Main Notebook

State of Idaho
DEPARTMENT OF HEALTH AND WELFARE

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BUREAU OF FACILITY STANDARDS

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INFORMATIONAL LETTER #97-1

DATE: March 6, 1997

TO: All Medicare Certified Hospitals

FROM: John W. Hathaway, Chief
Bureau of Facility Standards

SUBJECT: **CLARIFICATION REGARDING PROVIDERS THAT EXPAND SERVICE AREA**
PROVIDER-BASED DESIGNATION
DISCHARGE PLANNING INTERPRETIVE GUIDELINES

Enclosed is information received by our office from the Health Care Financing Administration, Region X Office, Seattle, Washington, which we believe may be beneficial to you.

If you have questions regarding the enclosed material, please contact Sylvia Creswell, Supervisor, Non-Long Term Care Section, Bureau of Facility Standards, at (208) 334-6626.

John W. Hathaway

JOHN W. HATHAWAY, Chief
Bureau of Facility Standards

JWH/nah
Enclosures
cc: Idaho Hospital Association

Printed on recycled paper.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 19 1996
FACILITY STANDARDS

April 16, 1996

Certification Improvement

STATE LETTER NO. 541

SUBJECT INDEX CATEGORY: 2

SUBJECT: Clarification Regarding Providers that Expand Service Areas

Enclosed is an April 3, 1996, memo from the Health Standards and Quality Bureau. It forwards clarification regarding providers that expand service areas by adding satellites, extensions, branches, individual or group practices or clinics to existing provider agreements or provider numbers.

If you have any questions, please contact your respective State Team.

Sincerely,

Teresa Trimble

Teresa L. Trimble, Manager
Certification Improvement

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date APR 0 3 1996

From

Technical Advisor
Center for Hospital and Community Care, HSQB

Subject

Addition of Sites to an Existing Provider

To

Associate Regional Administrator
Division of Health Standards and Quality
Regions I-X

The purpose of this memorandum is to clarify the Health Care Financing Administration's (HCFA) position concerning providers that expand their service areas by adding satellites, extensions, branches, and in the case of physicians, individual or group practices, or clinics to existing provider agreements or provider numbers. These provider expansions have implications for State agencies, regional offices, and intermediaries because they affect survey and certification, coverage and reimbursement. For example, a home health agency's (HHA) proposal to add a branch to a parent agency's geographical area requires a review of the proposal and may require a survey of the branch. The proposal could also affect the HHA's rural and urban reimbursement rates. A number of situations have arisen where a provider has been overpaid because it billed Medicare for services it provided at an expansion site without notification of the existence of the site or where it did report an expansion and never received notice that it was accepted as a part of the provider. The following guidelines apply to expanded locations including a hospital's purchase of a physician's office or clinic.

It is inherent in the provider certification process that a provider provide notication to HCFA of its proposal to expand its service area by adding a branch, satellite or extension location. The Medicare statute and applicable regulations are implicit that the proposed expanded service area meet the Conditions of Participation the same as the primary location that has signed the provider agreement or that has been assigned a provider number or both. In the absence of notification, HCFA has no way of determining whether the requirements critical to health and safety are met at the expanded location. For example, a hospice's request for a satellite location may be denied because it cannot demonstrate how the hospice will assume administrative and supervisory responsibility for the services provided at the expansion site. Moreover, there is no basis for a provider to bill Medicare for services provided by a site which has not been determined to meet applicable requirements of participation..

When an expansion request is received, before making a determination consider the following:

0 Whether the proposal meets Medicare statutory and regulatory requirements. For example, in the case of an HHA, does the proposed branch meet the definition of a branch

office at 42 CFR 484.2? If it is possible to make a decision based on the provider's description of how it intends to operate, an onsite survey may not be necessary;

0 If the proposal complies with State and local laws related to the particular type of provider/supplier; and

0 Whether Medicare reimbursement is affected by the proposal. For example, a hospital states that it has purchased a physicians'clinic that is now a part of the hospital. In such a case input from the Division of Medicare and the fiscal intermediary will likely be necessary. While HCFA does not dictate to a provider how it should operate its business, the provider does have to comply with Medicare requirements. Whenever an entity can meet the requirements of two different categories, e.g., sub-unit and independent home health agency, it is generally HCFA's policy to designate the category for which there is the least potential to increase Medicare costs. If a proposed branch is in an area that would receive a different payment rate than the parent HHA, it could be found to be in a different geographic area and determined not to be a branch.

Although legal authority exists for conducting a survey, a survey may not be necessary because the provider furnishes you with sufficient information to make a determination about its proposed expansion either at the time of its initial request or subsequently. If you believe a survey is required, but you are unable to conduct a survey within a reasonable period of time you may take one of the following actions:

0 Make a determination based on the expansion information provided by the provider and inform the provider of the decision; and

0 Inform the provider that a survey will be necessary and that it should not bill Medicare for services provided at the proposed expansion location until the survey is conducted and a determination is made.

In the absence of notification of an expansion, HCFA has the authority to deny bills for services furnished at the expanded site. When notification is received of a proposed expansion, the provider should be informed of whether the expanded site meets applicable requirements.. The fiscal intermediary should be notified of the decision. A copy of this memorandum should be provided to the State agencies, the RO's Division of Medicare, and the intermediaries.

APR 8 1996
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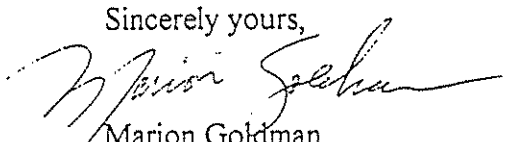
Sincerely yours,



Marion Goldman
Technical Advisor
Center for Hospital and Community Care
Health Standards and Quality Bureau

Program Memorandum
Intermediaries
HCFA Pub. 60A
Rev. A-96-7
08-96

SUBJECT: Policy Clarification: Provider-Based Designation

PURPOSE:

The purpose of this program memorandum (PM) is to consolidate and clarify the Health Care Financing Administration's (HCFA's) policy regarding provider-based and free-standing designation decisions. The various elements of this policy have been issued previously in regulations, program manuals, and letters to HCFA regional offices (ROs) or providers. This policy applies to all such designation decisions regarding any provider of services under Medicare, including physicians' practices or clinics that state they are part of a provider.

BACKGROUND:

The term or designation "provider-based" is an outgrowth of the Medicare cost reimbursement system. The main purpose of the provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider activity taking place within the same facility/organization, e.g., a hospital-based skilled nursing facility. This cost allocation and cost reimbursement more often than not results in Medicare program payments that exceed what would have been paid for if the same services were rendered by a free-standing entity.

With the growth of integrated delivery systems, HCFA has received numerous requests from entities requesting provider-based status. These requests, if approved, increase the portion of the facility's general and administrative costs that are supported by the Medicare program with no commensurate benefit to Medicare and its beneficiaries. Therefore, it is critical that HCFA designate only those entities that are unquestionably qualified as provider-based.

For example, some hospitals are purchasing physicians' clinics and multiple clinics in areas far from the licensed hospital and designating the clinics as "outpatient departments" of the hospital. If Medicare were to approve such designation as an "outpatient department" the hospital would then be allowed to increase Medicare payments by shifting overhead costs to the "outpatient department" and by increasing payments for indirect medical education. In addition to the payment impact, the Medicare coverage of "incident-to" services would also be affected if a physician's office is redesignated as a hospital outpatient department.

Medicare beneficiaries are also subject to an increased financial liability. In the example above of a hospital acquired physician practice, the

beneficiary pays the usual deductible and co-insurance for physician services which are capped by the physician fee schedule. He is also responsible for a second deductible and co-insurance for a "clinic visit" or "facility fee" to the hospital. These charges are not subject to the Medicare allowable charge or limiting charge restrictions of a physician's office.

Moreover, it should be noted that it is the intent of existing statutory and regulatory criteria for Medicare to operate as a prudent purchaser of services that enhance the care of beneficiaries. Medicare must comply with Congressional intent as reflected in §1861(v)(1)(A) of the Social Security Act to pay only for those costs that are necessary for the efficient delivery of needed health services. The statute at §1861(v)(1)(A) also provides general and specific criteria for developing payment rules to carry out the basic intent of the law as well as provisions when aggregate reimbursement produced by existing methodologies proves to be inadequate or excessive.

POLICY STATEMENT:

It is HCFA's policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g. from the same service, or catchment, area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body), and the accrediting body recognizes the entity as part of the provider;

4. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based, as evidenced by the following:

- The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;

- The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and

- The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

- The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and

- Administrative functions of the entity, e.g., records, billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;

o The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;

o All medical staff committees or other professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;

o Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;

o Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and

o Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly);

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

o The entity and the provider where it is based have an agreement for the sharing of income and expenses; and

o The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider where it is based.

DETERMINATIONS:

Determinations concerning whether an entity is provider-based (e.g., common licensure, governance, professional supervision criteria, reimbursement and accounting information) will be made by the appropriate HCFA RO components, i.e., the RO Division of Health Standards and Quality and the RO Division of Medicare with the assistance of the State survey agencies and the fiscal intermediary.

Please note that the issuance of this clarifying instruction may result in identification of previous provider-based decisions that would not be in accordance with the criteria described in this PM. In those instances, the ROs are not precluded from taking a corrective action on such erroneous designation/determinations. However, any corrective action is to be applied prospectively.

This PM may be discarded after JULY 31, 1997.

For further information, please contact David Goldberg at (410) 786-4512.

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED
MAY 6 1996
FACILITY STANDARDS

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April 30, 1996

Certification Improvement

STATE LETTER NO. 542

SUBJECT INDEX CATEGORY: 7

SUBJECT: Discharge Planning Interpretive Guidelines

The Health Standards and Quality Bureau has provided the enclosed information regarding the discharge planning interpretive guidelines. Please note that the interpretive guidelines are draft only and subject to change based on Office of Management and Budget final approval.

If you have any questions, please contact your respective State Team.

Sincerely,

Teresa Trimble

Teresa L. Trimble, Manager
Certification Improvement

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE: APR 19 1996

FROM: Nurse Consultant
Center for Hospitals and Community Care
Health Standards and Quality Bureau

SUBJECT: Discharge Planning Interpretive Guidelines

TO: Associate Regional Administrator
Division of Health standards and Quality
Regions I - X

The purpose of this memo is to update you on the clearance package for the discharge planning interpretive guidelines. Discharge planning was elevated to the level of a Medicare hospital condition of participation (CoP) at 42 CFR 482.43 as of January 13, 1995.

The clearance package for the interpretive guidelines is still under review within the Health Care Financing Administration. However, in the latest version of ASPEN, you will find that the hospital CoP deficiency data tags A330 - A344, which are now allocated to the discharge planning CoP, include the reglation text draft interpretive guidelines.

Attached is a copy of the draft interpretive guidelines on discharge planning. We welcome any substantive comments you may have after reviewing the document. Please share these draft guidelines with your State agencies and remind them that the interpretive guidelines are draft only and subject to change based on Office of Management and Budget (OMB) final approval. Once the interpretive guidelines are cleared through OMB, a State Operations Manual transmittal will be published to update the hospital interpretive guidelines (Appendix A) to reflect the discharge planning CoP.

I hope this information has been helpful. If you have any questions, you may contact either Rachael Weinstein at (410) 786-6775 or myself at (410) 786-6747.

Sincerely,

Judy Goldfarb

Judy Goldfarb

Attachment

APR 26 1996
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TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A330	§482.43 Condition of Participation: Discharge Planning 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.	Interpretive Guidelines: §482.43 The written discharge planning process must reveal a thorough, clear, comprehensive process which is understood by the hospital staff. Survey Procedures and Probes: §482.43 Review hospital written policies and procedures to determine the existence of a discharge planning process. Interview a sample of hospital staff who are involved in direct patient care. Ask the following questions: o How is discharge planning conducted at this hospital? o How are you kept apprised of the hospital's policies and procedures for discharge planning?
A331	(a) Standard: Identification of patients in need of discharge planning. 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.	Interpretive Guidelines: §482.43(a) Medicare participating hospitals are afforded great flexibility in setting the criteria for identifying patients who are likely to suffer adverse health consequences upon discharge without adequate discharge planning. Presently there is no nationally accepted tool or criteria for identifying these individuals. However, the following factors have been identified as important: functional status, cognitive abilities and family support. Patients at high-risk of requiring post-hospital services must be identified through the screening process. The hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge as they may change based on the individual's status. There is no set time frame for identification of patients requiring a discharge planning evaluation other that it must be done as early as possible. The timing is left up to the hospital, its staff and attending physicians. Survey Procedures & Probes: §482.43(a) o How does the hospital's high-risk screening system work? o What staff are involved? Who is ultimately accountable? o How is the system evaluated to make sure patients are appropriately evaluated (do not suffer adverse consequences due to inappropriate evaluation).

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(b) Standard: Discharge planning evaluation.	
A332	(1) 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.	Interpretive Guidelines : §482.43(b)(1) The needs assessment can be formal or informal. A needs assessment generally includes: an assessment of factors that impact on an individual's needs for care after discharge from the acute care setting. These may include assessment of biopsychosocial needs, the patient's and caregiver's understanding of discharge needs and identification of post-hospital care resources. At the present time, there is no nationally accepted standard. The purpose of a discharge planning evaluation is to determine continuing care needs after the patient leaves the hospital setting. It is not intended to be a care planning document. The hospital may develop an evaluation tool or protocol. Survey Procedures and Probes: §482.43(b)(1) Interview a sample of hospital staff and ask: o How are patients made aware of their rights to request a discharge plan? Talk to a sample of patients and family members who are expecting a discharge soon and ask: o Did the hospital staff assist them in planning for post-hospital care? Does the patient/family express that they feel prepared for discharge? o Are you given the pamphlet, "Important Message From Medicare"? o Are you aware that you may request assistance with discharge planning?
A333	(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) Responsibility for discharge planning is often multidisciplinary; there is no restriction to a particular discipline. The hospital has flexibility in designating the responsibilities of the registered nurse, social worker or other appropriate qualified personnel for discharge planning. The responsible personnel should have experience in discharge planning, knowledge of social and physical factors that affect functional status at discharge, knowledge of community resources to meet post-discharge clinical and social needs and assessment skills. Ideally, discharge planning will be an interdisciplinary process, involving disciplines with specific expertise, as dictated by the needs of the patient. For example, for a patient with emphysema, the discharge planner could coordinate respiratory therapy and nursing care and financial coverage for homecare services, oxygen equipment and patient/caregiver education utilizing cost-effective, available community services in an expedient manner.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
		Survey Procedures and Probes: §482.43(b)(2) o Review the written policy and procedure that designates discharge planning responsibilities. o Review the job descriptions of the designated personnel for discharge planning expectations. o Ask the designated personnel to describe their qualifications for and experience with discharge planning and evaluate whether they are congruent with the community standard of practice. o If licensing is required, current credentials must be on file.
A334	(3) 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.	Interpretive Guidelines: §482.43(b)(3) The hospital is responsible for developing the discharge plan for patients who need a plan and for arranging its initial implementation. The hospital's ability to meet discharge planning requirements is based on the following: 1)implementation of a needs assessment process with high risk criteria identified; 2)complete, timely and accurate assessment; 3)maintenance of a complete and accurate file on community-based services and facilities including long term care, subacute care, home care or other appropriate levels of care to which patients can be referred; and 4)coordination of the plan among various disciplines responsible for patient care. The hospital has latitude to demonstrate this function in the most efficient way possible. Survey Procedures and Probes: §482.43(b)(3) o What is the process the hospital uses to identify patients who need a discharge plan? (including non-Medicare beneficiaries) o Does the hospital use quality assurance and/or utilization review screens that determine whether the discharge planning process effectively identifies patients in need of plans and whether the plans are adequate and appropriately executed? o Review clinical records of several patients identified for discharge planning for appropriateness, adequacy and execution; ask staff responsible for the patients' care to describe the steps taken to implement the plan initially for the selected patients. o Ascertain whether various disciplines are involved with discharge planning, including physical, speech, occupational and respiratory therapists and dietitians, in addition to physicians, nurses and social workers.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A335	(4) 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 hospitals.	Interpretive Guidelines: §482.43(b)(4) The capacity for self-care includes the ability and willingness for such care. The choice of a continuing care provider depends on the self-care components, as well as, availability, willingness and ability of family/caregivers and the availability of resources. Patient preferences should also be considered; however, preferences are not necessarily congruent with the capacity for self care. Patients should be evaluated for return to the pre-hospital environment but also should be offered a range of realistic options to consider for post-hospital care. This includes patients admitted to a hospital from a SNF, who should be evaluated for an appropriate discharge site. Hospital staff should incorporate information the patient and/or caregivers provide for the process to be implemented. Survey Procedures and Probes: §482.43(b)(4) o Gather information about the patient's self-care capacity from the clinical record, direct clinical observation and information obtained from the patient, caregiver and staff involved in the care of the patient; judge appropriateness of discharge disposition. o Note if appropriate interdisciplinary input is documented. o Did the patient and/or caregiver participate in the needs assessment and decision for post-hospital care resources? o Is a patient who was admitted from a SNF given a full-range of realistic options for post-hospital continuation of care?
A336	(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) Patient hospital length of stay varies widely. The timing of the discharge evaluation should be relative to the patient's clinical condition and anticipated length of stay. Assessment should start as soon after admission as possible and be updated periodically during the episode of care. Information about the patient's age, sex, etc. could be collected on admission while functional ability data is best collected closer to discharge, indicating more accurately a patient's continuing care requirements. Medicare beneficiaries have the right to choosing a post-hospital vendor of services, both from community vendors and hospital sources.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
		Survey Procedures and Probes: §482.43(b)(5) o Review several patients' discharge plans for the appropriate coordination of health and social care resources based on the patient's and caregiver's post-hospital care needs. o Is length of stay prolonged because implementation of post-hospital care was delayed?
A337	(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.	Interpretive Guidelines: §482.43(b)(6) The hospital must demonstrate the development of discharge plans for patients in need and the initial implementation of the plan. Documentation of these activities is expected but the hospital has the latitude to demonstrate this in the most efficient way possible. The discharge plan generally can be found in the clinical notes if there is no dedicated form. The hospital will be expected to document its decision about the need for a plan, document the existence of plans when needed and indicate what steps were taken to implement the plans initially. Evidence of an ongoing evaluation of the discharge planning needs is the important factor. Documented evidence of discussion of the evaluation with the patient (if possible), interested persons and the next caregiver should exist in the medical record. Although not mandated, it is preferred that hospital staff would seek information from the patient and family that would make the discharge plan as realistic and viable as possible. Survey Procedures and Probes: §482.43(b)(6) o Review several clinical records for evidence of a discharge planning evaluation. o Through review of the clinical record notes and questioning of the patient and/or caregiver and staff, verify discussion of the evaluation with the involved persons.
A338	(c) Standard: Discharge Plan (1) 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) It is a management function of the hospital to assure proper supervision of its employees. The existing training and licensing of a registered nurse and social worker in discharge planning is sufficient; "other appropriate qualified personnel" may include a physician. The hospital should determine who has the requisite knowledge and skills to do the job regardless of how these were acquired. However, because post-hospital services and, ultimately, the patient's recovery and quality of life can be affected by the discharge plan, the plan should be supervised by qualified personnel to ensure professional accountability.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
		Survey Procedures and Probes: §482.43(c)(1) o Examine patients' clinical records for reference to a registered nurse, social worker or other designated qualified personnel or their signature on a written discharge plan notation. o Ask staff to describe who oversees the development of a discharge plan.
A339	(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) The physician can make the final decision as to whether a discharge plan is necessary. The hospital will develop a plan if a physician requests one even if the interdisciplinary team had determined one to be unnecessary. Survey Procedures and Probes: §482.43(c)(2) o Review the hospital policy and procedure to determine who may request a discharge plan. o Is there reference to or existence of a discharge plan in the clinical record when requested by a physician? o Ask a physician involved with discharge planning about experiences with requesting development of discharge plans when the interdisciplinary team does not recommend a plan.
A340	(3) The hospital must arrange for the initial implementation of the patient's discharge plan.	Interpretive Guidelines: §482.43(c)(3) The hospital is required to arrange for the initial implementation of the discharge plan. This includes arranging for necessary post-hospital services and care, and educating patients/family/caregivers/community providers about post-hospital care plans. Survey Procedures and Probes: §482.43(c)(3) o There is documented evidence of implementation of the discharge plan, including contact and transmission of information to the patient (when possible) and the next caregiver.
A341	(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) The discharge planning evaluation should be initiated as soon as possible after admission and updated as changes in the patient's condition and needs occur, and, as close as possible to the patient's actual discharge.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
		Survey Procedures and Probes: §482.43(c)(4) o Review the hospital's policy on reassessment of discharge plans. o Review several clinical records for evidence of reassessment of the patient and related changes in the discharge plan when warranted. o Ask staff involved with discharge planning to discuss the reassessment process and/or present a clinical record that documents reassessment.
A342	(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)(5) Evidence should exist that the patient and/or family and/or caregiver are provided information and instructions in preparation for post-hospital care. Hospital personnel are in the best position to judge the appropriate time for such guidance. Use of family caregivers in providing post-hospital care should occur when the family is both willing and able to do so. It is appropriate to use community resources with or without family support whenever necessary. Survey Procedures and Probes: §482.43(c)(5) o Where possible, interview patients and their family members to determine whether they have been instructed in post-hospital care e.g., medication administration, dressing changes, cast care, etc. If the patient is being transferred to an alternate care delivery setting, has this information been shared with the patient? Have goals for care in the other setting been set? o Is there documentation of communication of care information to this post-hospital care setting?
A343	(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 followup or ancillary care.	Interpretive Guidelines: §482.43(d) The hospital must assure that patients receive proper post-hospital care within the constraints of a hospital's authority under State law and within the limits of a patient's right to refuse discharge planning services. If a patient exercises the right to refuse discharge planning or to comply with a discharge plan, documentation of the refusal is recommended. "Medical information" may be released only to authorized individuals according to provision §482.24 (b)(3). Examples of necessary information include functional capacity of the patient, requirements for health care services/procedures, discharge summary and referral forms (see §482.21 (b)(2)). "Appropriate facilities" refers to facilities that can meet the patient's assessed needs on a post-discharge basis, that comply with Federal and State standards, participate in payment programs suitable for the patient's care and are within reasonable distance of the patient's residence so that relatives and friends may visit.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
		Survey Procedures and Probes: §482.43(d) o Ask staff involved with discharge planning to describe the process of transfer of patient information from the hospital to a post-discharge facility. o Does the process assure continuity of care? o Are the patient's rights, such as for confidentiality, refusal and preference considered? o If required, is there evidence of written authorization by the patient before release of information?
A344	(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: §482.43(e) The hospital must have a mechanism in place for ongoing reassessment of its discharge planning process. Although specific parameters or measures that would be included in a reassessment are not required, the hospital should assure the following factors in the reassessment process: 1.The effectiveness of the criteria to identify patients needing discharge plans. 2.The quality and timeliness for discharge planning evaluations and discharge plans. 3.The hospital discharge personnel maintain complete and accurate information to advise patients and their representatives of appropriate options. 4.The hospital has a coordinated discharge planning process that integrates discharge planning with other functional departments, including the quality assurance and utilization review activities of the institution and involves various disciplines. Survey Procedures and Probes: §482.43(e) o Review hospital policies and procedures to determine how often the discharge planning process is reassessed. o Ask hospital staff how often the discharge planning process is reassessed. What data is examined to determine how well the process is working in providing for continued care of the patient?