5 Sure-Fire Methods

Complying with Standard PC.04.01.01

Thorough planning and implementation of discharge and transfer processes—including the continuation of care, treatment, and services—are essential to reducing patient risk for complications and readmissions. Provision of Care, Treatment, and Services (PC) Standard **PC.04.01.01** requires that hospitals have a process to address the patient's need for continuing care, treatment, and services after discharge or transfer (*see* "Related Requirements" on page 3 for the entire standard).

Ineffective discharge planning can seriously impact a patient's health and future care.

Some hospitals struggle with compliance. According to Jane Schetter, RN, MSN, CNS, CJCP, senior Continuous Service Readiness (CSR) consultant, Joint Commission Resources, one of the reasons hospitals are having difficulty with this standard is that they do not have clearly defined processes. "Those who do have defined processes don't always apply them consistently," she adds.

Standard PC.04.01.01 includes additional requirements for hospitals that use Joint Commission accreditation for deemed status purposes. Melissa Hager, BSN, RN, CMS consultant, Joint Commission Resources, says that in some cases, hospital policies do not mirror the US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. "The CMS regulations require that all inpatients be screened for discharge planning and that those who meet certain criteria be evaluated," she says. "A patient and/or a physician can also request an evaluation, in which case one would also be required. In some cases, hospital policies don't address how the person who is responsible for discharge planning will be made aware of changes in a patient's condition that might later trigger a need for a discharge evaluation."

Schetter and Hager offer the following five strategies that can help hospitals to better comply with Standard PC.04.01.01:

1 **Review Joint Commission and CMS requirements.** CMS has a discharge planning booklet* that outlines the CMS requirements. The elements

* *See* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf.

Related Requirements

Standard PC.04.01.01
The hospital has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer.

Elements of Performance for PC.04.01.01

1. The hospital describes the reason(s) for and conditions under which the patient is discharged or transferred.
2. The hospital describes the method for shifting responsibility for a patient's care from one clinician, hospital, program, or service to another.
3. The hospital describes the mechanisms for external transfer of the patient.
4. The hospital agrees with the receiving organization about each of their roles to keep the patient safe during transfer.

22. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital informs the patient or the patient's family of his or her freedom to choose among participating Medicare providers and, when possible, respects the patient's and family's preferences when they are expressed. The hospital does not limit the qualified providers that are available to the patient.
23. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the discharge planning evaluation indicates a need for home health care, the hospital includes in the discharge plan a list of participating Medicare home health agencies (which have requested to be on the list) that are available and serve the patient's geographic area. For patients enrolled in managed care organizations, the hospital lists home health agencies that have a contract with the managed care organization.
24. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the discharge planning evaluation indicates a need for posthospital extended care services, the hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the hospital lists skilled nursing facilities that have a contract with the managed care organization.
25. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital documents in the patient's medical record that the list of home health agencies or skilled nursing facilities was presented to the patient or to the individual acting on the patient's behalf. The discharge plan identifies disclosable financial interests between the hospital and any home health agency or skilled nursing facility on the list.
Note: *Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420.206.*
26. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has written discharge planning policies and procedures applicable to all patients.

of performance for PC.04.01.01 outline the Joint Commission requirements. Joint Commission Resources has also developed a Discharge Planning and Continuity of Care Evaluation and Tracer Tool (*see* Figure 1 on pages 17–18 of the online version of this newsletter) that can be used to assess preparedness and for conducting tracer activities.

2 **Clearly define your processes.** "It's important to have clearly defined processes and that all staff understand those processes, including which outpatient services should be included in discharge planning," Schetter says. "For example, when a patient does not meet the full discharge criteria from a service, but does not meet criteria for continued care in that service, there needs to be a plan in place for transfer either internally or externally."

3 **Consider providing a discharge plan for all inpatients.** "Although developing a plan for all inpatients is not a requirement, it's a good practice because it can help keep people from falling through the cracks," says Hager. "In other words, there would be no gaps if a patient didn't initially meet the criteria for discharge planning, but conditions changed over the course of his or her hospital stay that caused the patient to meet the criteria."

4 **Update patient resource lists.** Hospitals that use Joint Commission accreditation for deemed status purposes are required to provide lists of outside services, when applicable. "It's very important to keep up-to-date lists and also know which services each outside organization provides so you can make appropriate referrals," Schetter says. "You also need to disclose any financial interests between the hospital and the facilities on your lists. One way to provide that information would be to add footnotes to your handouts."

5 **Conduct periodic chart reviews.** "On an ongoing basis, review records to ensure that the hospital is meeting its own processes for identifying patient discharge and transfer needs and making arrangements to meet those needs," says Schetter. "Interview staff to assess their understanding of the processes and required documentation. Review and update processes, as needed, if you find that you're not appropriately identifying patients who may need a discharge plan." TS

Figure 1. Discharge Planning and Continuity of Care Evaluation and Tracer Tool

	Comments/Follow-Up Needed	Y	N
Review the hospital's discharge planning screening procedure.			
• Does it identify patients who need discharge planning evaluations?			
• How does the hospital's high-risk screening procedure work?			
• What staff are involved?			
• Review the written policy and procedure that designates discharge-planning responsibilities.			
• Is it clear who is ultimately accountable?			
• Who evaluates the procedure to make sure patients are appropriately evaluated and that patients do not suffer adverse consequences due to lack of or insufficient discharge planning?			
Interview a sample of hospital staff and ask:			
• How are the patients who are in need of discharge planning identified?			
• How are patients and caregivers 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:			
• Did the hospital staff assist them in planning for posthospital care? Does the patient/family express that they feel prepared for discharge?			
• Were you given any handouts?			
• Are you aware that you may request assistance with discharge planning?			
Determine who is responsible for discharge planning.			
• Ask the designated personnel to describe their qualifications for and experience with discharge planning.			
• Evaluate whether they are familiar with the community standard of practice.			
• Review the job description(s) of the designated personnel for discharge planning expectations.			
• If licensing is required, are current credentials on file?			
• Ascertain whether various disciplines are involved with discharge planning, including physical, speech, occupational, and respiratory therapists, and dietitians, in addition to MD/DOs, nurses, and social workers.			
Review a sample of discharge planning evaluations.			
• Gather information about the patient's self-care capacity from the clinical record, direct observation, and information obtained from the patient, caregiver, and staff involved in the care of the patient; judge appropriateness of discharge disposition.			
• Note if appropriate interdisciplinary input is documented.			
• Did the patient and/or caregiver participate in the needs assessment and decision for posthospital care resources?			
• Is a patient who was admitted from a home or another setting given a full range of realistic options for posthospital continuation of care?			
Review several patients' discharge plans for the appropriate coordination of health and social care resources based on the individual patient's and caregiver's expected posthospital needs.			
• Is there a pattern of prolonged length of stay for certain patient populations because the evaluation for posthospital care was delayed? o If so, is the delay due to circumstances beyond the hospital's control (e.g., inability to reach the beneficiary's responsible person(s), continuing change in the patient's condition), and/or is the delay due to poor hospital planning for timely posthospital arrangements)?			

(continued on page 18)

Figure 1. Discharge Planning and Continuity of Care Evaluation and Tracer Tool (continued)

	Comments/Follow-Up Needed	Y	N
Review several clinical records for evidence of a discharge planning evaluation.			
• 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.			
Examine patients' clinical records for references to a registered nurse, social worker, or other designated qualified personnel or their signature on a written discharge plan notation.			
• Ask staff to describe who oversees the development of a discharge plan.			
Review the hospital policy and procedure to determine who may request a discharge plan.			
• Is there reference to or existence of a discharge plan in the clinical record when requested by a physician?			
• Ask a physician involved with discharge planning about experiences with requesting development of discharge plans when the interdisciplinary team does not recommend a plan.			
Review a sample of patient records.			
• Determine if 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.			
• Ask staff responsible for the patient's care to describe the steps taken to implement the plan initially for the patients.			
Review the hospital's policy on reassessment of discharge plans.			
• Review several clinical records for evidence of reassessment of the patient and related changes with regard to the care plan/critical pathway(s) in the discharge plan when warranted.			
• Ask staff involved with discharge planning to discuss the reassessment process and/or present a clinical record that documents reassessment.			
• Where possible, interview patients and their family members to determine whether they have been instructed in posthospital care. Potential training could include the timing and dosage of medications, and the wide effects of medications, treatments, and therapy regimens.			
• If the patient is being transferred to an alternate care delivery setting, has this information been shared with the patient?			
Transfer or referral			
• Ask staff involved with discharge planning to describe the process of transfer of patient information from the hospital to a postdischarge facility.			
• Does the process assure continuity of care?			
• Are the patient's rights, such as for confidentiality, refusal, and preference, considered?			
• If required, is there evidence of written authorization by the patient before release of information?			
• Is there documentation that care instruction has been communicated to the posthospital care setting?			
Review hospital policies and procedures to determine how often the discharge planning process is reassessed.			
• Does the hospital's QAPI program determine whether its discharge planning process effectively identifies patients who need discharge planning, whether the plans are adequate, and whether the plans are effectively executed?			
• Ask hospital staff how often the discharge planning process is reassessed.			
• What data are examined to determine how well the process is working in providing for continued care of the patient?			