Tool 6: Conditions of Participation Checklist Tool

**Purpose:** Review whether current practice meets updated CMS guidelines.

**Description:** This one-page tool, adapted from the CMS Conditions of Participation surveyor guidance, prompts consideration of whether a set of standardized improvements are being provided to all patients, regardless of “risk.”

**Staff:** Quality improvement, nursing, case management staff.

**Time required:** 2 hours
### Tool 6: Conditions of Participation Checklist Tool*  

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| ❑ Have written procedures for transitional care planning that apply to all inpatients? | • Do you identify patients in need of transitional care planning early during the hospitalization?  
• Do you identify which staff are responsible for carrying out the evaluation to identify patients likely to need transitional care planning? |
| ❑ Use an evidence-based method for SCREENING patients for transitional care planning needs? | • If you do not develop a transitional care plan for every inpatient, do you screen all inpatients to determine which ones are high risk for adverse consequences, including readmission, if there is no adequate transitional care planning? |
| ❑ Provide a transitional care planning EVALUATION upon request by the patient, or patient’s family/informal caregiver(s), or the patient’s physician? | • Does the evaluation address: (1) the likelihood of a patient needing posthospital services and the availability of the services; (2) the likelihood of a patient’s capacity for self-care or being cared for in the environment from which he or she entered the hospital; and (3) coordination with insurers and other payers to ensure resources prescribed are approved and available?  
• Is the evaluation completed early—prior to discharge—to allow services to be arranged? |
| ❑ Engage the patient and the patient’s caregiver(s) in creating the discharge plan? | • Do you discuss the evaluation and customized discharge plan with the patient?  
• Do you discuss the results of the evaluation, i.e., the need for and availability of posthospital care, with the patient and/or caregiver? |
| ❑ Know the capabilities of postacute and community providers, including support services? | • Are you knowledgeable about the specific care capabilities of long-term care facilities and community-based services, including home health, behavioral health, transitional care, and housing, and social supports particularly relevant to the Medicaid population? |
| ❑ Arrange for posthospital services prior to discharge and effectively communicate with “receiving” providers? | • Do you not just refer—but arrange for—followup appointments?  
• Do you not just refer—but arrange for—durable medical equipment to be secured?  
• Do you not just refer—but arrange for—posthospital services and supports?  
• Do you communicate—allowing for questions and clarification—with receiving providers? |
| ❑ Routinely reassess patients for their transitional care needs? | • Do you have in place a routine reassessment of all patients or a process for triggering a reassessment of the patient’s transitional care needs when significant changes in the patient’s condition or available supports occur? |
| ❑ Teach patients and their families self-care skills using the teach-back technique? | • Is the education and training provided to the patient or patient’s caregiver(s) tailored to the patient?  
• Is teach-back used to confirm understanding of medication, appointments, self-management tasks, and other followup activities? |
| ❑ Analyze and trend readmission data and look for root causes? | • Do you reassess the effectiveness of your discharge planning process on an ongoing basis? Does it include a review of discharge plans to ensure that they are responsive to discharge needs?  
• Do you track readmissions to your own hospital on an ongoing basis (i.e., at least quarterly) and identify opportunities for continual improvement? |

* Developed based on May 17, 2013, Centers for Medicare & Medicaid Services updated interpretive guidelines for hospital discharge planning.