On October 29, 2015, Centers for Medicare & Medicare Services (CMS) proposed a new rule that would require hospitals to have a comprehensive discharge process and plan in place for all patients. The purpose of the proposed rule is to engage patients in their plan of care, both during their hospital visit or stay, and after they are discharged with a focus on patient preferences. CMS states the expected outcome of the proposed ruling is to reduce patient readmissions, complications and adverse events, ultimately improving the quality of care and patient experience.

The proposed rule would also mandate a discharge planning process under the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The IMPACT Act requires hospitals and facilities to partner with patients on their discharge planning process, and include the individual patient’s goals for their care plan in that process.

Let’s look at the details and impact this rule would have for both hospitals and patients.

**Which healthcare facilities would be impacted?**
- Acute Care Hospitals (including inpatient rehabilitation facilities and long-term care hospitals)
- Critical Access Hospitals
- Home Health Agencies

**What is the scope of this proposed rule?**
The proposed rule would apply to all inpatients and certain types of outpatients, including patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and emergency department patients who have been identified by a practitioner as needing a discharge plan.

**What is required of hospitals?**
If passed, hospitals would be required to provide both patients and other facilities with relevant medical information. Patients being discharged to their homes would receive detailed discharge instructions to aid in their recovery. If being discharged to another facility, hospitals would be required to share specific medical information with those facilities. Hospitals would also be required to have medication reconciliation processes in place and create a post-discharge follow-up process (required by hospitals and critical-access hospitals only).

The proposed rule states that a discharge plan must be in place within 24 hours of patient admission and completed prior to discharge for all inpatients and certain outpatients such as same-day surgery where anesthesia is used, emergency department patients in need of a discharge plan per their provider and patients under observation status. The proposed rule will also require an established post-discharge follow-up process (proposed for hospitals and critical access hospitals only).
What is the impact on patients?
The proposed rule is designed to provide better quality and individualized care to patients. It would ensure patients understand their diagnosis, can name their medications, dosages and side effects, and agree to their follow-up care plan. Further, the rule would ensure that patient’s needs, preferences and goals for their care are met by healthcare providers.

In the press release announcing the proposed rule, CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc states “This rule puts the patient and their caregivers at the center of care delivery.” He continues “Patients will receive discharge instructions, based on their goals and preferences, that clearly communicate what medications and other follow-up is needed after discharge, and pertinent medical information will be communicated to providers who care for the patient after discharge. This leads to better care, smarter spending, and healthier people.”

Access the press release shared by CMS.

Read the proposed rule in its entirety on the Federal Register.

Where do we start?
Studer Group has always recognized the importance of the post-discharge phase of healing as critical to high quality clinical outcomes. We have found that post-discharge/visit phone calls are an effective way to provide quality touch points along a patient’s continuum of care following their visit. In order to meet the needs of both patients and hospitals, we created Patient Call Manager℠: The Clinical Call System (PCM). It’s designed to make patients part of the collaborative care team and extends care outside the hospital walls – both before patients enter the healthcare organization and after they leave. Post-discharge/visit phone calls are proven to improve patient safety, quality and experiences, and reduce readmissions. Through the use of PCM, one organization that partners with Studer Group was able to realize a cost avoidance of $1.5 million during an eight month time frame by reducing their sickle cell readmissions from 14.8% to 2.5%.

To learn more about Patient Call Manager℠ and post-visit calls, contact Accelerators@studergroup.com or visit studergroup.com/pcm. Studer Group will continue to provide updates as the proposed rule is finalized.