1. **PURPOSE**

The facility recognizes that an effective discharge planning process that focuses on the patient’s goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in post-discharge care is an important part of ensuring effective care transitions for the patient and reducing factors leading to preventable hospital readmission. The purpose of this policy is:

1. To establish discharge planning policies and procedures to ensure discharge plans are consistent with the patient’s goals for care and the patient’s treatment preferences, ensure effective transitions to post-discharge care, and reduce the factors leading to preventable hospital readmissions.
2. To establish standards for the Discharge Planning Process, Discharge Planning Evaluations, and Discharge Plans to fulfill the purpose of this Policy.
3. To establish leadership and responsibility for the standards contained in this Policy.
4. To fulfill Critical Access Hospital conditions of participation in the Medicare program and Joint Commission accreditation standards, including those applicable to Swing-Bed patient/residents and patients discharged from rehabilitation or psychiatric distinct part units of the facility.
5. **POLICY / SCOPE**
6. The governing body or responsible individual is responsible for ensuring that a policy is in place to govern Discharge Planning.
7. RNs, Social Workers, or Qualified Personnel (as defined below) are responsible for developing, or supervising the development of, and implementing the Discharge Planning Evaluation and Discharge Plans required by this Policy.
8. The standards captured in this Policy applies to all patients discharged from the facility.
9. The patient, the patient’s representative, the patient’s family, and the patient’s caregiver/support person(s) will be involved in the patient’s care, treatment, and services, and in planning the patient’s discharge.
10. All clinical and non-clinical staff and/or departments involved in the discharge process, including but not limited to licensed independent practitioners, physicians, clinical psychologists, and the staff involved in the patient’s care, treatment, and services will participate in planning the patient’s discharge.
11. **DEFINITIONS**
12. ***“Discharge Plan”*** means the plan for post-discharge care and services for a patient based on the Discharge Planning Evaluation.
13. ***“Discharge Planning Evaluation”*** means, at a minimum, an evaluation of a patient's likely need for appropriate post-discharge services, including, but not limited to, hospice care services, post-discharge extended care services, home health services, and non-health care services and community based care providers, and also includes a determination of the availability of the appropriate services as well as of the patient's access to those services.
14. ***“Discharge Planning Process”*** means the holistic process throughout the patient’s course of care, by which the facility: (1) identifies those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (2) ensures that those patients receive a Discharge Planning Evaluation and a Discharge Plan; (3) involves the patient’s family, caregiver(s), or support person(s) in the patient’s discharge; and (4) communicates information about the discharge to the patient and others.
15. ***“Qualified Personnel”*** means [INSERT STAFF TITLES] who are considered appropriately qualified and authorized to perform and/or develop Discharge Planning Evaluations and Discharge Plans. [PLACEHOLDER – include those “appropriately qualified personnel” that the facility will make responsible for developing or supervising the Discharge Planning Evaluations and Discharge Plans. This can be based on the facility’s historical practices, staffing capacity, etc., but should reflect a person who is qualified to perform those activities listed within this Policy.]
16. **PROCEDURES**
17. Discharge Planning Process. All staff involved in the patient’s care, treatment, or services and discharge are responsible for the requirements in this Section. The Discharge Planning Process is available to all patients.
	1. *Initiation of Discharge Planning Processes*. Patients will be included in the Discharge Planning Process and provided with a Discharge Planning Evaluation and Discharge Plan when:
		1. Requested by the patient;
		2. Requested by the patient’s representative;
		3. Requested by the patient’s physician;
		4. At an early stage of the patient’s episode of care, treatment, and services, the patient is identified as someone who is likely to require a Discharge Plan in order to avoid adverse health consequences post-discharge.
		5. [PLACEHOLDER – Include any organization-specific practices that address the screening/assessment that takes place to identify which patients need a Discharge Plan]
	2. *Assessment of Processes*.
		1. The facility will assess its Discharge Planning Process on a regular basis.
		2. The assessment must include ongoing, periodic review of a representative sample of Discharge Plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.
	3. *Medical Records*. The Discharge Planning Evaluation and Discharge Plan will be documented in the patient’s medical record. The medical record will also document the following:
		1. Provision of the pain management education to the patient, patient’s representative, and the patient’s family, caregiver(s), or support person(s) as applicable.
		2. Any medications dispensed or prescribed on discharge.
		3. A Discharge Summary to be provided to the patient or patient’s representative and the patient’s family, caregiver(s), and support person(s) to the extent involved in the decision-making or care. The Discharge Summary will contain the following information:
			1. The reason for hospitalization.
			2. The procedures performed.
			3. The care, treatment, and services provided.
			4. The patient’s progress towards goals.
			5. A list of the community resources or referrals made or provided to the patient.
			6. The patient’s condition and disposition at discharge.
			7. Information provided to the patient and family.
			8. Provisions for follow-up care.
18. Discharge Planning Evaluation. The RN, Social Worker, or other Qualified Personnel who is responsible for the patient’s Discharge Planning Evaluation is responsible for the requirements of this Section and for ensuring that all other relevant clinical and non-clinical staff and the patient’s family, caregiver(s), and/or support person(s) are involved in the performance of this section to the extent applicable and appropriate.
	1. *Timing*. The Discharge Planning Evaluation will be performed in a timely manner when the patient to ensure that appropriate arrangements for post-discharge care will be made before discharge and to avoid unnecessary delays in discharge.
	2. *Scope*. The Discharge Planning Evaluation will focus on the patient’s goals and treatment preferences when conducting the Discharge Planning Evaluation and developing the results of such evaluation for discussion with the patient or the patient’s representative.
	3. *Medical Record*. The Discharge Planning Evaluation will be documented in the patient's medical record.
	4. *Results of the Evaluation*. The results of the Discharge Planning Evaluation must be discussed with the patient or the patient's representative, where applicable.
19. Discharge Plan. The RN, Social Worker, or other Qualified Personnel who is responsible for the patient’s Discharge Planning Evaluation is responsible for the requirements of this Section and for ensuring that all other relevant clinical and non-clinical staff and the patient’s family, caregiver(s), and/or support person(s) are involved in the performance of this section to the extent applicable and appropriate.
	1. *Contents*. The Discharge Plan includes and/or addresses the following:
		1. The patient’s goals and treatment preferences.
		2. The patient’s discharge diagnosis.
		3. Description of the reason(s) for and conditions under which the patient is being discharged.
		4. The method for shifting responsibility for the patient’s care from the facility and its clinical staff to the post-discharge facility and health care providers, including but not limited to the patient’s primary care provider.
		5. The patient’s assessed needs and the post-discharge provider’s ability to meet those needs.
		6. For patient’s discharged from rehabilitation or psychiatric distinct part units, the Discharge Plan will include a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient).
			1. The list is only presented to patients for whom the specific services offered by the listed facilities are identified as needed.
			2. The person responsible for the Discharge Plan will document in the patient’s medical record that this list was presented to the patient or the patient’s representative.
	2. *Post-Acute Care Providers*. Prior to discharge the facility will
		1. Arrange or assist in arranging the services required by the patient after discharge to meet the patients ongoing care and service needs.
		2. Assist the patient, his or her family, or the patient’s representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital data on quality measures and data on resource use measures.
		3. Ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
	3. *Reevaluation of Patient’s Condition*. During the patient’s course of care, the patient’s condition will be regularly reevaluated to identify changes that require modification of the Discharge Plan and the Discharge Plan will be updated as needed to reflect these changes.
	4. *Pain Management Education*. At or before the time when the patient is discharged, the person responsible for the patient’s Discharge Plan or a qualified clinical staff person will:
		1. Educate the patient and the patient’s family, caregiver, and/or support person(s) on the aspects of the Discharge Plan related to pain management, including the following:
			1. Pain management plan of care.
			2. Side effects of pain management treatment.
			3. Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues.
			4. Safe use, storage, and disposal or opioids when prescribed.
		2. Document provision of the pain management education in the patient’s medical record.
	5. *Disclosable Financial Interests*. For rehabilitation and psychiatric distinct part units, the Discharge Plan will identify any home health agency or skilled nursing facility in which the facility has a disclosable financial interest or which has a disclosable financial interest in the facility.
20. Information Communicated About Discharge. The RN, Social Worker, or other Qualified Personnel who is responsible for the patient’s Discharge Planning Evaluation is responsible for the requirements of this Section and for ensuring that all other relevant clinical and non-clinical staff and the patient’s family, caregiver(s), and/or support person(s) are involved in the performance of this section to the extent applicable and appropriate.
	1. *Notice of Discharge*. When the facility determines that the patient will be discharged, information about the patient’s discharge is promptly shared with the patient or the patient’s representative and also with the patient’s family, caregiver(s), and support person(s) when those people are involved in the patient’s decision-making or ongoing care.
	2. *Medical Information*.
		1. The facility informs the patient or patient’s representative, and also the patient’s family, caregiver(s), or support person(s) when involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.
		2. The facility must discharge the patient with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.
		3. The facility educates the patient or patient’s representative, and also the patient’s family, caregiver(s), or support person(s) when involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.
	3. *Discharge Summary*. At the time of the patient’s discharge, the Discharge Summary will be provided to the patient or patient’s representative, the patient’s family, caregiver(s) or support person(s) to the extent that such people are involved in decision-making and care, and to the services providers who will be providing care, treatment, or services to the patient post-discharge.
	4. *Choice of Providers*. For patient’s being discharged from rehabilitation or psychiatric distinct part units of the facility, the patient or the patient’s representative will be informed of his or her freedom to choose among participating Medicare providers of post-discharge services.
	5. *Coverage*. If a patient of a rehabilitation or psychiatric distinct part unit is enrolled in a managed care organization, the facility will make the patient aware of the need to verify whether post-discharge providers and practitioners are enrolled in the patient’s managed care organization network. If the facility has information on which providers or practitioners are in-network for the patient’s managed care organization, it shares this information with the patient or the patient’s representative.
21. Discharge Processes Following Operations, High-Risk Procedures, and/or the Administration of Moderate or Deep Sedation or Anesthesia.
	1. *Scope of Applicability*.
		1. This Section applies to the discharge of patients who receive, in any setting (inpatient, outpatient, or other), for any purpose, by any route, the following:
			1. General, spinal, or other major regional anesthesia
			2. Moderate or deep sedation (with or without analgesia) that, in the manner used, may be expected to result in the loss of protective reflexes.
		2. This Section applies in addition to the other criteria for discharges addressed in this Policy.
	2. *Licensed Independent Practitioners*. Only qualified licensed independent practitioners may discharge patients from the recovery area or the facility.
		1. In the absence of a qualified licensed independent practitioner, patients subject to this Section may be discharged according to the following criteria:
		2. [PLACEHOLDER – Insert criteria for identifying appropriately qualified practitioners to discharge patients subject to this Section. Clinical Leaders must approve any alternative criteria for discharge provided here. For example, consider whether supervision by a licensed independent practitioner, additional training, etc. are desirable to ensure safe and appropriate discharge of these patients.]
		3. The qualified licensed independent practitioner responsible for the patient’s care and for discharging the patient will document the following in the patient’s medical record:
			1. The use of approved discharge criteria that determined the patient’s readiness for discharge
			2. The name of the qualified licensed independent practitioner responsible for discharge. This information will also be included in the patient’s post-operative record.
	3. *Responsible Individuals Required for Outpatient Discharge*. Patients who have received sedation or anesthesia as outpatients are discharged in the company of an individual who accepts responsibility for the patient.
		1. The person responsible for discharging the patient will ask whether the individual assisting the patient at the time of discharge accepts responsibility for the patient.
		2. The person responsible for discharging the patient will document the individual’s acceptance in the patient’s medical record.
22. Discharge Planning Process Requirements Specific to Swing-Bed Patient/Residents
	1. *Additional Discharge Planning Process Requirements for Swing-Bed Patient/Residents*.
		1. Staff performing comprehensive assessments of swing-bed patients/residents will include discharge planning as part of the assessment and in accordance with this Policy and any other policies governing the care delivered to swing-bed patients
		2. The Swing-Bed patient’s/resident’s preferences and potential for future discharge will be taken into account in the patient’s treatment plan.
		3. Each Swing-Bed patient/resident will be involved in the development of his or her Discharge Plan.
		4. Thirty (30) days in advance of the date of discharge (or as soon as practicable when discharge is initiated due to danger posed to other patient/residents), written notice of the discharge will be given to Swing-Bed patient/residents. The notice For Swing-Bed patient/residents will include:
			1. The reason for transfer or discharge
			2. The effective date of transfer or discharge
			3. The location to which the resident is transferred or discharged
			4. A statement of the resident’s appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request
			5. The name, address (mailing and e-mail), and telephone number of the office of the state’s long-term care ombudsman
			6. For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000
			7. For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act.
	2. *Additional Medical Record Documentation Requirements*. The Discharge Planning Evaluation and Discharge Plan will be documented in the patient’s medical record. The medical record will also document the following:
		1. The discharge information provided to the patient/resident and/or to the receiving organization.
		2. The patient/resident’s physician documentation when the patient/resident is discharged because the patient/resident’s needs cannot be met in the facility’s swing bed.
		3. The patient/resident’s physician documentation when the resident is being discharged because the safety of other patient/residents would otherwise be endangered.
		4. In the event that the patient/resident is being discharged because he or she endangers the health and safety of other patient/residents or other individuals, the facility documents the danger that failure to discharge would pose.
	3. *Additional Discharge Summary Requirements*. In addition to the information otherwise required in the Discharge Summary, as indicated in Section (1)(e)(iii) above, the Discharge Summary for Swing-Bed Patient/Residents will also document the following:
		1. Contact information of the practitioner responsible for the care of the patient/resident.
		2. Patient/resident representative information, including contact information
		3. Advance directive information.
		4. All special instructions or precautions for ongoing care, when appropriate.
		5. The patient/resident’s comprehensive care plan goals.
	4. *Additional Discharge Planning Evaluation Requirements.*
		1. For Swing-Bed patient/residents, the facility only discharges the patient/resident when at least one of the following conditions is met:
			1. The patient/resident’s health has improved to the point where he or she no longer needs the facility’s services.
			2. The discharge is necessary for the patient/resident’s welfare and the facility cannot meet the patient/resident’s needs.
			3. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident.
			4. The health of individuals in the facility would otherwise be endangered.
			5. The patient/resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.
				1. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid.
			6. The facility ceases operation.
		2. The facility will not discharge a patient/resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.
	5. *Additional Information in the Discharge Plan for Swing-Bed Patient/Residents*. For Swing-Bed patient/residents, in addition to the information otherwise required by this Policy, the patient/resident’s Discharge Plan should additionally include the following:
		1. The reason for transfer, discharge, or referral.
		2. Treatment provided, diet, medication orders, and orders for the patient’s/resident’s immediate care
		3. Referrals provided to the resident, the referring licensed independent practitioner’s name, and the name of the licensed independent practitioner who has agreed to be responsible for the patient/resident’s medical care and treatment, if this person is someone other than the referring licensed independent practitioner.
		4. Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals.
		5. Information about the patient/resident’s behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation.
		6. Nursing information that is useful in the patient/resident’s care.
		7. Any advance directives.
		8. Instructions given to the patient/resident before discharged.
		9. Attempts to meet the patient/resident’s needs.
23. **KEY SEARCH WORDS / CROSS-REFERENCING**

Patient Care Policy: [PLACEHOLDER: Policy # – If applicable to your organization, cross-reference any relevant policies, procedures, or requirements that address or overlap with standards in alignment with this policy]

Medical Records / Information Management Policy: [PLACEHOLDER: Policy # – If applicable to your organization, cross-reference any relevant policies, procedures, or requirements that address or overlap with standards in alignment with this policy]

Swing-Bed Discharge Planning Policy (if separate from this policy): [PLACEHOLDER: Policy # – If applicable to your organization, cross-reference any relevant policies, procedures, or requirements that address or overlap with standards in alignment with this policy]

1. **RELATED DOCUMENTATION AND FORMS**

Discharge Planning Evaluation Form; Discharge Plan Form; etc. **[**PLACEHOLDER – Include any forms used to fulfill the requirements of this Policy, including those used to document the Discharge Planning Evaluation, Discharge Plan, and Communications about Discharge]

1. **SOURCES / REFERENCES**
2. 42 C.F.R. § 485.642.
3. The [State Operations Manual, Appendix W](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf) includes Survey Procedures and Interpretive Guidelines for this condition of participation. As of July 2021, the State Operations Manual interpretive guidance and survey procedures guidance is pending. In future revisions to this Policy, the State Operations Manual should be reviewed for updated sub-regulatory guidance related to this condition of participation.
4. The Joint Commission, Critical Access Hospital – Provision of Care, Treatment, and Services, PC.01.01.01 *et seq*.
5. The Joint Commission, Critical Access Hospital – Record of Care, Treatment, and Service, RC.02.04.01.