

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Discharge Planning





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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

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INTRODUCTION

Discharge planning is conducted to plan for when a patient or resident leaves a care setting. Health care professional(s) and the patient or resident participate in discharge planning activities.

The charts on the following pages provide information on Medicare discharge planning for the following provider types:

- ❖ Acute Care Hospitals, Inpatient Rehabilitation Facilities (IRF), and Long Term Care Hospitals (LTCH);
- ❖ Home Health Agencies (HHA);
- ❖ Hospices;
- ❖ Inpatient Psychiatric Facilities (IPF);
- ❖ Long Term Care (LTC) Facilities; and
- ❖ Swing Beds.



PROVIDER CHARTS

ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH)

Acute care hospitals provide acute hospital inpatient care to the patient. The average length of stay (LOS) for acute care hospitals is 2–3 days. IRFs and LTCHs provide post-acute care to the patient. The average LOS for IRFs is 13 days and for LTCHs it is 25 days.

Discharge Planning Process

When “you” is used in this chart, we are referring to acute care hospitals/post-acute care facilities.

An acute care hospital/post-acute care facility patient’s plan of care includes information about discharge planning activities and a discharge planning evaluation.

Discharge planning involves:

- ❖ Determining the appropriate post-hospital discharge destination for a patient;
- ❖ Identifying what the patient requires for a smooth and safe transition from the acute care hospital/post-acute care facility to his or her discharge destination; and
- ❖ Beginning the process of meeting the patient’s identified pre- and post-discharge needs.

When the discharge planning process is well executed and there are no unavoidable complications or unrelated illnesses or injuries, the patient may continue progressing toward the goals of his or her plan of care after discharge.



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning Process

Medicare-participating acute care hospitals/post-acute care facilities must identify patients who need or have requested a discharge plan at an early stage of their hospitalization. The discharge planning process must be thorough, clear, comprehensive, and understood by acute care hospital/post-acute care facility staff as well as the patient and/or the patient's representative.

The physician may make the final decision on whether a discharge plan is necessary. If a physician requests a discharge plan, you must develop such a plan, even if the interdisciplinary team determines that it is not necessary (as applicable).

Depending on the patient's needs, discharge planning may be completed by personnel in multiple disciplines who have specific expertise. You may designate discharge planning responsibilities to appropriate qualified personnel such as registered nurses, social workers, pharmacists, or other qualified personnel. These individuals should have:

- ❖ Discharge planning experience;
- ❖ Knowledge of social and physical factors that affect functional status at discharge;
- ❖ Knowledge of appropriate community-based services, supports, and facilities that can meet the patient's post-discharge clinical and social needs; and
- ❖ Knowledge of the patient's unique medical and other service and support needs.



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

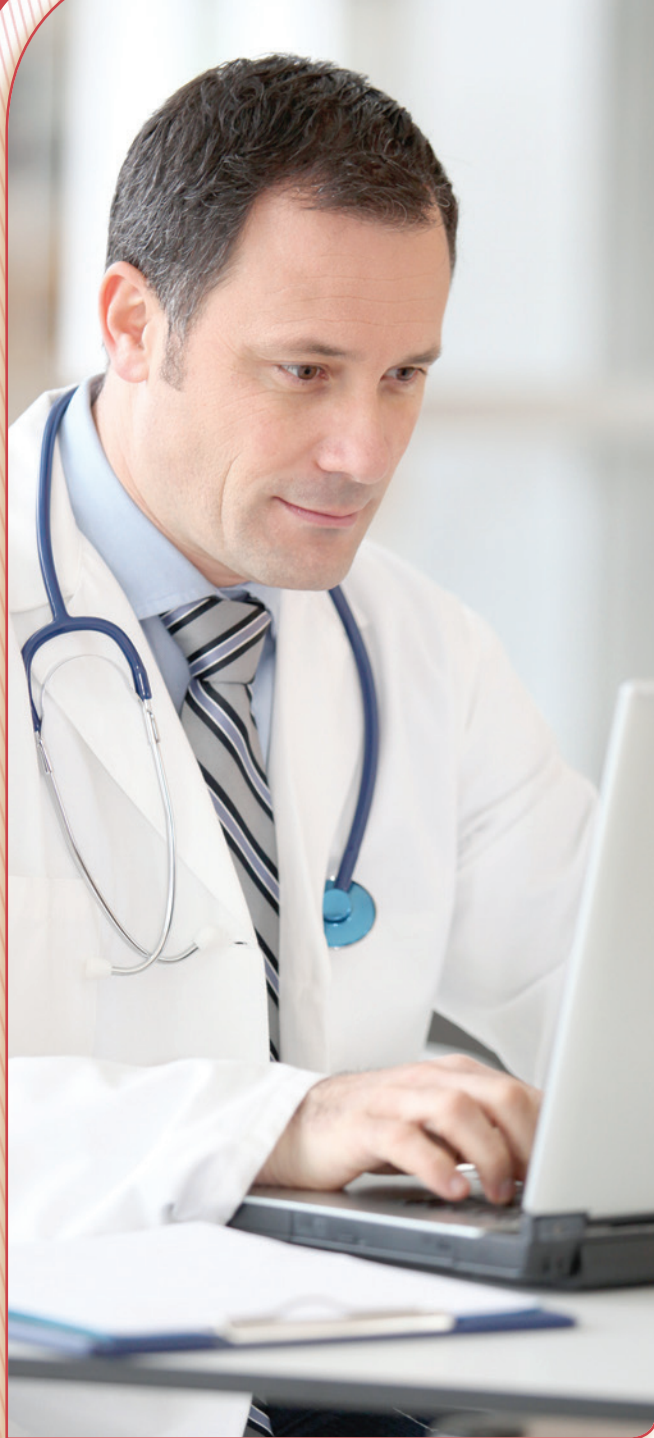
Discharge Planning Process

Appropriate facilities and vendors are those that can meet the patient's assessed needs on a post-discharge basis and comply with Federal and State health and safety standards.

The discharge planning process includes:

- ❖ Implementing a complete, timely, and accurate discharge planning evaluation process, including identification of high risk criteria;
- ❖ Maintaining a complete and accurate file of appropriate community-based services, supports, and facilities where the patient can be transferred or referred. These services, supports, and facilities include Nursing Facility (NF) or Skilled Nursing Facility (SNF) care, long-term acute care, rehabilitation services, Home Health care, Hospice, or other appropriate care (such as home-based supports); and
- ❖ Coordinating the discharge planning evaluation among various disciplines responsible for patient care.

Discharge planning is not required for outpatients, including those who present to an acute care hospital emergency department and who are not admitted as hospital inpatients. However, hospitals may find it beneficial to provide some discharge planning services to selected categories of outpatients (such as emergency department or same-day surgery patients).



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning Evaluation

Unless you develop a discharge planning evaluation for every patient, you must have a process to notify patients, patients' representatives, and attending physicians that they may request an evaluation. You must also convey that the discharge planning evaluation will be completed upon request.

The discharge planning evaluation determines the patient's continuing care needs after he or she leaves the acute care hospital/post-acute care facility setting. Appropriate qualified personnel must complete discharge planning evaluations:

- ❖ For every patient who is identified at potential risk of adverse health consequences without a discharge plan; and
- ❖ If the patient, the patient's representative, or the attending physician requests such evaluation.

Depending on the patient's clinical condition and anticipated LOS, you should complete the discharge planning evaluation as soon as possible after admission and update it periodically during the patient's stay.

You must include the discharge planning evaluation in the patient's clinical record. It considers the patient's care needs immediately upon discharge and whether the needs are expected to remain constant, lessen, or worsen over time. The discharge planning evaluation identifies appropriate after-acute care hospital/post-acute care facility care services, supports, and facilities as



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning Evaluation

well as the availability of such services, supports, and facilities. It includes an assessment of:

- ❖ A summary of the patient's stay, including:
 - Treatments;
 - Symptoms;
 - Pain management; and
 - Whether the patient was in seclusion or physically restrained;

This summary will be available for release to authorized individuals and agencies, with the consent of the patient or the patient's legal representative.

- ❖ The patient's biopsychosocial needs;
- ❖ The patient's medication therapy management needs;
- ❖ The patient's return to the pre-acute care hospital/post-acute care facility environment, including:
 - If the patient was admitted from his or her private residence, whether specialized medical equipment or permanent environmental modifications to the home are required and the feasibility of acquiring such equipment or modifications;
 - Whether the patient is capable of addressing his or her care needs through self-care. If



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning Evaluation

the patient is not able to address his or her care needs through self-care, whether family, friends, or other caregivers are available who are willing and able to provide the required care at the times needed or who you could train to sufficiently provide such care;

- Availability of community-based services (such as Hospice or palliative care, medical equipment and related supplies, transportation services, personal care, and meal services) if neither the patient nor the family or informal caregivers can address all of the patient's required care needs; and
- If the patient was admitted from a facility (such as a NF or SNF) and he or she wishes to return to the facility, whether it has the capability to provide the patient's after-acute care hospital/post-acute care facility care requirements;
- ❖ Information obtained from the patient and family/caregivers (such as financial and health and prescription coverage); and
- ❖ The patient's and family/caregiver's understanding of the patient's discharge needs.



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

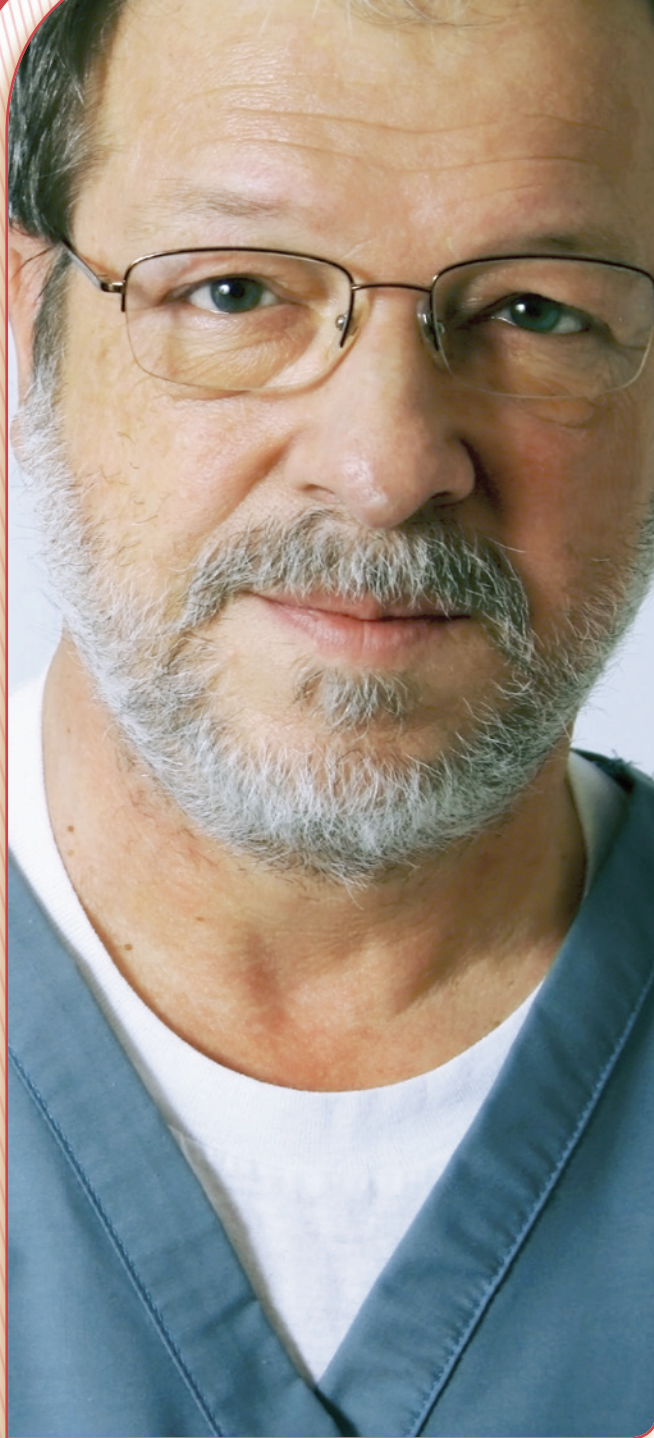
Discharge Planning

You must discuss results of the discharge planning evaluation with the patient or the individual acting on his or her behalf. You should offer the patient a range of realistic options to consider for after-acute care hospital/post-acute care facility care, depending on:

- ❖ The availability of appropriate services, supports, and facilities;
- ❖ A pharmacist's assessment of the patient's medication compliance and treatment;
- ❖ The patient's capacity for self-care;
- ❖ The patient's preferences and goals, as applicable; and
- ❖ The availability, willingness, and ability of family/caregivers to provide care.

Under Section 1861(ee) of the Social Security Act (the Act), Medicare participating acute care hospitals/post-acute care facilities must provide each patient, as appropriate, a list of Medicare-certified Home Health Agencies (HHA) that serve the geographic area where he or she resides, participate in the Medicare Program, and request inclusion on the list. The Act prohibits you from limiting or steering the patient to any particular HHA. You must identify those HHAs in which you have a disclosable financial interest or HHAs that have such an interest in you.

Under Section 1861(ee) of the Act, the discharge plan must include an assessment of the patient's likely



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning

need for Hospice care and after-acute care hospital/post-acute care facility extended care services. You must provide the patient with a list of the available Medicare participating SNFs that serve the geographic area he or she requests. The discharge plan cannot specify or limit qualified SNFs. You must identify those SNFs in which you have a disclosable financial interest or SNFs that have such an interest in you.

For patients enrolled in a managed care organization (MCO), you must provide the patient with information about Home Health and after-acute care hospital/post-acute care facility extended care services available through individuals and entities that have a contract with the MCO.

If you develop and maintain a list of HHAs and SNFs for the patient, you must update such lists at least annually. The lists must include information about HHAs and SNFs in which you have a disclosable financial interest and HHAs and SNFs that have such an interest in you. You may also provide a list of HHAs in the geographic area where the patient resides from Home Health Compare located at <http://www.medicare.gov/homehealthcompare> or a list of SNFs in the geographic area that the patient requests from Nursing Home Compare located at <http://www.medicare.gov/nursinghomecompare> on the Centers for Medicare & Medicaid Services website.



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning

You must arrange initial implementation of the discharge plan, which includes:

- ❖ Arranging necessary after-acute care hospital/post-acute care facility services and care, including transfer to facilities (such as rehabilitation hospitals), referrals (such as medical equipment suppliers, community resources, and HHAs), and appropriate access to medications post-transfer. Arrangements may include necessary medical information such as brief reason for hospitalization, principal diagnosis, and hospital course of treatment. If the patient transfers to another inpatient or residential health care facility, the information must accompany the patient to the facility. If the patient is referred for follow-up ambulatory care, the information should be transmitted to the patient's physician within 7 days after discharge or before the first appointment for ambulatory services, whichever occurs first. If the physician is unable to accept the information electronically, you may instruct the patient to provide it to the physician at the next appointment; and
- ❖ Educating the patient, family/caregivers, and community providers about the patient's after-acute care hospital/post-acute care facility care plans. Individuals who will be providing care should know and be able to demonstrate and verbalize the patient's care needs. You should



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

Discharge Planning

provide the patient and family/caregivers with information and written and verbal instructions in preparation for the patient's after-acute care hospital/post-acute care facility care, including:

- Post-discharge options;
- Medications to discontinue or take and how to use them properly after discharge;
- What to expect after discharge; and
- What to do if concerns, issues, or problems arise.

You must ensure that the patient receives proper post-discharge care within your authority under State law and within the limits of a patient's right to refuse discharge planning services.

You must document the following in the patient's clinical record:

- ❖ Discharge planning evaluation activities;
- ❖ Results of the discharge planning evaluation were discussed with the patient and family/caregivers;
- ❖ Refusal of the patient or the patient's legally responsible representative to participate in discharge planning or comply with a discharge plan, if applicable;



ACUTE CARE HOSPITALS, INPATIENT REHABILITATION FACILITIES (IRF), AND LONG TERM CARE HOSPITALS (LTCH) (continued)

| | |
|--|--|
| <p><i>Discharge Planning</i></p> | <ul style="list-style-type: none"> ❖ The patient or an individual acting on the patient's behalf was provided a list of HHAs or SNFs, as appropriate if such services are needed; and ❖ Attempts to arrange after-acute care hospital or post-acute care facility care with a HHA or SNF, as applicable, that meet the patient's or family's expressed preference. If such arrangements could not be made, include the reason(s) they could not be made. |
| <p><i>Discharge Planning Reassessment</i></p> | <p>The Quality Assessment and Performance Improvement Program must include a mechanism for ongoing reassessment of its discharge planning process through review of discharge plans in closed clinical records. This reassessment determines whether the discharge planning process was responsive to patients' post-discharge needs.</p> |



HOME HEALTH AGENCIES (HHA)

HHAs provide Home Health care to the patient with certain care needs and who meets program requirements.

Discharge Summary

When “you” is used in this chart, we are referring to HHAs.

The HHA discharge summary must include the patient’s medical, health, and medication status at discharge. It may be incorporated into routine summary reports furnished to the physician.

You should document the discharge summary in the patient’s clinical record. This summary will be available for release to authorized individuals and agencies, with the consent of the patient or the patient’s legal representative.

A physician’s order is not required to discharge the patient unless you have such a policy or it is required by State law. You should document in the patient’s clinical record that the physician was notified of the discharge. You must inform the attending physician that the discharge summary is available and send it to him or her upon request.



HOSPICES

Under certain conditions, the Medicare Hospice benefit provides Hospice services for the palliation and management of a patient's terminal illness and related conditions.

Discharge Planning Process

When “you” is used in this chart, we are referring to Hospices.

You must have a discharge planning process in place that accounts for the prospect that the patient's condition might stabilize or otherwise change such that he or she no longer meets the terminal illness certification or re-certification requirements.

The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she no longer meets the terminal illness certification or re-certification requirements.

Discharge Summary

Prior to discharging the patient, you must obtain a written physician's discharge order from the Hospice medical director. If the patient has an attending physician involved in his or her care, this physician should be consulted before discharge. The attending physician's input and recommendations should be included in the discharge summary.

The Hospice discharge summary must include:

- ❖ A summary of the patient's stay, including treatments, symptoms, and pain management. This summary will be available for release to



HOSPICES (continued)

Discharge Summary

authorized individuals and agencies, with the consent of the patient or the patient's legal representative;

- ❖ Whether the patient was in seclusion or physically restrained;
- ❖ The patient's current plan of care, including changes in medication therapy;
- ❖ The patient's latest physician(s) orders; and
- ❖ Any other documentation that will assist in post-discharge continuity of care or is requested by the attending physician or receiving facility.

The discharge summary should be documented in the patient's clinical record.

If the care of a patient is transferred to another Medicare- or Medicaid-certified facility, you must forward a copy of the following to the receiving facility:

- ❖ The Hospice discharge summary; and
- ❖ The patient's clinical record, if requested.

If a patient revokes the election of Hospice care or is discharged from Hospice, you must forward a copy of the following to the patient's attending physician:

- ❖ The Hospice discharge summary; and
- ❖ The patient's clinical record, if requested.

INPATIENT PSYCHIATRIC FACILITIES (IPF)

IPFs, which are classified as psychiatric hospitals or psychiatric units, provide the patient with acute psychiatric treatment that can be reasonably expected to improve his or her condition.

Discharge Planning

When “you” is used in this chart, we are referring to IPFs.

The IPF discharge planning process considers:

- ❖ The discharge alternatives addressed in the psychosocial and behavioral health assessment; and
- ❖ The extent to which the goals in the treatment plan have been met.

The patient and all relevant professionals in each service caring for the patient should participate in this process.

The discharge planning process should address anticipated problems after discharge and suggested means for intervention, including:

- ❖ Accessibility and availability of community resources and support systems, including transportation;
- ❖ Accessibility and availability of medications and counseling by a pharmacist; and
- ❖ Special needs related to the patient’s functional ability to participate in aftercare planning.



INPATIENT PSYCHIATRIC FACILITIES (IPF) (continued)

Discharge Summary

You should complete the IPF discharge summary within a reasonable timeframe and provide:

- ❖ A recapitulation of the patient's hospitalization which includes a summary of the patient's stay, including symptoms, treatments, and pain management;
- ❖ A summary of the patient's condition on discharge. This summary will be available for release to authorized individuals and agencies, with the consent of the patient or the patient's legal representative;
- ❖ A summary of medication therapy changes and instructions; and
- ❖ Recommendations for appropriate services for follow-up or aftercare.

The discharge summary must include:

- ❖ The reasons for the patient's admission to the IPF;
- ❖ Nursing and health care providers' notes (such as social workers);
- ❖ A plan that outlines psychiatric, medical, and physical treatment and medication therapy management, as applicable;
- ❖ A list of medication modifications and patient instructions;



INPATIENT PSYCHIATRIC FACILITIES (IPF) (continued)

Discharge Summary

- ❖ Documentation that the patient received electroconvulsive therapy, if such treatment was provided;
- ❖ Whether the patient was in seclusion or physically restrained;
- ❖ Evidence of the patient's and family's response to treatment interventions;
- ❖ Health care providers' discharge summaries (such as nurse practitioners or physicians);
- ❖ Documentation that a complete history and physical examination, medication reconciliation, and psychosocial evaluation were performed at discharge;
- ❖ Discharge disposition (such as outpatient follow-up services and arrangements with treatment and other community resources to provide follow-up services, including prior verbal and written communication and exchange of information with such resources);
- ❖ The extent to which the patient achieved treatment goals during hospitalization;
- ❖ A baseline of the physical, psychosocial, and behavioral functioning of the patient at discharge; and
- ❖ Appropriate services and resources, including medication counseling, which will be effective on the day of discharge.

You must document the discharge summary in the patient's clinical record.



LONG TERM CARE (LTC) FACILITIES

LTC Facilities, also known as Nursing Facilities (NF) or Skilled Nursing Facilities (SNF), primarily engage in providing the resident with either skilled nursing care and related services or rehabilitation services (based on his or her needs).

Discharge Planning

When “you” is used in this chart, we are referring to LTC Facilities.

You must complete discharge planning when you anticipate discharging a resident to a private residence, another NF or SNF, or another type of residential facility. Discharge planning includes:

- ❖ Assessing the resident’s continuing care needs, including:
 - Consideration of the resident’s and family/caregiver’s preferences for care;
 - How services will be accessed; and
 - How care should be coordinated among multiple caregivers, as applicable;
- ❖ Developing a plan designed to ensure that the resident’s needs will be met after discharge from the facility, including resident and family/caregiver education needs;
- ❖ Initiating and maintaining collaboration between the NF and the local contact agency (LCA) to support the resident’s transition to community living, as applicable, including making referrals to the LCA under the process established by the State; and





LONG TERM CARE (LTC) FACILITIES (continued)

| | |
|---------------------------|--|
| Discharge Planning | <ul style="list-style-type: none"> ❖ Assisting the resident and family/caregivers in locating and coordinating post-discharge services. |
| Discharge Summary | <p>The LTC Facility discharge summary must include:</p> <ul style="list-style-type: none"> ❖ A recapitulation of the resident's stay; ❖ A final summary of the resident's status at discharge. This summary will be available for release to authorized individuals and agencies, with the consent of the resident or the resident's legal representative; and ❖ A post-discharge plan of care (POC), developed with the resident's and his or her family's/ caregiver's participation. The post-discharge POC assists the resident in safely adjusting to his or her new living environment and any changes in medication therapy. <p>You should document the discharge summary in the resident's clinical record.</p> |



SWING BEDS

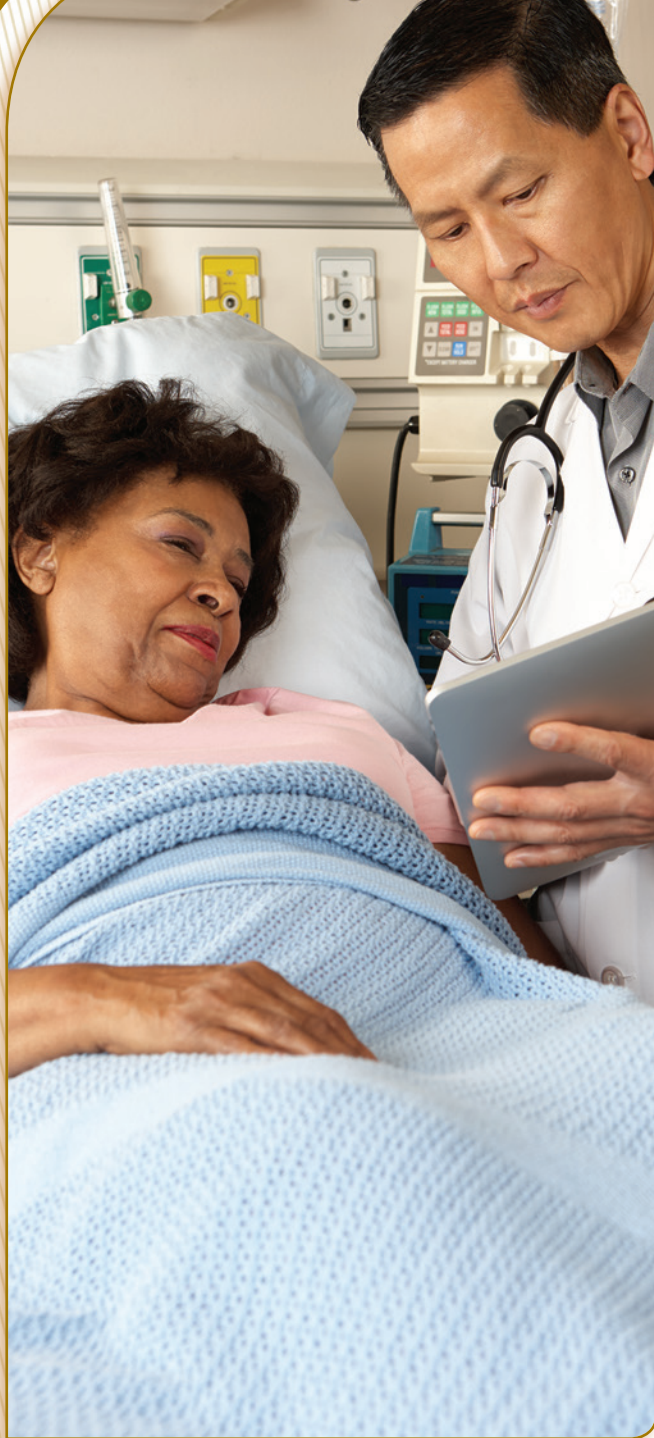
Swing Beds are hospitals, as defined in Section 1861(e) of the Social Security Act, or Critical Access Hospitals (CAH) with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services approval to provide Swing Bed services, that may use their beds as needed to provide the patient with either acute or Skilled Nursing Facility-level care.

Discharge Planning

When “you” is used in this chart, we are referring to hospitals or CAHs.

You must complete discharge planning when you anticipate discharging a patient from a Swing Bed. Discharge planning includes:

- ❖ Assessing the patient’s continuing care needs, including:
 - Consideration of the patient’s and family/caregiver’s preferences for care;
 - How services will be accessed; and
 - How care should be coordinated among multiple caregivers, as applicable;
- ❖ Developing a plan designed to ensure that the patient’s needs will be met after discharge from the facility, including patient and family/caregiver education needs; and
- ❖ Assisting the patient and family/caregivers in locating and coordinating post-discharge services.



SWING BEDS (continued)

Discharge Summary

The discharge summary must include:


- ❖ A recapitulation of the patient's stay;
- ❖ A final summary of the patient's status at discharge. This summary will be available for release to authorized individuals and agencies, with the consent of the patient or the patient's legal representative; and
- ❖ A post-discharge plan of care (POC), developed with the patient's and his or her family's participation. The post-discharge POC assists the patient in adjusting to his or her new living environment.

You should document the discharge summary in the patient's clinical record.

RESOURCES

The chart below provides discharge planning resource information.

Discharge Planning Resources

| For More Information About... | Resource |
|---|---|
| Discharge Planning | <p>“Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html on the Centers for Medicare & Medicaid Services (CMS) website</p> <p>Appendices of the “State Operations Manual” (Publication 100-07) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html on the CMS website</p> |
| All Available Medicare Learning Network® (MLN) Products | <p>“MLN Catalog” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right</p>  |
| Provider-Specific Medicare Information | <p>MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website</p> |
| Medicare Information for Patients | <p>http://www.medicare.gov on the CMS website</p> |



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