Care coordination and continuity processes are supported by the following:

- Guidelines
- Clinical pathways
- Referral forms
- Checklists

Measurable Elements of ACC.03.00

1. Ⓓ Hospital leaders implement processes that support the continuity and coordination of care across all care settings. (*See also* ACC.02.02, ME 4; ACC.05.00, ME 1; GLD.06.00, ME 4)
2. The patient's medical record is available to those practitioners who are authorized to have access and need it for the care of the patient. (*See also* MOI.01.01, ME 4)
3. The patient's medical record is up to date with the patient's latest information.
4. The patient's medical record or a summary of patient care information is transferred with the patient to another service or unit in the hospital. (*See also* ACC.01.00, ME 5)
5. Ⓓ The written transfer summary of the patient's medical record contains, at minimum, the following:
   - The reason for admission
   - Significant findings and test results
   - Diagnosis
   - Procedures performed
   - Medications administered during hospitalization, including last time of administration and current medications (*See also* MMU.04.02, ME 2)
   - Other treatments
   - Patient condition at time of transfer
6. Care coordination and continuity are supported using various tools, such as care plans, guidelines, or protocols.

Standard ACC.03.01

There is a qualified individual responsible for the patient's care.

Intent of ACC.03.01

A clearly identified individual overseeing a patient's entire hospital stay improves continuity, coordination, patient satisfaction, quality, and clinical care outcomes.

The individual with responsibility for the patient's overall care coordination is clearly identified, for all the different phases of patient care. This individual may be a physician or another qualified individual. The individual responsible is identified in the patient's medical record. This individual collaborates and communicates with the other health care practitioners. When more than one individual is responsible for coordination of care, there is a higher likelihood of uncertainty and a lack of effective coordination. Hospital policy defines the process for the transfer of responsibility to another individual during vacations, holidays, and other periods.

The hospital creates a policy that guides the process for patient oversight, including the following:

- Identifying the individual overseeing all phases of patient care; for example, a physician or other advanced provider
- Defining the process for transfer of oversight responsibility during off days; for example, vacations, sick days, holidays
- Identifying consultants, on-call physicians, locum tenentes, or others who take responsibility
- Defining how transfer of responsibility occurs and what documentation is required to ensure coordination and documentation of their participation or coverage; for example, when a patient moves from one phase of care to another

Measurable Elements of ACC.03.01

1. A qualified individual responsible for the coordination of the patient's care is available through all phases of inpatient care and is identified in the patient's medical record.
2. There is a process for transferring the responsibility for coordination of care.
3. Ⓓ The process identifies how transferred responsibility is assumed, and the participation or coverage is documented.

Discharge, Referral, and Follow-Up

Standard ACC.04.00

The hospital develops and implements a discharge planning and referral process based on the patient's readiness for discharge.

Intent of ACC.04.00

Effective and early discharge planning can decrease the risk of hospital readmission, improve recovery, ensure safe medication practices, and help prepare patients and/or families in having safe, posthospital care.

Discharge planning is a process used to help determine what types of continued care and services a patient may need after leaving the hospital. Improvements in hospital discharge planning significantly improve outcomes for patients as they move to the next level of care. Early initiation of the discharge planning process is paramount to maximizing outcomes. The discharge planning process includes assessing and identifying the patient's need for continuing care or services. The patient's principal health care provider determines readiness for referral or discharge.

Referring or discharging a patient to a health care provider outside the hospital, another care setting, home, or family is based on the patient's health status and readiness for discharge. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. An organized process is required to ensure that any continuing needs are met.

Patients not directly referred or transferred to another health care practitioner receive clear instructions on where and how to receive continuing care. This is essential to ensure that all care needs are met. The instructions include the name and location of sites for continuing care, any return to the hospital for follow-up, and when urgent care should be obtained. The process includes referring patients to sources of care outside the region when required.

The hospital begins to plan for the continuing needs as early in the care process as possible. The discharge planning process begins with the initial assessment and is updated throughout the care process as the patient's discharge needs become clearer. Discharge planning includes any special education the patient may require related to continuing care outside of the hospital. The patient, the patient's family, health care practitioners, and others involved in the patient's care participate in planning the patient's discharge or transfer.

The hospital establishes a method to determine a patient's readiness for discharge. This includes the use of the following:

- Relevant criteria
- Clinical indications
- Clinical guidelines/protocols

The hospital establishes a process to ensure that patients receive any continuing care or support services they need following discharge. Continuing care needs include the following:

- Referral to a medical specialist
- Rehabilitation services