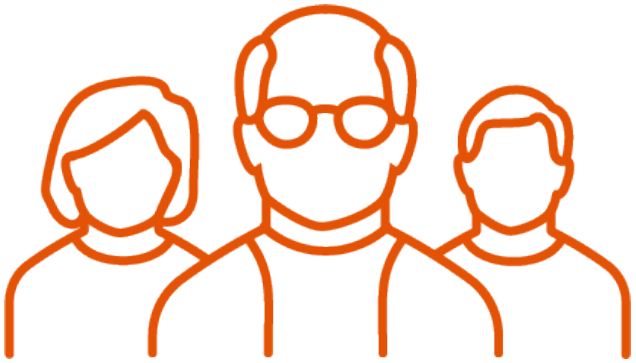
A renewed emphasis on creating a clean line of communication between patients and their providers during the discharge process was finalized last September with the Centers for Medicare & Medicaid Services' (CMS) Discharge Planning Rule.

The final rule tasks providers with giving patients the information required to make an informed care decision, engaging them throughout the discharge planning process. The goal? Better care coordination from beginning to end: from the time of the acute event, to the post-acute care (PAC) setting, to the eventual return home.

"Patients will now no longer be an afterthought; they'll be in the driver's seat, playing an active role in their care transitions to ensure seamless coordination of care," said CMS Administrator Seema Verma in a September statement.

Managed care among patients who are high users of post-acute care is complicated, and that won't change. But the rule does provide an opportunity for improved communication with patients and their caregivers, which will ultimately result in more effective discharge planning, better care coordination, and a better patient experience for patients and providers.

Let's look at a few of these benefits to patients and providers that the discharge planning rule makes more prevalent:



1. The patient is more involved

At the end of the day, better outcomes are closely tied to patient experience. And if the patient's experience with the discharge planning process is limited to being transferred from a hospital bed to a PAC bed in a facility he knows nothing about, the likelihood of that experience being a positive one is slim. In fact, if he's discharged to a PAC setting that isn't appropriate for his care needs, he'll likely end up back where he started. The reality is this: no one knows what's best for the patient better than the patient (or his caregiver) himself.

While a patient may not always make the best choice on his own, his perspective and preferences are nonetheless critical—and need to be heard.

According to Patient Engagement HIT, the new rule requires hospitals to assess any patients they believe are at risk for readmission or relapse. This protects providers who may have a patient wanting to go home before he's truly ready. However, in the case of a patient or family caregiver who is concerned about an early discharge recommended by the provider, the rule allows the patient or caregiver to provide a discharge summary, both physically and an electronic version of their medical record.

The rule also requires hospitals to provide PAC facility quality scores that would potentially help impact the patient or caregiver their decision. These types of quality measures can be related to things such as the number of pressure ulcers in a given facility, the proportion of falls that lead to injury and the readmission rate, according to CMS.

2. There's an improvement in the patient's social determinants of health profile

When patients and caregivers are placed in a PAC that doesn't fit all of their needs, there is an increased risk of isolation and loneliness on the part of the patient, while also causing stress on the caregiver and family members who cannot visit frequently enough to lessen that loneliness and isolation.

Social determinants of health (SDOH) are tremendously valuable in reducing readmission and ensuring a successful hospital discharge. By keeping the patient and caregiver engaged and informed throughout the journey from hospital to home, providers can better consider the necessary and appropriate value of SDOH for the patient's long-term success.

3. There's a reduction in readmissions

Getting home faster isn't always best for the patient but going to the wrong place after discharge can prolong—or even prevent—the return home. Thanks to better data accessibility, as required by this new rule, patients and providers can work together to prevent unnecessary readmissions.

By leveraging tools like the Skilled Nursing Facility (SNF) Compare website from CMS, patients and providers have equal access to quality measures data and are set up for better communication, which in turn improves care coordination. The rule and the SNF Compare website are a part of CMS' broader mission to expand interoperability across healthcare settings to ensure patients' health data is accessible and shared across providers. Patients become a true stakeholder in their care when they're invited into the post-acute referral conversation, allowing them to be involved early in the decision-making process and providing access to other available care transition tools.

Kathryn Bowles, the van Ameringen Chair in Nursing Excellence, told Patient Engagement HIT just how tricky discharge planning can be for medical providers.

"With hospitals working toward shorter lengths of stay, families have been left scrambling to decide whether they will utilize post-acute care, and where. This tool simplifies their options," Bowles said.

CMS' final discharge rule is more than just an additional attempt at helping providers lower readmission rates. This rule addresses the potential significant communication lapses between patients and providers during the discharge process. When both parties work together toward finding the next care option that provides the best chance for improvement, families will no longer find themselves feeling alone and in the dark at one of the most stressful times of their lives, but rather supported, guided and empowered during their important care journey.