharge plans, including registered nurses and social workers, must have knowledge of clinical, social, insurance/financial and physical factors that must be considered when evaluating how a patient's expected post-discharge care needs can be met.

The hospital CoP governing patients' rights at §482.13(b) provides that "The patient has the right to participate in the development and implementation of his or her plan of care." (CMS views discharge planning as part of the patient's plan of care). "The patient or his/her representative (as allowed under State law) has the right to make informed decisions regarding his/her care" and "The patient's rights include being involved in care planning and treatment." Accordingly, hospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge plan, not only to provide them the necessary education and training to provide self-care/care, but also to incorporate the patient's goals and preferences as much as possible into the plan. A patient will be more likely to cooperate in the implementation of a discharge plan that reflects his/her preferences, increasing the likelihood of a successful care transition and better health outcomes.

A patient's goals and preferences may be, in the hospital's view, unrealistic. A hospital is not obligated to develop a discharge plan that cannot be implemented. However, the fact that a plan incorporating the patient's goals and preferences might be more time-consuming for the hospital to develop and implement than another alternative does not make the patient's preferred plan unrealistic.

(8) §482.43(c)(2) - In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

Interpretive Guidelines:

§482.43(c)(2)

If a patient is not identified through the hospital's discharge planning evaluation process as requiring a discharge plan, the patient's physician may nevertheless request a discharge plan. The hospital must develop a discharge plan when requested to do so by the patient's physician. If the hospital's policies and procedures call for a discharge plan for every hospital inpatient, then it is not necessary to include a separate provision in those policies requiring development of a plan upon physician request, since such a provision would be superfluous.

(9) §482.43(c)(3) - The hospital must arrange for the initial implementation of the patient's discharge plan.

§482.43(c)(5) - As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

Interpretive Guidelines:

§482.43(c)(3) & §482.43(c)(5)

The hospital is required to arrange for the initial implementation of the discharge plan. This includes providing in-hospital education/training to the patient for self-care or to the patient's family or other support person(s) who will be providing care in the patient's home. It also includes arranging:

- Transfers to rehabilitation hospitals, long term care hospitals, or long term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;
- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction and training in how to provide care is essential. The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance. Although it may be an important component of the

discharge instructions, it is not acceptable to only advise a patient to “return to the ED” whenever problems arise.

There are a variety of tools and techniques that have focused on improving the support provided to patients who are discharged back to their homes. A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including, but not limited to:

- Improved education) to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help. Teaching methods must be based on recognized methodologies. CMS does not prescribe any specific methodologies, but examples include the teach-back, repeat-back approach and simulation laboratories;
- Written discharge instructions, in the form of checklists when possible, that are legible, in plain language, culturally sensitive and age appropriate;
- Providing supplies, such as materials for changing dressings on wounds, needed immediately post-discharge; and
- A list of all medications the patient should be taking after discharge, with clear indication of changes from the patient’s pre-admission medications;

The education and training provided to the patient or the patient’s caregiver(s) by the hospital must be tailored to the patient’s identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training.

It is also necessary to provide information to patients and their support persons when the patient is being transferred to a rehabilitation or a long term care hospital, or to a long term care setting, such as a skilled nursing facility or nursing facility. The information should address questions such as: the goal of treatment in the next setting and prospects for the patient’s eventual discharge home.

The hospital must document in the patient’s medical record the arrangements made for initial implementation of the discharge plan, including training and materials provided to the patient or patient’s informal caregiver or representative, as applicable.

(10) §482.43(c)(4) - The hospital must reassess the patient’s discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

Interpretive Guidelines:
§482.43(c)(4)

Changes in a patient's condition may warrant adjustments to the discharge plan. Hospitals must have in place either a routine reassessment of all plans or a process for triggering a reassessment of the patient's post-discharge needs, capabilities and discharge plan when significant changes in the patient's condition or available supports occur.

(11) §482.43(c)(6) - The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) - This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) - For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(12) §482.43(c)(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(13) §482.43(c)(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

Interpretative Guidelines:

§482.43(c)(6), §482.43(c)(7) & §482.43(c)(8)

The hospital must include a list of Medicare-participating home health agencies (HHAs) and skilled nursing facilities (SNFs) in the discharge plan for those patients for whom the plan indicates home health or post-hospital extended care services are required.

- "Extended care services" are defined at sections 1861(h) and (i) of the Social Security Act as items or services furnished in a skilled nursing facility (SNF). SNFs included on the list must be located in a geographic area that the patient or patient's representative indicated he/she prefers.
- For Home Health Agencies (HHAs) the list must consist of Medicare-participating HHAs that have requested the hospital to be listed and which serve the geographic area where the patient lives. Hospitals may expect the HHA to define its geographic service area when it submits its request to be listed.

During the discharge planning process the hospital must inform the patient of his/her freedom to choose among Medicare-participating post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit which qualified providers the patient may choose among. Hospitals have the flexibility either to develop their own lists or to print a list of skilled nursing facilities and home health agencies in the applicable geographic areas from the CMS websites, Nursing Home Compare (<https://www.medicare.gov/nursinghomecompare/search.html>) and Home Health Compare (<https://www.medicare.gov/homehealthcompare/>). If hospitals develop their own lists, they are expected to update them at least annually. (69 FR 49226, August 11, 2004)

If the patient is enrolled in a managed care insurance program that utilizes a network of exclusive or preferred providers, the hospital must make reasonable attempts, based on information from the insurer, to limit the list to HHAs and SNFs that participate in the insurer's network of providers.

If the hospital has a disclosable financial interest in a HHA or SNF on a patient's list, or an HHA or SNF on the list has a disclosable financial interest in the hospital, these facts must also be stated on the list provided to the patient. Surveyors are not expected to know the requirements for a disclosable financial interest under Part 420, Subpart C, but hospitals are expected to know and comply with these requirements, and to identify for the surveyor whether there are such disclosable financial interests between the hospital and any specific HHAs or SNFs to which they refer/transfer patients. When the patient or the patient's family has expressed a preference, the hospital must attempt to arrange post-hospital care with an HHA or SNF, as applicable, which meets these preferences. If the hospital is unable to make the preferred arrangement, e.g., if there is no bed available in the preferred SNF, it must document the reason the patient's preference could not be fulfilled and must explain that reason to the patient.

(14) §482.43(d) Standard: Transfer or Referral - The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Interpretive Guidelines:

§482.43(d)

The hospital must take steps to ensure that patients receive appropriate post-hospital care by arranging, as applicable, transfer to appropriate facilities or referrals to follow-up ambulatory care services.

"Appropriate facilities, agencies, or outpatient services" refers to entities such as skilled nursing facilities, nursing facilities, home health agencies, hospice agencies, mental health agencies, dialysis centers, suppliers of durable medical equipment, suppliers of physical and occupational therapy, physician offices, etc. which offer post-acute care services that address the patient's post-hospital needs identified in the patient's discharge planning evaluation. The term does not refer to non-healthcare entities, but hospitals also are encouraged to make appropriate referrals to community-based resources that

offer transportation, meal preparation, and other services that can play an essential role in the patient's successful recovery.

"Appropriate facilities" may also include other hospitals to which a patient is transferred for follow-up care, such as rehabilitation hospitals, long term care hospitals, or even other short-term acute care hospitals.

Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient's physician aware of the outcome of hospital treatment or follow-up care needs. This is particularly important since the increasing use of hospitalists in the inpatient hospital setting means the patient's physician may have had no interaction with the patient throughout the hospital stay. When the hospital provides the patient's physician with necessary medical information promptly, among other things, this provides an opportunity for the patient's physician to discuss with the hospital care team changes to the patient's preadmission medication regimen or other elements of the post-discharge care plan about which the physician may have questions. Facilitating opportunities for such communication and dialogue enhances the likelihood of better patient outcomes after discharge.

The "medical information" that is necessary for the transfer or referral includes, but is not limited to:

- Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;
- Brief description of hospital course of treatment;
- Patient's condition at discharge, including cognitive and functional status and social supports needed;
- Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);
- List of allergies (including food as well as drug allergies) and drug interactions;
- Pending laboratory work and test results, if applicable, including information on how the results will be furnished;
- For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and
- For patients discharged home:
 - Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);
 - If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.
 - If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.

The regulation requires transfer or referral along with necessary medical information. In the case of a patient being transferred to another inpatient or residential health care facility, the necessary information must accompany the patient to the facility. However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient's physician may take place up to 7 days after discharge or prior to the first appointment for ambulatory care services that may have been scheduled, whichever comes first. If the patient's physician is not yet able to accept the information electronically from the hospital, the hospital may provide the information to the patient with instructions to give this information to the physician at their next appointment.

It is recognized that hospitals have certain constraints on their ability to accomplish patient transfers and referrals:

- They must operate within the constraints of their authority under State law;
- A patient may refuse transfer or referral; or
- There may be financial barriers limiting a facility's, agencies, or ambulatory care service provider's willingness to accept the patient. In such cases the hospital does not have financial responsibility for the post-acute care services. However, hospitals are expected to be knowledgeable about resources available in their community to address such financial barriers, such as Medicaid services, availability of Federally Qualified Health Centers, Area Agencies on Aging, etc., and to take steps to make those resources available to the patient. For example, in most states hospitals work closely with the Medicaid program to expedite enrollment of patients eligible for Medicaid.

(15) §483.43(e) Standard: Reassessment - The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Interpretive Guidelines:

§483.43(e)

The hospital must reassess the effectiveness of its discharge planning process on an ongoing basis. Since the QAPI CoP at §482.21 requires the QAPI program to be hospital-wide, the discharge planning reassessment process is considered an integral component of the overall hospital QAPI program.

The hospital must have a mechanism in place for ongoing reassessment of its discharge planning process. The reassessment process must include a review of discharge plans in closed medical records to determine whether they were responsive to the patient's post-discharge needs. One indicator of the effectiveness of the discharge plan is whether or not the discharge was followed by a preventable readmission. Accordingly, hospitals are expected to track their readmission rates and identify potentially preventable readmissions.

Typically readmissions at 7, 15, 30 days, or even longer, after discharge are tracked by analysts studying readmissions to short-term acute care hospitals.

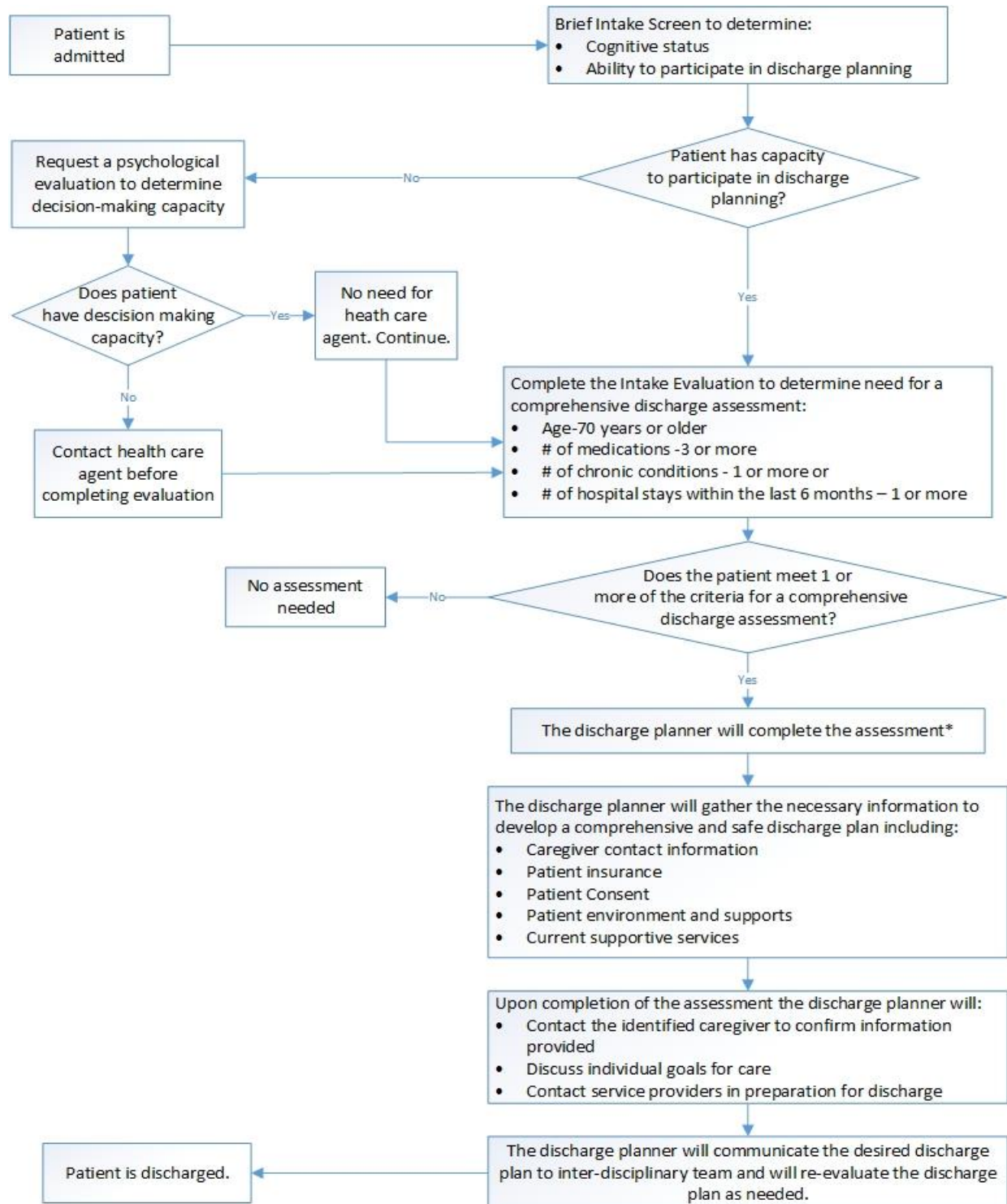
Hospitals must choose at least one interval to track. Since there are National Quality Forum-endorsed readmissions measures that use a 30-day interval, and since such measures are permitted by law to be used by CMS for payment-related purposes, it might be prudent for a hospital to track its 30-day readmissions rate, but other intervals are permissible. It is understood that information on post-discharge admissions to other hospitals may not be readily available to hospitals, but all hospitals are expected to track readmissions to their own hospital, and to do so on an ongoing basis, i.e., at least quarterly. Hospitals may employ various methodologies to identify potentially preventable readmissions. There are proprietary products that, for example, use claims data to identify such cases. Hospitals are expected to document their methodology for tracking their readmissions rates.

Once the hospital has identified potentially preventable readmissions, it is expected to conduct an in-depth review of the discharge planning process for a sample of such readmissions (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger is suggested but not required) in order to determine whether there was an appropriate discharge planning evaluation, discharge plan, and implementation of the discharge plan.

Hospitals are also expected to follow up on trends identified through analysis of their readmissions, such as a concentration of readmissions related to post-surgical infections, discharges from a particular service or unit, discharges to a particular extended care facility or home health agency, discharges with the same primary diagnosis on the first admission, etc. Such clustering or concentration may identify areas requiring more follow-up analysis and potential remedial actions.

Having identified factors that contribute to preventable readmissions, hospitals are expected to revise their discharge planning and related processes to address these factors. Consistent with the requirements under the QAPI CoP, the hospital's governing body, medical leadership and administrative leadership are all expected to ensure that identified problems are addressed, with further ongoing reassessment to achieve improvement.

11. APPENDIX C: EXAMPLE OF A DISCHARGE PLANNING PROCESS



*no later than 2 business days after admission

12. APPENDIX D: CARE TRANSITIONS MODELS

Current Care Transition Projects

The Community-Based Care Transitions Program

The CMS has provided funding through 2015 for the CCTP, created by Section 3026 of the ACA, to test care delivery models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. These demonstration programs partner with hospitals and other providers to provide care transition services to effectively manage Medicare patients' transitions and improve their quality of care.

CCTP differs from a grant program in that it does not pay for administrative overhead and infrastructure costs. Community-based organizations (CBOs) will be paid an all-inclusive rate per eligible discharge, determined based on the cost of care transition services provided at the patient level and systemic changes at the hospital level; however, the CBO will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

New York State has six projects that have been funded through this initiative.

Lifespan of Greater Rochester Inc. has partnered with four acute care hospitals; Rochester General, Unity, Strong Memorial, and Highland Hospitals; two home health agencies; two additional CBOs; and the Finger Lakes Health Systems Agency to provide care transition services to high-risk Medicare beneficiaries across four counties (Monroe, Wayne, Livingston and Ontario) in Western New York State.

Using a multi payer pilot applying the Coleman Care Transitions Intervention (CTI) model, Home Health Care (HHC) agencies and CBOs provide coaching services for Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or Medicare Advantage patients insured by two commercial plans and by the local Medicaid HMO. Coaching is currently implemented at four hospitals – two with high preventable readmission rates as reported by CMS. A New York State HEAL19 grant is implementing coaching for uninsured and Medicaid fee-for-service (FFS) patients.

The project designed a two-pronged intervention – the Coleman model CTI and enhanced hospital-based interventions for an estimated 5,500 patients. Approximately 70% of the 5,500 patients will be offered coaching and the enhanced hospital interventions.

Approximately 30% of the 5500 patients discharged to a SNF will receive just the enhanced hospital interventions.

Enhanced hospital-based services include a Pharmacist to obtain an accurate medication history at admission and to attend daily patient huddles; discharge

medication reconciliation to identify potential drug-related problems and use of hospital-based call centers to improve the transfer of information from the hospitalist to PCP and nursing homes.

Brooklyn Care Transition Coalition provides transition services and assistance to Medicare fee-for-service beneficiaries across 26 zip codes throughout northern and central areas of Brooklyn. The Cobble Hill Health Center will serve as the lead CBO, partnering with The Brooklyn Hospital Center, the Interfaith Medical Center, and Independent Living Systems, Inc.

The P2 Collaborative of Western New York, Inc. serves as the regional coordinating body for 10 community hospitals across seven rural counties in western New York: Brooks Memorial Hospital (Chautauqua); Jones Memorial Hospital (Allegany); Olean General Hospital (Cattaraugus); Orleans Community Health (Orleans); TLC Health Network Lake Shore Health Care Center (Chautauqua); United Memorial Medical Center (Genesee); Westfield Memorial Hospital (Chautauqua); WCA Hospital (Chautauqua), and Wyoming Community Hospital (Wyoming County). Each participating hospital collaborates with a local CBO to build upon and expand existing care transition services for Medicare beneficiaries.

The Tompkins County Rural Community-based Care Transition Program (TCRCCTP) serves the Finger Lakes region of rural Central New York. The Tompkins County Office for the Aging works with Cayuga Medical Center, the County's sole hospital, and multiple local host agencies to improve the quality of care and reduce avoidable hospitalizations among Medicare beneficiaries.

Mt. Sinai Hospital and Mt. Sinai Hospital in Queens are partnering with the Institute for Family Health, a Federally Qualified Health Center network, to provide and expand care transition services to an estimated 4,800 high-risk Medicare beneficiaries per year. Aimed at decreasing readmission rates for high-risk Medicare beneficiaries, the program includes the development of a regional Queens Care Transition Collaborative. The Collaborative is a network of five acute care hospitals partnering with five community-based aging service providers. Participating hospitals include: Jamaica Hospital Medical Center, Flushing Hospital Medical Center, New York Hospital Queens, Queens Hospital Center, and Elmhurst Hospital Center.

Dominican Sisters Family Health Service, Inc. Building on a series of care transition pilots, Dominican Sisters Family Health Service, Inc., located in Long Island, New York, will spearhead the Suffolk County CCTP in partnership with Southampton Hospital and Stony Brook University Hospital. Using the LACE index risk prediction model for readmissions, hospitals will identify over 2,000 high-risk Medicare beneficiaries annually to receive the evidence-based CTI. The LACE index score is based on length of stay, Acuity of the admission, Co-morbidities and Emergency Department visits in the previous 6 months.

Balancing Incentive Program Innovation Grants

Through the BIP funding, several demonstration projects are being funded to pilot innovative concepts to enhance the discharge process.

Selfhelp Community Services, Inc., in New York City, is working to prevent hospital readmissions by targeting high-risk groups and supporting them through the discharge process to ensure a plan is in place and follow up is done. The project mirrors a CMS-funded program for Medicare and outlines use of similar procedures/protocols. The project is estimated to reach an estimated 1,380 patients from 3 hospitals.

Tompkins County Transitions Support Program provides a modified Coleman Care Transition Intervention model to support transitions from hospital to home. This project is based on previous work done through a CMS Innovation project funded through Section 3026 of the ACA, as well as work completed through a 2010 grant funded through the Administration on Community Living.

The program has two main tenets, the first being a Registered Nurse (RN) who provides medication reconciliation education and follow-up for any appointments with their PCP or other service providers; provides education to the patient on how to identify warning signs and how to address any of these symptoms, implements tele-monitoring when indicated; provides a home safety evaluation; and provides referrals to other services and supports when needed. Secondly, the Transitions Support Program will provide outreach to community service providers to enhance awareness and knowledge of the program and provide education on how to refer patients and clients to the program.

Building Bridges to Home and Community project in Niagara Falls provides education to discharge planners and strengthens the role of family caregivers of individuals with physical and behavioral issues through training, education and support.

Other care transition programs

New York Methodist Hospital in Brooklyn developed a patient-centric, post-acute care partnership to coordinate care when a patient is transferred from a hospital to a SNF or HHC service. By working with SNFs and HHC agencies, New York Methodist was able to improve the coordination of care for patients transitioning to another setting in the care continuum. As a result, the level of readmissions for patients enrolled in the program was reduced by almost 50%.

Elizabethtown Community Hospital ensures all patients are provided with a full continuum of care when they are discharged from the hospital. Every patient is called 24 to 72 hours after being discharged and assigned a Care Transitions Coach as needed. The Care Transitions Coach makes home visits, coordinates community services, and provides medication support for those patients at risk for readmission.

A Community-Based Care Transitions Committee, made up of 21 service agencies within the neighboring five counties, supports this program by providing key referrals for the supportive services needed by discharged patients. The efforts of the Care Transitions Program resulted in a 6% decrease in all-cause hospital readmissions in 2013.

Northeast Health uses a care transition program that focuses on high risk diagnoses of chronic heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease, and diabetes. Using this care transition model, Northeast Health has reduced its combined readmission rates for chronic heart failure, chronic obstructive pulmonary disease, and diabetes from 25% to 13.4% in two years.

Previous demonstration programs

Access to Community Care Project; In 2010, the CMS awarded “Implementing the Affordable Care Act: Aging and Disability Resource Centers” funding to the NYSDOH. The grant funded a pilot program that facilitated collaboration between Glens Falls Hospital, Washington County NY Connects and the Nursing Home Transition and Diversion (NHTD) program. The collaborative group developed protocols that expedited and enhanced access to community-based long term care for Medicaid eligible hospital patients and strengthened the relationship among local service providers and NY Connects. Recommendations from that program included:

- Use of a consistent assessment tool and process for assessing needs and developing service plans to promote continuity of care among successive Care Managers
- Long-term supports and service options from which to make informed choices should be clearly and concisely presented to the patient and family. It is important to provide this information via one-on-one meetings so that questions can be answered and new concerns can be immediately addressed
- Discharge plans should address short and long term patient needs and options, and be sufficiently flexible to accommodate evolving patient circumstances
- New Case Managers and Discharge Planners should be educated on available *HCBS and the availability of NY Connects as a resource to identify available HCBS*
- A dedicated staff person who “follows” patients across the continuum of care and assists nursing homes in fulfilling their Minimum Data Set (MDS) Section Q requirements by providing discharge planning assistance to those nursing home residents that have identified as wanting to receive more information about returning to the community

CTI Plus; With grants from the Administration on Community Living in 2009 and 2010, NYSOFA developed a volunteer patient navigation program based on Coleman’s CTI designed to supplement the formal care transition coach role. The

Tompkins County program was designed as a stand-alone effort in collaboration with Cayuga Medical Center. In Albany County, the Navigator program was a supplement to the 30-day CTI being implemented by Northeast Health in Albany Memorial and Samaritan Hospitals with the intent of looking at both 30 and 90-day outcomes. The volunteer provided guidance and assistance with non-medical tasks following discharge and provided patients and their families with the knowledge and awareness of available services in their community.

- In the Albany County Project less than 9% of patients who agreed to participate in traditional care transitions were readmitted to the hospital in 30 days; five of those who participated in the Navigation were readmitted within 30 days and all ten within 90 days. A review of patient data confirmed that the Navigation participants were more frail at baseline than the general care transitions participants
- In the Tompkins County Project all twelve participants completed a Navigation-only intervention and all 10 avoided readmission at 30 days and at 90 days.

Evidence Based Care Transitions Models Side by Side, March 2011

Evidence-based care transition models strive to smooth the transition from one setting to another and to reduce re-hospitalizations and other potentially adverse events. The following tables detail four hospital-to-home care transitions models and two models of care coordination that center on primary care. It is provided as a resource for organizations within the Aging Network that are interested in getting more involved with care transitions. The Technical Assistance Exchange (TAE) gathered the information presented here through a review of published articles about each model, a review of materials used in each model, and interviews with the founders of the models.

The models share the following elements:

- Interdisciplinary Communication/Collaboration
- Patient/Participant Activation
- Enhanced Follow-up

The Aging Network and Care Transitions: Preparing Your Organization

Hospital-to-Home Transitions Models

Model	Care Transitions Intervention (CTI), commonly called the "Coleman Model"	Transitional Care Model (TCM, commonly called the "Naylor Model")	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
<p>Short Description</p> <p>Transition Coach helps patients and families learn transition-specific self-management skills by:</p> <ul style="list-style-type: none"> • Conducting a hospital visit to introduce the program and tools such as the Personal Health Record (PHR) • Conducting one home visit 24-72 hours post-discharge <ol style="list-style-type: none"> 1. Actively engages patients in medication reconciliation and how to respond to medication discrepancies; helps them develop a clear, easy understandable medication regimen and enter into Personal Health Record 2. Uses role-playing and other tools to transfer skills to patients and family members on how to communicate care needs effectively during encounters with health care professionals 3. Reviews any "red flags" that indicate a worsening condition, and strategies for how to respond <ul style="list-style-type: none"> • Making three follow up phone calls focused on reviewing the progress toward established goals, discussing any encounters with other health care professionals, reinforcing the importance of maintaining and sharing the personal health record, and supporting the patient's self-management role 	<p>The Transitional Care Nurse:</p> <ul style="list-style-type: none"> • Visits patient in the hospital to <ol style="list-style-type: none"> 4. Conduct an in-hospital assessment (including the patients' functional status) 5. Collaborate with care-team members to reduce adverse events and prevent functional decline 6. Develop a streamlined, evidenced-based plan of care <ul style="list-style-type: none"> • Conducts home visit within 24 hrs of discharge to assess safety in completing ADLs and IADLs, recommend adaptations to the environment, and refer to other services • Accompanies patient on first visit with the physician post-discharge and subsequent visits if needed • Facilitates physician-nurse collaboration across episodes of care • Conducts weekly home visits for first month • Makes telephone contact for each week an in-person visit is not scheduled • Is on call seven days per week for home visits and telephone access • Provides active engagement of patients and family caregivers with focus on meeting their goals • Provides communication to, between, and among the patient, family caregivers, and health care providers. 	<p>BOOST includes specific interventions to mitigate high risk patients' risks for adverse events:</p> <ul style="list-style-type: none"> • A standardized discharge process • Efforts to improve patient/caregiver preparedness • Medication safety • Follow-up care <p>Tool for Addressing Risk: a Geriatric Evaluation for Transitions: TARGET is a 4-part tool that includes</p> <ul style="list-style-type: none"> • Risk stratification process using eight domains • Risk-specific intervention plan linked to the 8P risk score summary • Universal set of expectations for all patients being discharged from the hospital to home (the Universal Checklist) • General Assessment of Preparedness (GAP), a component list of issues important to providers and patients (and their caregivers) surrounding the readiness of patients for transition out of the hospital 	<p>A hospital-based social work model designed for older adults discharged home from an inpatient hospital stay to safely transition back to the community by providing:</p> <ul style="list-style-type: none"> • Intensive care coordination that starts in the hospital and continues after discharge to the community • Aging Resource Centers (ARC) inside hospitals that provide a dedicated space for older adults and their caregivers to explore community resources, health information and caregiving materials, and to develop community care plans prior to discharge. <p>Pre-discharge: Bridge Care Coordinators (BCCs) identify older adult patients who may be at risk for post-discharge complications and meet with them and/or their caregivers to identify unmet needs and to set up services prior to discharge. BCCs also prepare for discharge by reviewing medical records or meeting with an interdisciplinary team within the hospital.</p> <p>Post-discharge: BCCs call consumers 2 days after discharge to conduct a secondary assessment and intervene on identified needs, including understanding discharge instructions, transportation issues, physician follow-up, burdened caregivers, problems with home health care, difficulty obtaining and/or understanding medications.</p> <p>Follow-up: The BCC follows up with consumers at 30 days post-discharge to track their progress and address emerging needs.</p>	

The Aging Network and Care Transitions: Preparing Your Organization

Hospital-to-Home Transitions Models, continued

Model	Care Transitions Intervention (CTI), commonly called the "Coleman Model"	Transitional Care Model (TCM, commonly called the "Naylor Model")	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
Target Population	<p>Individuals 65 years or older, although applicable to younger populations as well. Patients should be community-dwelling adults with a working telephone. Appropriate for persons with depression or dementia provided they have a willing and able family caregiver.</p>	<p>Evaluation included cognitively intact older adults (program tested with patients 65 or older) with two or more risk factors among the following:</p> <ul style="list-style-type: none"> » Poor self-health ratings » Multiple chronic conditions » History of recent hospitalizations. <p>Currently being tested among cognitively impaired hospitalized older adults and long-term care recipients transferring to and from acute care hospitals</p>	<p>High-risk patients, particularly older adults</p>	<p>Older adults age 60+ years (and their caregivers) discharged home from the hospital, and who fulfill two of the following criteria:</p> <ul style="list-style-type: none"> » Discharged with a home health referral » Lives alone » Hospitalized in the past 6 months » Caregiver assessed as "stressed" or "overburdened" » Determination of need (DON) of 29 or higher
Length	<p>Four weeks</p>	<p>One to three months</p>	<p>During hospital stay with outpatient follow-up visit and or a 72-hour follow-up call for particularly high risk patients</p>	<p>During hospital stay and 30 days post-discharge</p>
Training	<p>In order to ensure model fidelity to achieve desired outcomes, to be recognized as an official Care Transitions Intervention, staff must attend a one-day training delivered either on-site or in Aurora (Denver)</p>	<p>The team at University of Pennsylvania has developed a series of web-based training modules that prepare nurses to become Transitional Care Nurses, as well as training on the clinical information system. It takes, on average, one month to orient a new Transitional Care Nurse.</p>	<ul style="list-style-type: none"> • 2 day training session for quality improvement teams to learn about the intervention, exchange ideas with other sites and work with their mentor to establish an action plan • Participation in the web-based BOOST National collaborative • Teach-Back training, video and curriculum for local use to train clinicians to improve communication with patients. 	<p>Bridge Training Module</p>

The Aging Network and Care Transitions: Preparing Your Organization

Hospital-to-Home Transitions Models, continued

Model	Care Transitions Intervention (CTI, commonly called the "Coleman Model")	Transitional Care Model (TCM, commonly called the "Naylor Model")	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
Staff qualifications	Transition Coach needs strong interpersonal and communication skills, the ability to make the shift from doing things for patients to facilitating skill transfer so that patients can do more for themselves.	Transitional Care Nurse in published studies was an advanced practice nurse (had a masters degree in nursing with advanced knowledge and skills in serving older adults). Currently evaluating outcomes with bachelors-prepared nurses.	Hospital-based multidisciplinary teams	Master's prepared social workers deployed at hospitals
Estimated costs	From research study: The total annual intervention cost was \$74,310 (\$196 per patient)	From research study: The total annual intervention cost was \$115,856 (\$982 per patient)	NA	NA
Web site	http://www.caretransitions.org	http://www.transitionalcare.info/	http://www.hospitalmedicine.org/ResourceRoom/ReDesign/RR_CareTransitions/html_CC/03BestPmc/03_Literature.cfm	www.transitionalcare.org

13. APPENDIX E: DEFINITIONS

Medication Reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
Observation Status	A hospital outpatient is a person who has been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services from the hospital.
Care Transition	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Care Transition Models	Evidence-base care transition models strive to smooth the transition from one setting to another and to reduce re-hospitalizations and other potentially adverse events.
Presumptive Eligibility	Presumptive Eligibility allows an individual who appears to be eligible for Medicaid to be temporarily enrolled while the full eligibility process is completed. This allows the individual to receive services while final Medicaid determination is confirmed.
Discharge Planning	Discharge planning is the term used to describe how a patient will be cared for when he or she is discharged from a hospital, or acute care setting. It is a process that typically involves a panel that may include a dedicated discharge planner, nurse, case manager, or interdisciplinary team. The goal is to conduct an assessment, which will identify the patient's post discharge needs. In doing so, the team, along with family may effectively coordinate, plan and implement any steps necessary to ensure a safe and healthy environment for the patient.
Patient Centered Approach	While traditional models of providing medical care may involve physicians diagnosing patients and dictating a treatment plan, a patient-centered approach involves patient participation in the medical decision-making process. This concept is based on the premise that patients can accurately determine how well their needs are being met and, therefore, physicians should work in collaboration with their patients.

14. APPENDIX F: ACRONYMS

Acronym	Description
ACA	Affordable Care Act
ACO	Accountable Care Organization
ADM	Administrative Directives
BIP	Balancing Incentive Program
CARE Act	Caregiver Advise, Record and Enable Act
CBO	Community-Based Organization
CCTP	Community-Based Care Transitions Program
CMS	Centers For Medicare & Medicaid Services
CoP	Conditions of Participation
CTI	Care Transitions Intervention
DSRIP	Delivery System Reform Incentive Payment Program
FFS	Fee-for-Service
LDSS	Local Department of Social Services
LEP	Limited English Proficient
LTSS	Long-Term Services and Supports
HANYS	Healthcare Association of New York State
HARP	Health and Recovery Plan
HCBS	Home and Community Based Services
HHC	Home Health Care
HMO	Health Maintenance Organization
HPE	Hospital Presumptive Eligibility
IT	Information Technology
MDS	Minimum Data Set
MLTC	Managed Long Term Care
MOLST	Medical Orders for Life-Sustaining Treatment
MRG	Medicaid Reference Guide
NHTD	Nursing Home Transition and Diversion Program
NWD	No Wrong Door
NYS	New York State
NYSDOH	New York State Department of Health
NYSOFA	New York State Office for the Aging
OMH	Office of Mental Health
OPWDD	Office for People with Developmental Disability.
PASRR	Preadmission Screen Resident Review

Acronym	Description
PCP	Primary Care Physician
PE	Presumptive Eligibility
PPO	Preferred Provider Organization
PRI	Patient Review Instrument
RHIO	Regional Health Information Organization
RHCF	Residential Health Care Facility
RN	Registered Nurse
SHIN-NY	Statewide Health Information Network for New York
SNF	Skilled Nursing Facility
TCRCCTP	Tomkins County Rural Community-based Care Transition Program
UAS	Uniform Assessment System
VBP	Value Based Payment

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