I. SCOPE:
This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:
The purpose of this policy is to ensure transition management is conducted in accordance with regulatory requirements and accreditation standards for patients admitted to Inpatient and Outpatient Observation status.

III. DEFINITIONS:

A. “Transition Management” means the process of assessing and reassessing patients for post-hospital needs and then developing and implementing a plan to coordinate those services identified as necessary for the patient when they leave the hospital. The process includes a mechanism for a Case Management Registered Nurse or Social Worker to identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon Discharge or Transfer if there is inadequate planning.

B. “Case Management” means a collaborative process of assessment, planning, facilitation, care coordination, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

C. “Inpatient” means any person who has been admitted to a Tenet Hospital for bed occupancy for purposes of receiving hospital services.

D. “Outpatient” means a person who has not been admitted to a Tenet Hospital as an Inpatient but is registered on the Tenet Hospital records as an Outpatient and receives services from the Tenet Hospital. The duration of services and time of day are not determinative of Outpatient Status. Observation Services are considered an Outpatient level of care.

E. “Observation Services” or “Observation” means assessment, short-term treatment, reassessment, and stabilization before decision to admit to Inpatient or discharge.

F. “Admitting or Attending Physician” means, in the context of this policy, a physician or any licensed independent practitioner who is legally accountable for establishing the patient’s diagnosis and has been granted admitting privileges by the Tenet Hospital’s Medical Staff. Emergency Department physicians may be
considered Admitting or Attending Physicians when they have been granted admitting privileges by the Medical Staff.

G. “Physician Order” means an order from the Physician admitting the patient to the Tenet Hospital or the Physician responsible for the patient’s general medical management during the admission. The order may be electronic, in writing, or be a telephone/verbal order as allowed by the Tenet Hospital’s medical staff bylaws.

H. “TEMPO” means Team Engagement to Manage Patient Outcomes as a multi-disciplinary patient throughput visual management system to coordinate and sequence efficient and quality care planning.

IV. POLICY:

A Case Management Registered Nurse or Social Worker will complete an initial Adult Transition or Infant/Child Transition Evaluation and make his or her best efforts to complete the initial assessment within 24 but no later than 48 hours of admission or registration to develop an initial discharge plan for patients admitted to Inpatient or Outpatient Observation status based on the goals, preferences and needs for each applicable patient. The discharge plan must be completed and documented before the patient is discharged home or transferred to another facility. Labor and Delivery, Post-Partum and Normal Newborn patients are excluded, and a discharge planning evaluation may be requested at any time during the hospital stay.

This applies to all inpatients and patients receiving observation services. This may also include certain types of outpatients, including, outpatients in a bed and Emergency Department patients who have been identified by a practitioner as needing a discharge plan. Patients who are undergoing surgery or other same day procedures where anesthesia or moderate sedation is used will be assessed by a Registered Nurse in the department where the procedure is performed. If there are complex discharge needs, Hospital Case Management assistance must be requested.

A discharge planning evaluation may be requested for any patient when there is an identified need. This request may be initiated by the patient and/or patient’s representative, family, hospital staff or physician.

V. PROCEDURE:

A. Case Management staff will perform and document all Transition Management processes and enter the documentation into the patient’s medical record.

B. The patient and/or patient’s representative, family, hospital staff, or physician may request a Case Management Registered Nurse or Social Worker to complete a transition/discharge planning assessment for any patient (including Labor and Delivery, Post-Partum and Normal Newborn patients) at any time during the hospital stay.

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1This patient population is excluded because their transition needs are routinely addressed during their hospitalization as outlined in the Plan for Provision of Nursing Care. A discharge planning evaluation may be requested at any time during the hospital stay.
hospital stay. Case Management Registered Nurse or Social Workers will complete the requested assessment within 24 hours of the request.

C. Transition planning includes coordination of hospital, community providers, and support systems to enable the patient to return home safely or through referral of the patient to an appropriate level of care. The discharge planning process addresses all transitions between levels of care with an emphasis on continuity of care.

D. Case Management Transition assessments will include a mechanism to evaluate patients at risk for readmission or with complex discharge needs, aka “high risk screening.” Those identified as “High Risk” will be referred to a Social Worker to complete complex assessment and planning.

E. The Transition Plan includes an assessment of the patient’s capability to manage their post discharge physical care and psychological needs. This includes whether care needs identified will remain constant or lessen over time. Patient/caregiver goals and preferences will be determined and utilized in the transition planning process. The Transition Plan requires the multidisciplinary team to actively solicit information from the patient and/or patient’s representative, family, or support persons.

F. The process will include review of the patient’s chart and discussion with patient, and/or patient’s representative, family, hospital staff, or physicians involved with the care of the patient, multidisciplinary team TEMPO Huddles, and other relevant sources. The patient’s plan will be reassessed and updated during the hospitalization as the patient’s condition or preferences change.

G. Once the Case Management Registered Nurse and/or Social Worker complete the transition evaluation and plan, they may delegate tasks to support staff to make the necessary arrangements required to execute the transition plan including arranging post-acute provider(s) and/or transportation. The Case Management Registered Nurse and/or Social Worker are responsible to provide oversight to the support staff and ensure all elements of the transition plan are implemented and communicated to the patient, and/or patient’s representative, family, hospital staff, or physicians and multidisciplinary healthcare team and accepting agency/facility.

H. Case Management staff will provide post-acute care options and available resources. Documentation of the transition planning evaluation(s) and plan(s), patient choice or preferences and referrals, if needed, will be made, in the case management documentation system and reflected in the patient’s medical record. In the event the patient or family refuses to participate in the discharge planning process, Case Management staff will document refusal and all attempts to facilitate a safe discharge transition.
I. Referrals for patients requiring post-hospital services will be made electronically via the case management documentation referral system. Case Management staff will facilitate all necessary authorizations for post-acute care services and document in the case management documentation system. All referrals will comply with Case Management policy PMI.CMT.102 Requirements for Patient Choice for Post-Hospitalization Services.

J. Responsible Person

The Tenet Hospital’s Director of Case Management is responsible for ensuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Hospital, and that instances of noncompliance with this policy are reported to his/her Supervisor and the Tenet Vice President of Performance Effectiveness, PMI.

K. Auditing and Monitoring

Audit Services will audit adherence to this policy as part of the full scope audit process.

L. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. REFERENCES:

- Allscripts/MIDAS Standard Operating Procedures (SOP) and Job Aids

- Hospital Conditions of Participation – Title 42: Public Health, Part 412 – Prospective Payment Systems for Inpatient Hospital Services; 42 CFR § 482.43 Discharge Planning

- American Case Management Association (ACMA) Standards of Practice and Scope of Services, revised 2012

- CMS Survey Questions 2013

- Regulatory Compliance policy COMP-RCC_4.01_Hospital_Discharge/Transfer_Policy_for_Medicare_Patients

- Case_Management_policy_PMII.CMT.102_Requirements_for_Patient_Choice_for_Post-Hospitalization_Services
- Quality, Compliance, and Ethics Program Charter


- CMS Discharge Planning Checklist  https://www.medicare.gov/Pubs/pdf/11376.pdf