Overview of CMS Requirements for Hospital Discharges to Post-Acute Care Providers

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group
QSO-23-16-Hospitals Memorandum

March 27, 2024 – 1:00-2:00 pm EST

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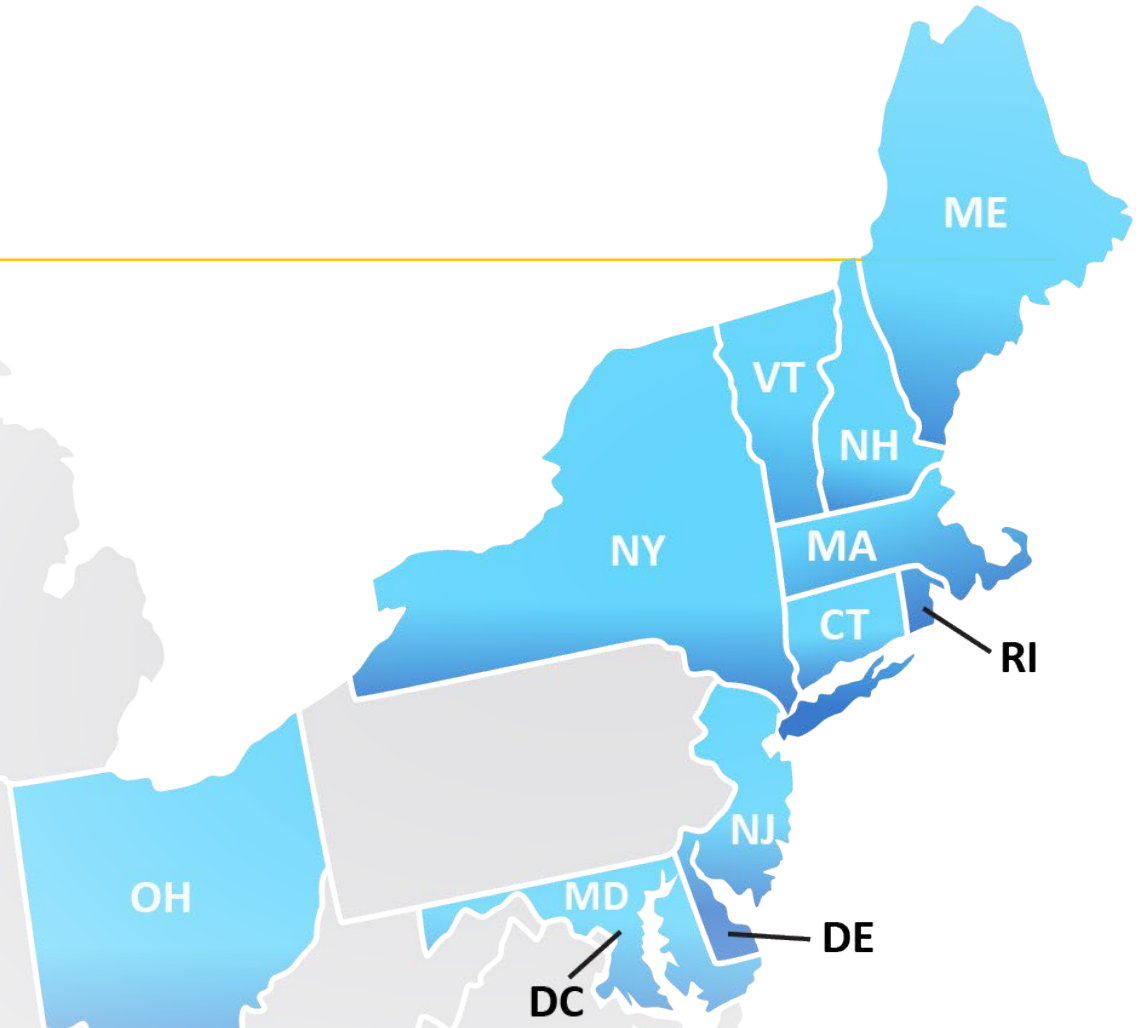

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Today's Discussion

- Review CMS QSO 23-16- Hospital Memorandum
  - CMS Areas of Concern
- Impact of Missing or Inaccurate Patient Information
- Hospital Discharge Planning Requirements - CMS (42 CFR §482.43) Conditions of Participation
- Partner with Post-Acute Care Providers to Create Seamless Care Transitions
- Resources to Facilitate Accurate and Timely Information Sharing with Post-Acute Care Providers
- IPRO QIN-QIO Region Quarterly Care Transitions Data Reports

Memorandum QSO 23-16-Hospitals Summary

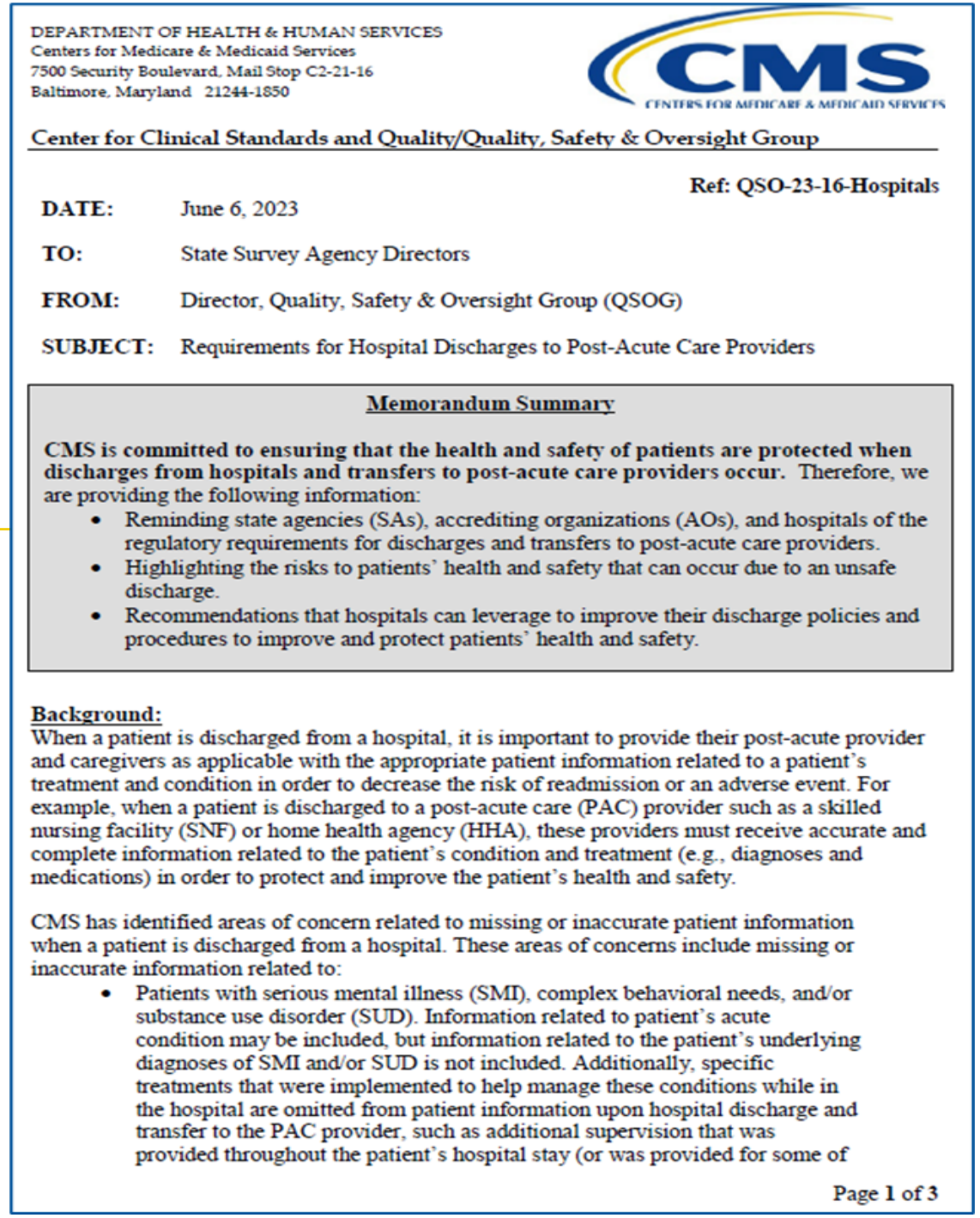
CMS is committed to ensuring that the health and safety of patients is protected when discharges from hospitals and transfers to post-acute care providers occur.

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the ***regulatory requirements*** for discharges and transfers to post-acute care providers
- Highlighting the ***risks to patient's health and safety*** that can occur due to an unsafe discharge
- Sharing recommendations that hospitals can leverage to improve their discharge policies and procedures and protect patients' health and safety

CMS Areas of Concern

Missing or Inaccurate Patient Information

https://www.cms.gov/files/document/qso-23-16-hospitals.pdf



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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-16-Hospitals

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

Memorandum Summary

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur due to an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

Background:

When a patient is discharged from a hospital, it is important to provide their post-acute provider and caregivers as applicable with the appropriate patient information related to a patient's treatment and condition in order to decrease the risk of readmission or an adverse event. For example, when a patient is discharged to a post-acute care (PAC) provider such as a skilled nursing facility (SNF) or home health agency (HHA), these providers must receive accurate and complete information related to the patient's condition and treatment (e.g., diagnoses and medications) in order to protect and improve the patient's health and safety.

CMS has identified areas of concern related to missing or inaccurate patient information when a patient is discharged from a hospital. These areas of concerns include missing or inaccurate information related to:

- Patients with serious mental illness (SMI), complex behavioral needs, and/or substance use disorder (SUD). Information related to patient's acute condition may be included, but information related to the patient's underlying diagnoses of SMI and/or SUD is not included. Additionally, specific treatments that were implemented to help manage these conditions while in the hospital are omitted from patient information upon hospital discharge and transfer to the PAC provider, such as additional supervision that was provided throughout the patient's hospital stay (or was provided for some of

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Impact of Missing or Inaccurate Patient Information

- Providers may not be equipped or trained to care for certain conditions
- Puts patient's health at risk
- Increases readmissions
- Complications
- Adverse events
- Patient may receive treatments that are unnecessary or inconsistent with their wishes

CMS Areas of Concern - Hospital Discharges to Post-Acute Care Providers
Ref: CMS QSO-23-16-Hospitals

Serious Mental Illness (SMI), Complex Behavioral Needs, and/or Substance Use Disorder (SUD)

- Underlying diagnosis of SMI and/or SUD not included
- Were there special treatments such as additional supervision during the hospital stay, or discontinued prior to discharge (24-48 hrs. before discharge)

Medications

- Incomplete comprehensive list of all medications
- Patient diagnoses or problem lists, clinical indications, lab results, clear orders for post-discharge medication regimen
- Omissions for psychotropic medications and narcotics (i.e., provided on paper vs. electronic (as required by law)

Skin Tears, Pressure Ulcers, Bruising, or Lacerations

- Conditions noted upon hospital admission and/or acquired during hospitalization
- Orders or instructions for cultures, treatments, or dressings
- Skin healing equipment: mattress, wound vacuum machine
- Other wound products needed for healing

Durable Medical Equipment

- CPAP/BiPap or high-flow oxygen (respiratory treatments)
- Mattresses, wound vacuum machine, surgical wounds, pressure ulcers, diabetic ulcers (skin healing equipment)

Patient's Preferences

- Patient choices for treatment
- Advance directives for end-of-life care

Communication

- Patient's needs at home
- Home environment (fall risk, homelessness, family/caregiver involvement

CMS Code of Federal Regulations (42 CFR §482.43)

Conditions of Participation - Hospital Discharge Planning Process

Discharge Planning Evaluation

The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his/her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable readmissions.

- Must be made on a timely basis to ensure appropriate arrangements for post-acute care are made before discharge
- Must include an evaluation of a patient's likely need for appropriate post-hospital services
- Must be included in the patient's medical record and the results must be discussed with patient (or representative)
- Must require regular re-evaluation of the patient's condition to identify changes that need modification/ updating of the discharge plan
- Must include a determination of the availability of the appropriate services as well as patient's access to those services
- Must assess its discharge planning process on a regular basis
- Hospital must assist patients and their families in selecting a post-acute care provider and share data that includes quality measures

CMS Code of Federal Regulations (42 CFR §482.43)

Conditions of Participation - Hospital Discharge Planning Process

Transmission of Patient's Medical Information

All necessary medical information pertaining to the patient must be provided to post-acute care providers, including:

- Patient's current course of illness and treatment
  - Past medical history
  - Code status
  - Assessment (vitals, labs, neurological status, behavioral/mental health, skin/pressure ulcers)
- Post-discharge goals of care
  - Discharge plan
  - Pending tests/consults
  - Follow-up appointments
  - Education – patient/family using teach back
  - Case management/social service needs
  - SDOH indicators
  - Durable Medical Equipment (DME) needs
  - Risk assessment/prevention (infection, falls)
- Medication management
- Patient's treatment preferences at the time of discharge

CMS Code of Federal Regulations (42 CFR §482.43)

Conditions of Participation - Hospital Discharge Planning Process

Requirements Related to Post-Acute Care Services

For patients transferred to home and referred for HHA services, or those transferred to a SNF, IRF, or LTCH for specialized hospital services

- Must include in the discharge plan a list of available providers available to patient and who are participating in Medicare program, with documentation in the patient's medical record
- The hospital must document in the patient's medical record that this list was presented to patient or to the patient's representative

Hospital Discharge Organizational Assessment Tool

Hospital Discharge Planning
Organizational Assessment Tool

Use this checklist to evaluate your hospital's discharge planning process to ensure compliance with CMS' Conditions of Participation (42 CFR §482.43) and QSO 23-16-Hospitals Memorandum

Does your hospital's discharge planning process strategy include:

Yes	No	
		Early identification and assessment of patient's medical, functional, psychosocial, and environmental needs?
		Coordination with the multidisciplinary team involved in the patient's care and identify and address any potential barriers or challenges to the discharge process?
		The patient and family as full partners in the discharge planning process?
		Education for the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout their hospital stay?
		Assessment of how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back? (HCAHPS Hospital Survey)?
		Listen to and honor the patient and family's goals, preferences, observations, and concerns?
		Communication with follow-up providers

Does your discharge plan include the following information as outlined in CMS' QSO 23-16-Memo?

Yes	No	
		Patient's current course of illness and treatment (including past medical history and code status, assessment (vitals, labs, neurological status, behavior/mental health status, substance use disorder (SUD), skin/pressure ulcers)?
		Post discharge goals of care
		Discharge plan
		Pending tests/consults
		Follow-up appointments scheduled
		Education – patient/family using teach back
		Case management/social service needs
		Social Determinants of Health (SDOH) indicators (i.e., homelessness, food insecurity, transportation)
		Durable Medical Needs (DME)
		Risk Assessment/Prevention (infection, risk of falls)
		Medication Reconciliation/Management
		Patient's treatment preferences (advance directives, EOL care) at the time of discharge

Sources: Code of Federal Regulations/Part 482-Conditions of Participation for Hospitals: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482

QSO-23-16-Hospitals Memorandum Summary – Requirements for Hospital Discharges to Post-Acute Care Providers

Your IPRO QIN-QIO Quality Improvement Specialists are here to provide any assistance with any of the requirements listed herein. Please contact us @ xxx.qio.

Partner with Post-Acute Care Providers to Create Seamless Care Transitions

- Engage patient and care partner in discharge planning throughout the care continuum
- Improve cross setting partnerships and communication for care coordination and management
- Focus on reducing unplanned readmissions and emergency department utilization
- Establish 24-7 hospital and facility point-of-contact list, including off hours and weekends
- Create streamlined and standardized cross-setting handover processes, information transfer, and circle back
- Know the clinical capabilities of your post-acute care providers to ensure fit between patient's needs and facility's capacity to provide care
- Conduct cross-setting medication reconciliation
- Provide cross-setting staff education

Resources To Facilitate Accurate and Timely Information Sharing with Post-Acute Care Providers

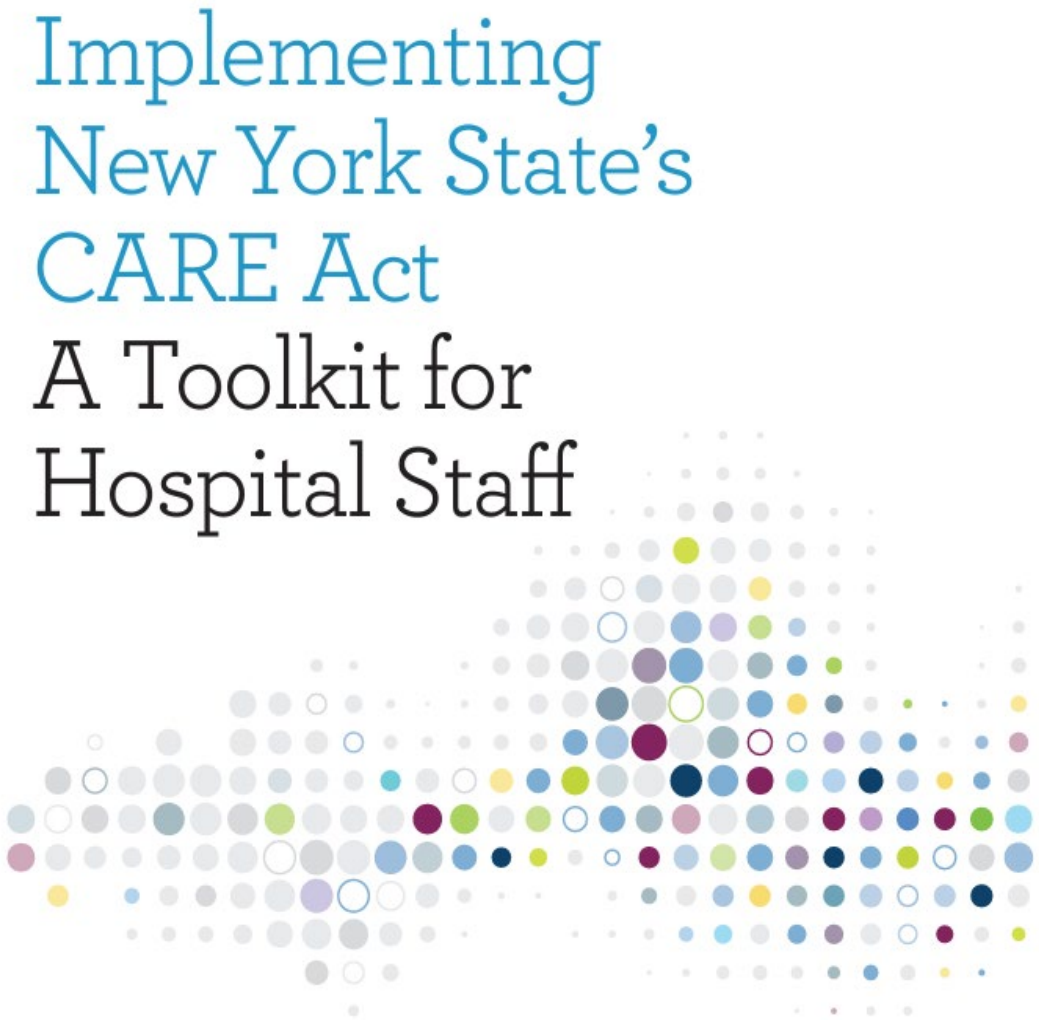
- Project RED (Re-Engineered Discharge) – Role of Discharge Advocates
- Project BOOST (Better Outcomes by Optimizing Safe Transitions)
- Key Clinical Services Tool
- Nurse-to-Nurse Report Tool
- SNF Transfer to ED Process Map
- Hospital/Post-Acute Provider Readmission Case Review
- Quality Improvement Initiative (PDSA) Worksheet
- Care Transitions Warm Handoff Report
- Hospital Contact Information for Post Acute Providers
- Improving Care Transitions: Resource Guide
- FAST FACTS for ED from Post Acute Care Providers
- SNF/NF to Hospital Transfer Form
- Discharge Medications: Nurse-to-Nurse Warm Handoff Guidance

Additional Resources

The Caregiver Advise, Record, Enable (CARE) Act, developed by AARP, has been enacted in 40 states.

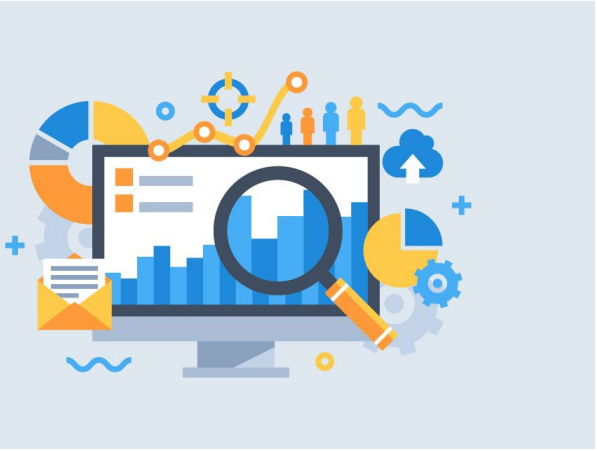
The United Hospital Fund has developed a toolkit to help administrators, nurses, discharge planners, social workers, and others integrate the legislation's requirements into hospitals' daily practice, with step-by-step guidelines for engaging family caregivers in the discharge process.

You can find this resource here: *Implementing New York State's CARE Act: A Toolkit for Hospital Staff*



IPRO QIN-QIO Region Care Transitions Report

Hospital Utilization by Select Demographics



Gender

Category	Readmissions Number	Readmissions Rate	Admissions Number	Admissions Rate	ED Visits Number	ED Visits Rate	Observation Visits Number	Observation Visits Rate	Total Beneficiaries
Male	97,970	38.8	547,279	216.5	690,850	273.3	97,168	38.4	2,527,693
Female	102,576	34.9	618,732	210.7	897,087	305.5	129,722	44.2	2,936,071

Race/Ethnicity

Category	Readmissions Number	Readmissions Rate	Admissions Number	Admissions Rate	ED Visits Number	ED Visits Rate	Observation Visits Number	Observation Visits Rate	Total Beneficiaries
Asian	2,388	20.7	14,422	125.1	15,898	137.9	2,808	24.4	115,310
Black	25,615	48.5	127,872	242.2	193,247	366.0	27,013	51.2	528,029
Hispanic	3,236	35.2	16,122	175.4	31,671	344.6	3,483	37.9	91,897
Native American	233	46.5	1,225	244.3	2,505	499.6	271	54.0	5,014
White	161,457	36.6	961,007	218.1	1,276,153	289.6	184,358	41.8	4,405,920
Other/Unknown	7,617	24.0	45,363	142.9	68,463	215.6	8,957	28.2	317,551

Age

Category	Readmissions Number	Readmissions Rate	Admissions Number	Admissions Rate	ED Visits Number	ED Visits Rate	Observation Visits Number	Observation Visits Rate	Total Beneficiaries
< 65	35,360	51.8	160,200	234.8	353,162	517.6	30,906	45.3	682,314
65 - 74	58,007	21.1	351,778	128.2	506,290	184.5	70,613	25.7	2,743,446
75 - 84	64,271	43.9	383,599	262.1	455,655	311.3	75,186	51.4	1,463,791
> 84	42,908	74.7	270,434	471.0	272,830	475.1	50,185	87.4	574,212

Category	Readmissions Number	Readmissions Rate	Admissions Number	Admissions Rate	ED Visits Number	ED Visits Rate	Observation Visits Number	Observation Visits Rate	Total Beneficiaries
Beneficiaries w/ disability	64,465	60.8	312,313	294.7	543,871	513.3	58,402	55.1	1,059,605
Beneficiaries w/o disability	136,081	30.9	853,698	193.8	1,044,066	237.1	168,488	38.3	4,404,158

Source: IPRO QIN-QIO Region Care Transitions Report (Oct-22 – Sep 23) – CMS Claims Paid Data

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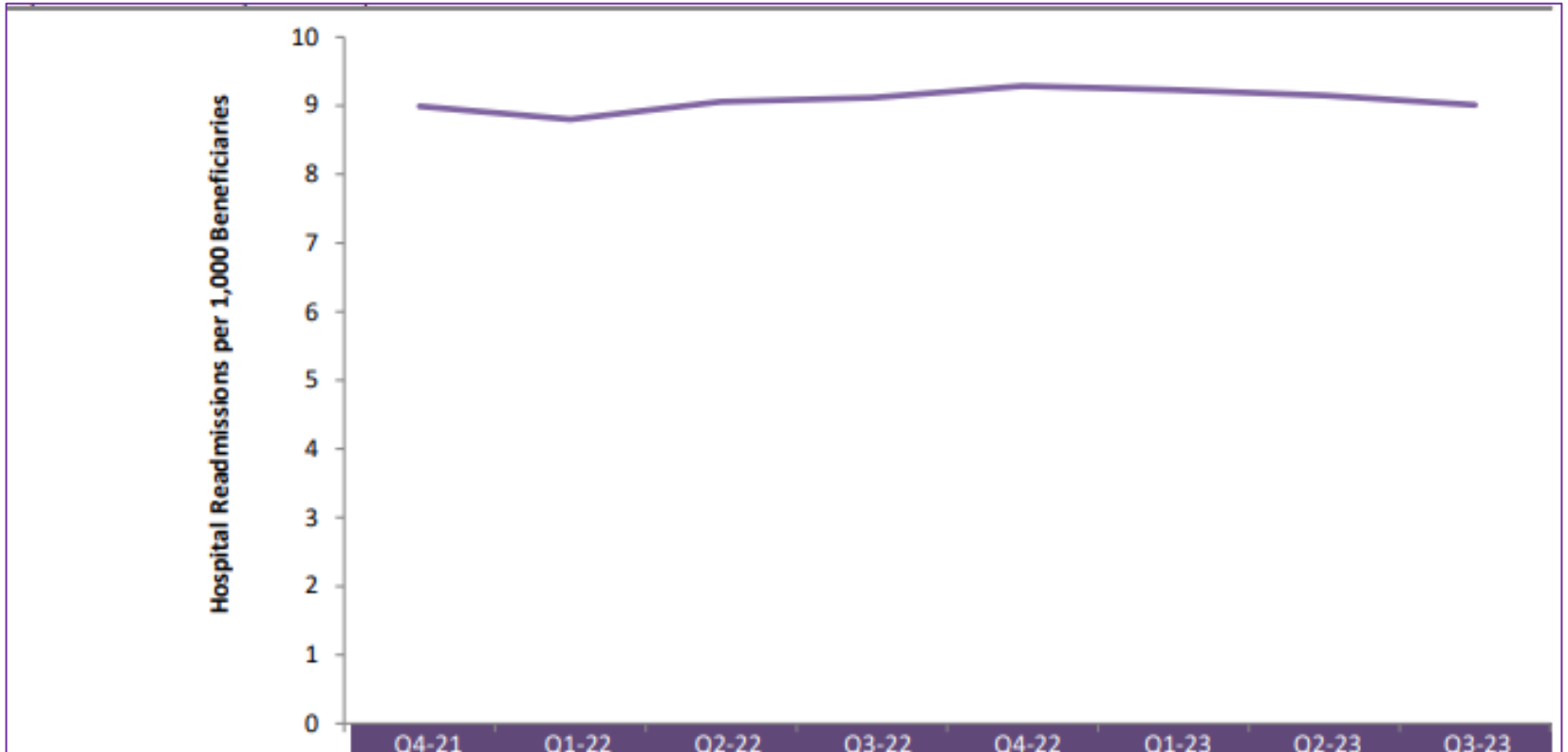
All Cause 30-Day Hospital Readmissions



	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23
IPRO QIN Communities	9.0	8.8	9.1	9.1	9.3	9.2	9.1	9.0
IPRO QIN Readm. per Day	561.6	544.1	553.7	551.1	562.9	557.0	545.7	532.3
IPRO QIN Readmissions	51,663	48,967	50,383	50,704	51,788	50,127	49,658	48,973
IPRO QIN Medicare FFS Pop.	5,744,633	5,563,628	5,562,383	5,562,916	5,576,106	5,429,908	5,428,278	5,434,489

IPRO QIN-QIO Community Care Transitions Report

Readmissions by Discharge Status – Stratified by Days to Readmission

All Discharges, Oct-2022 to Sep-2023

Group	Setting Discharged To	Readmits Within 30 Days	Discharges	30-Day Readmit Rate	Days to Readmission									
					1-2 Days		3-7 Days		8-14 Days		15-20 Days		21-30 Days	
					N	%	N	%	N	%	N	%	N	%
IPRO QIN Region	HHA	54,449	260,890	20.9%	5,946	10.9%	13,319	24.5%	14,019	25.7%	9,203	16.9%	11,962	22.0%
	Home	79,206	503,694	15.7%	8,347	10.5%	19,437	24.5%	20,067	25.3%	13,585	17.2%	17,770	22.4%
	Hospice	739	36,102	2.0%	121	16.4%	175	23.7%	167	22.6%	138	18.7%	138	18.7%
	Inpt. Psych.	379	1,500	25.3%	108	28.5%	58	15.3%	85	22.4%	63	16.6%	65	17.2%
	Inpt. Rehab.	8,467	44,977	18.8%	747	8.8%	1,793	21.2%	2,146	25.3%	1,626	19.2%	2,155	25.5%
	Nursing Home	54,245	258,378	21.0%	5,366	9.9%	12,519	23.1%	13,975	25.8%	9,607	17.7%	12,778	23.6%
	Other Hospital	2,424	14,193	17.1%	257	10.6%	604	24.9%	571	23.6%	401	16.5%	591	24.4%
	Other	637	2,882	22.1%	117	18.4%	149	23.4%	122	19.2%	109	17.1%	140	22.0%
	Total	**200,546**	**1,122,616**	**17.9%**	**21,009**	**10.5%**	**48,054**	**24.0%**	**51,152**	**25.5%**	**34,732**	**17.3%**	**45,599**	**22.7%**

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IPRO QIN-QIO Region Care Transitions Report

Top Index and Readmission Diagnosis Categories

Time Period: Oct-2022 to Sep-2023

Index Admission: Principal Diagnosis Category (Top 10)	Number of Readmissions for Specified Diagnosis	Total Readmissions in Region	Percent of Total Readmissions
Septicemia	20,756	200,546	10.3%
Heart failure	14,447	200,546	7.2%
Urinary tract infections	5,943	200,546	3.0%
Pneumonia (except that caused by tuberculosis)	5,672	200,546	2.8%
Cardiac dysrhythmias	5,370	200,546	2.7%
Acute and unspecified renal failure	5,343	200,546	2.7%
Diabetes mellitus with complication	4,931	200,546	2.5%
COVID-19	4,509	200,546	2.2%
Chronic obstructive pulmonary disease and bronchiectasis	4,134	200,546	2.1%
Respiratory failure; insufficiency; arrest	3,967	200,546	2.0%

Time Period: Oct-2022 to Sep-2023

Readmission: Principal Diagnosis Category (Top 10)	Number of Readmissions for Specified Diagnosis	Total Readmissions in Region	Percent of Total Readmissions
Septicemia	24,939	200,546	12.4%
Heart failure	14,529	200,546	7.2%
Acute and unspecified renal failure	5,868	200,546	2.9%
Pneumonia (except that caused by tuberculosis)	5,546	200,546	2.8%
Urinary tract infections	5,435	200,546	2.7%
Complication of other surgical or medical care, injury, initial encounter	5,381	200,546	2.7%
Cardiac dysrhythmias	5,094	200,546	2.5%
Respiratory failure; insufficiency; arrest	4,923	200,546	2.5%
Complication of genitourinary device, implant or graft, initial encounter	4,478	200,546	2.2%
Diabetes mellitus with complication	4,315	200,546	2.2%

IPRO QIN-QIO Region Care Transitions Report

Emergency Department (ED) Visits per 1,000 Medicare Beneficiaries

	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23
IPRO QIN Communities	72.9	64.2	75.3	78.0	74.0	68.7	73.2	74.5
IPRO QIN ED Visits per Day	4,552	3,972	4,600	4,717	4,483	4,146	4,367	4,402
IPRO QIN ED Visits	418,808	357,437	418,604	433,974	412,465	373,102	397,374	404,996
IPRO QIN Medicare FFS Pop.	5,744,633	5,563,628	5,562,383	5,562,916	5,576,106	5,429,908	5,428,278	5,434,489

Emergency Department (ED) Top Diagnosis Categories

Time Period: Oct-2022 to Sep-2023

Principal Diagnosis Category (Top 10)	Total ED Visits in Region
Superficial injury; contusion, initial encounter	74,360
Musculoskeletal pain, not low back pain	74,239
Abdominal pain and other digestive/abdomen signs and symptoms	70,576
Nonspecific chest pain	68,251
Urinary tract infections	54,916
Respiratory signs and symptoms	54,298
Other unspecified injury	40,424
COVID-19	39,616
Open wounds to limbs, initial encounter	34,183
Open wounds of head and neck, initial encounter	30,939

This measure looks at the rate of ED visits for the entire Medicare Fee-For-Service population in the community. ED visits are defined as a visit to the emergency department that does not result in a hospital admission or observation stay. ED visits per day are also provided, this number is calculated by dividing the number of ED visits by the number of days in each quarter.

IPRO QIN-QIO Region Care Transitions Report

Observation Visits per 1,000 Medicare Beneficiaries

	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23
IPRO QIN Communities	10.5	9.8	11.2	10.9	10.6	10.4	10.4	10.0
IPRO QIN Obs. per Day	653	606	683	661	645	626	623	592
IPRO QIN Observations	60,094	54,536	62,121	60,806	59,367	56,323	56,711	54,489
IPRO QIN Medicare FFS Pop.	5,744,633	5,563,628	5,562,383	5,562,916	5,576,106	5,429,908	5,428,278	5,434,489

Observation Visit Top Diagnosis Categories

Time Period: Oct-2022 to Sep-2023

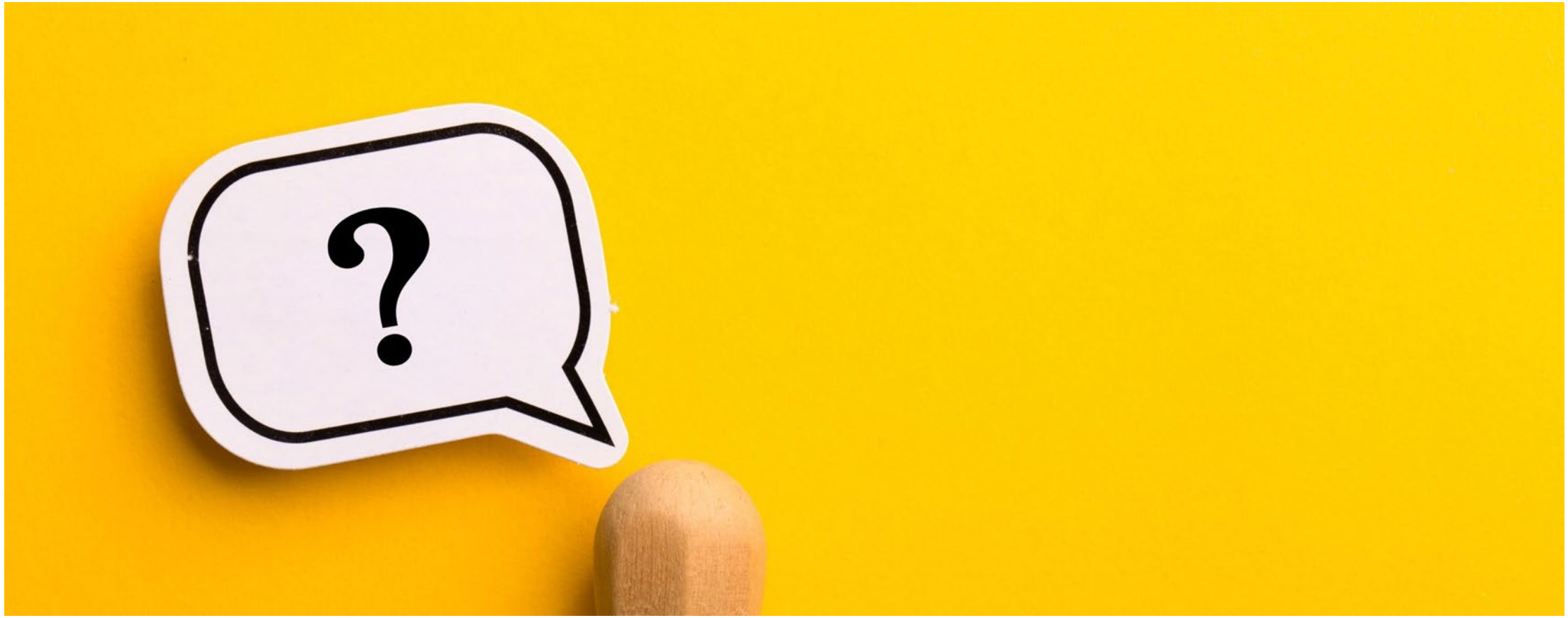
Principal Diagnosis Category (Top 10)	Total Observation Visits in Region
Nonspecific chest pain	23,378
Syncope	13,216
Cardiac dysrhythmias	7,884
Nervous system signs and symptoms	7,704
General sensation/perception signs and symptoms	7,307
Osteoarthritis	6,184
Transient cerebral ischemia	5,829
Urinary tract infections	5,662
Malaise and fatigue	5,274
COVID-19	4,314

This measure looks at the rate of observation visits for the entire Medicare Fee-For-Service population in the community. Observation visits are defined as an observation as a visit that does not result in a hospital admission. Observation visits per day are also provided, this number is calculated by dividing the number of observation visits by the number of days in each quarter.

We Want to Hear From You!

Provide your feedback on our Jamboard (comments are anonymous)!
https://jamboard.google.com/d/1Znf7p4MXAunWJ5bUfI721yn5LUa1vxQyoj5OcFQ0QOk/viewer?f=0

Questions or Comments



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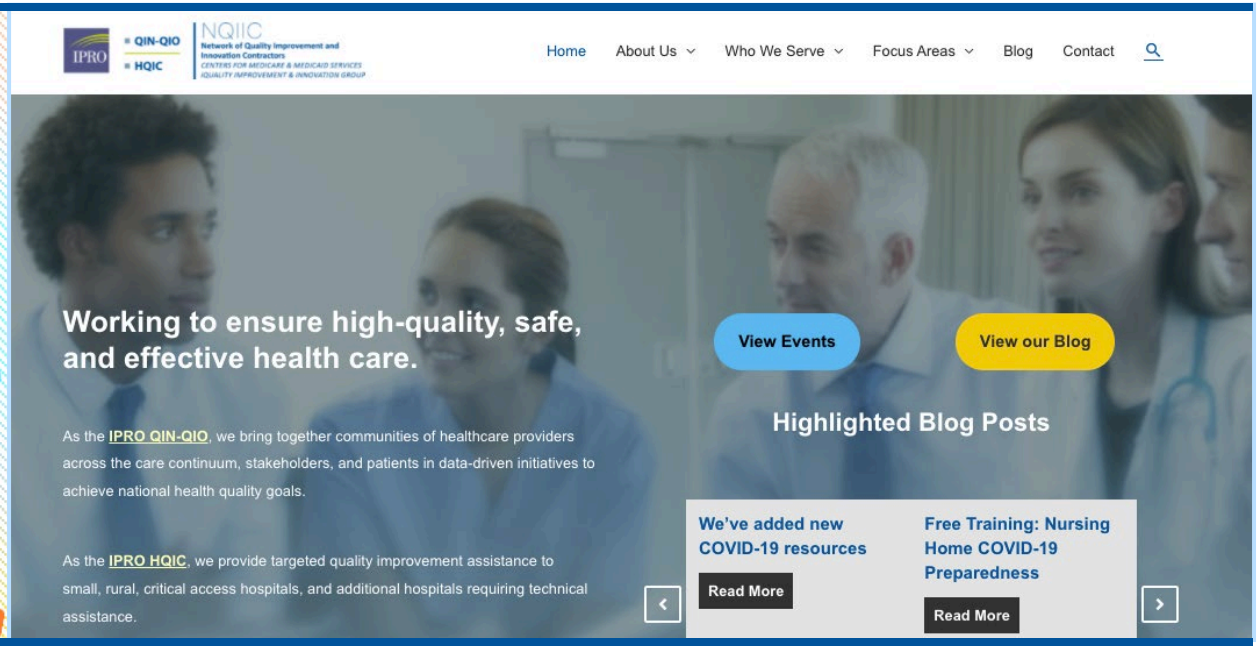

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