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

the hospital stay, but discontinued prior to discharge (e.g., 24-48 hours before discharge));

- Medications, such as an incomplete comprehensive list of all medications that have been prescribed to a patient during, and prior to, their hospital stay. Common omissions also include patient diagnoses or problem lists, clinical indications, lab results, and/or clear orders for the post-discharge medication regimen. Medication information omissions have been most commonly reported for psychotropic medications and "hard" prescriptions for narcotics (i.e., provided on paper, not electronic, as required by law);
- Skin tears, pressure ulcers, bruising, or lacerations (e.g., surgical site(s), skin conditions noted upon hospital admission and/or acquired during hospitalization), including orders or instructions for cultures, treatments, or dressings;
- Durable Medical Equipment, such as Trilogy, CPAP/BiPap or high-flow oxygen which are used for respiratory treatments and skin healing equipment for example mattresses, wound vacuum machine for treatment of a variety of wounds including surgical wounds, pressure ulcers, diabetic ulcers, etc;
- A patient's preferences and goals for care, such as their choices for treatment or their advance directives for end-of-life care; and
- Communication (with PAC providers and/or caregivers) about a patient's needs at home, or how their home environment may impact their ability to maintain their health and safety after discharge from the SNF (e.g., risk of falls, family or caregiving involvement/availability, homelessness, etc.).

Discussion:

When the above issues occur, PAC providers are not properly prepared to care for new admissions, and caregivers are not properly prepared to care for their loved ones at home. Also, PAC providers may not be equipped or trained to care for certain conditions that apply to patients whose information they were not previously informed of by the hospital and have accepted for transfer and admission. Not only can this place the patient's health at risk, it can also put the health and safety of other residents (in the patient's home or in a SNF), as well as provider staff, at risk. These situations can cause avoidable readmissions, complications, and other adverse events. Finally, when an individual's preferences for end-of-life care are not known, they may receive treatments that are unnecessary or inconsistent with their wishes.

Therefore, we are reminding state agencies (SAs), accrediting organizations (AOs), and hospitals that when patients are discharged (per 42 CFR 482.43), CMS regulations require hospitals to, "have 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 the discharge planning for post-discharge care." Also, "the hospital must discharge the patient, and also transfer or refer the patient where applicable, along 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." When conducting surveys, SAs and AOs should be alert to the common issues identified above and ensure these discharges are occurring in a compliant and safe manner.

Hospitals have discretion to develop their own policies and procedures to meet the requirements. However, CMS is also providing the following recommendations that providers may find helpful:

- There are several resources available that hospitals can use to improve their discharge policies and procedures, such as the Agency for Healthcare Research and Quality (AHRQ) Re-Engineered Discharge (RED) Toolkit.
- Collaborate with PAC providers, such as agreeing on standardized processes, information, or forms that are used during discharges, such as the InterACT Hospital to Post Acute Care Transfer Form.
- Also, conduct case reviews of previous discharges to improve the outcomes of future discharges.
- Enable access to patient information in electronic health records (EHRs) across hospitals and PAC providers, so providers can access the necessary information to improve transitions.

Contact:

For questions or concerns relating to this memorandum, please contact QSOG_Hospital@cms.hhs.gov.

Effective Date:

Immediately.

/s/
David R. Wright
Director, Quality, Safety & Oversight Group

Resources to Improve Quality of Care:

Check out CMS's new Quality in Focus interactive video series. The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid. Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the Quality, Safety, & Education Portal Training Catalog, and select Quality in Focus