Federal Hospital Care Transitions Resources and the Aging and Disability Network

The COVID-19 public health emergency led many hospitals to quickly plan how to address rising hospitalization rates, reduced bed capacity, and expedited discharges. Due to infection control concerns at nursing facilities, hospitals discharge many individuals to the community and there is an emergent need to rely on community based organizations (CBOs) to support transitions of care. As a result, CBOs providing care transitions services have a heavy emphasis on hospital-to-home transitions and nursing home diversion activities. These services are an important tool to manage hospital surge capacity and to support people with nursing home level of care needs to live safely in the community. When the pandemic slows and hospitals return to normal capacity, hospital to home transitions can continue as an important option for many individuals discharging from hospital stays.

The resources below are tools the aging and disability network can use to better facilitate these transitions. They inform decision making processes with hospitalists, population health managers, discharge planners, and other stakeholders to develop and refine their discharge strategy during the COVID-19 pandemic. A consistent recommendation is that hospitals collaborate with CBOs, such as Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs), to address surge capacity and the home and community based services (HCBS) needs of high-risk populations. CBOs have become a valuable resource to hospitals to address the holistic range of needs of older adults and persons with disability.

Discharge Planning and Care Coordination during the COVID-19 Pandemic

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) released the *Discharge Planning and Care Coordination during the COVID-19 Pandemic* toolkit for hospital discharge planners that includes resources and promising practices to facilitate safe hospital discharges during the COVID-19 pandemic.[1] The toolkit relates the CMIST Framework (CMIST: C = communication, M = Maintaining Health I = Independence, S = Safety, Support Services, and Self-Determination, T = Transportation), to COVID-19 discharge planning, applying the five categories to address accessibility and functional needs of individuals during a public health emergency. This toolkit is one of numerous HHS resources and regulations that recognize the important role of the aging and disability network in providing hospital care transitions services. In the Returning Home

> **Returning Home - Maintaining Health**
> "If the individual needs long term services and support (LTSS) and/or HCBS, the **discharge planning process** should work to establish those services, either in-person or virtually, with **assistance from the ADRCs/No Wrong Door (NWD) System**."

[1] U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response. (2020). Discharge Planning and Care Coordination during the COVID-19 Pandemic. Available at https://www.phe.gov/emergency/events/COVID19/atrisk/discharge-planning/Pages/default.aspx

section of the toolkit, the second CMIST category, Maintaining Health, describes how hospital discharge planners can leverage care transitions providers in the Aging and Disability Resource Centers (ADRCs)/No Wrong Door (NWD) System.

In addition to the recent HHS/ASPR resource, the Centers for Medicare and Medicaid (CMS) issued the September 2019 CMS *Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies final rule*.[2] This final rule urged hospitals to develop ongoing and collaborative partnerships with CBOs, such as ADRCs, AAAs and CILs to help patients, families and friends connect to community services and supports. The rule has proven pertinent to the current environment. Safely transitioning individuals home from hospital stays reduces exposure risk to COVID-19, a priority of hospitals and the aging and disability network.

> *We [HHS] "expect CILs, AAAs, and ADRCs would assist patients in accessing LTSS, and would have staff trained to help patients and their families exercise their choice and control over the types of LTSS that work best for them in their lives… We therefore urge hospitals to develop collaborative partnerships with these community-based care organizations in their respective areas to improve transitions of care that might support better patient outcomes."*
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> *Source: CMS. Federal Register. Volume 84. No. 189. September 30, 2019., Page 51852,Available Online: https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20732.pdf*

A final resource is the 2020 CMS *Hospital Discharge Planning Worksheet*.[3] Although the work sheet was released prior to the height of the pandemic, it is supportive of partnerships between CBOs and hospitals, which remain important to meeting hospital needs. On January 1, 2020, CMS released an updated version of the *Hospital Discharge Planning Worksheet* that includes a list of items to address during on-site assessments to determine hospital compliance with the Discharge Planning Condition of Participation regulation.[4] The checklist provides questions to include in a chart review. It asks if community-based services were deployed, based on an identified need. One section of the checklist focuses on hospital referrals to CBOs, such as AAAs, ADRCs, and CILs, to meet the needs of hospitalized patients that require HCBS or LTSS.

> **CMS Discharge Planning Checklist Section 4.18g**
> Referrals, if applicable, to community-based resources other than health services, e.g. Depts. of Aging, elder services, transportation services, etc.

The resources in this document outline steps and strategies that encourage hospitals to partner with CBOs to meet the transition needs of individuals discharging home. Aging and disability network entities can use the resources to encourage connections and partnerships with hospital staff to develop and refine their discharge strategy.

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[2] Centers for Medicare & Medicaid Services (CMS), HHS. (2020). Discharge Panning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Available at: https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals

[3] Centers for Medicare & Medicaid Services (CMS), HHS. (2020). Hospital Discharge Planning Worksheet. Available at: https://www.hhs.gov/guidance/document/hospital-discharge-planning-worksheet

[4] Centers for Medicare &Medicaid (CMS), HHS. Electronic Code of Federal Regulations (e-CFR). Title 42 – Public health, Part 482 – Conditions of Participation for Hospitals, 482.43 Condition of participation: Discharge planning. Available at: https://www.law.cornell.edu/cfr/text/42/482.43