# Wrench and hammer tool logo  Tool 8: Conditions of Participation Handout

### Purpose

In November 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed revision to the Conditions of Participation (COPs). CMS specified new and unique elements that are particularly germane to reducing Medicaid readmissions and improving whole-person transitional care. Many hospitals have implemented some elements of these new CMS COPs for their high-risk patients. These best practices will improve care for all patients, especially Medicaid and other patients with high-risk diagnoses (e.g., HIV, liver disease, sickle cell disease), behavioral health conditions, and social support needs.

This tool is meant to assist in promoting awareness of the contents of the CMS COPs so that hospital staff can better understand how their work relates to CMS guidance.

### Description

This 1-page handout offers an overview of the transitional care practices as outlined by the guidance and proposed changes to the CMS COPs. It can be used as a handout, in educational sessions, and as a guide to the work of your readmission reduction team.

### Staff

Readmission reduction champion (in strategic planning); day-to-day leader (education and improvement work).

### Time Required

10 minutes to review and consider circulating or discussing at next readmission team meeting.

### Additional Resources

**Tool 10: Discharge Information Checklist** and Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for additional information.

## Improving Transitional Care for All Patients

CMS has recommended that hospitals do the following to improve discharge planning, now referred to as “transitional care.” These expectations apply to Medicare and Medicaid patients.

* Have a documented discharge planning process, approved by the hospital’s governing board;
* Provide discharge planning for all inpatients, observation patients, and certain ED patients;
* Analyze and track readmission rates;
* Review readmissions to look for patterns;
* Conduct root cause analyses on readmissions to assess whether the discharge planning process meets patients’ needs;
* Craft a discharge plan that can be realistically implemented;
* Actively solicit the input of the patient and family/friends/support persons;
* Address behavioral health followup as part of the discharge plan;
* Provide customized education to patients and their caregivers;
* Provide oral instructions using the teach-back technique;
* Arrange for (not just refer to) posthospital services;
* Know the capabilities of postacute and community-based providers, including Medicaid home- and community-based services;
* Provide patients data to help inform their choice of high-quality postacute providers;
* Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency who can assist with these issues; and
* Follow up with high-risk patients after discharge.

[Our hospital] is working to meet these expectations—and we need your help. Please contact your manager or supervisor if you have feedback or ideas to improve how we deliver safe and high-quality transitional care to all our patients. For more information, contact [Readmission Champion].