CLIENT DISCHARGE PROCESS

Discharge Planning is initiated for every home care client (pediatric or adult) at the time of the client's admission for home care. The transfer process is based on the client's assessed needs.

The purpose of Discharge Planning is to facilitate the client's discharge or transfer to another entity, to ensure continuity of care, treatment and services when needed and to assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency.

The procedure for discharge planning is as follows;

1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client/family will participate in this process beginning with the initial assessment visit.
2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge. If no improvement or no discharge is expected, the agency shall document in the consumer record this assessment.
3. The agency will assist each consumer or authorized representative to find an appropriate placement with another agency if the client continues to require care and/or services upon discharge. The agency will document the due diligence to ensure continuity of care upon discharge and in protecting the client's safety and welfare.
4. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan.
5. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family/caregivers.
6. The Registered Nurse or therapist shall review the clinical record to assure accuracy and completion. A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family.
7. The Registered Nurse/Therapist shall ensure that the treatment goals and client outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing client needs.
8. When applicable, clients will be given the Notice of Medicare Non-Coverage as indicated and/or appropriate Home Health Change of Care Notice to explain agency decision related to discharge from services.
9. Refer to the Client Transfer (Policy C-840) for additional information on the transfer referral process.
10. Upon discharge to self-care, the client will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and

follow-up visits for physician care.

11. To ensure the process of reasonable changes in service regarding discharge agency documentation will include the following:
    a. Evidence that the client, family and physician are informed of the decision to discharge client from the agency.
    b. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated.
    c. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician.
    d. The client or authorized representative will be notified verbally and/or in writing, as applicable, of the intent to discharge and the reasons for the discharge. Written notice shall be provided via certified mail, return receipt requested., or by hand.
        1) For agencies located in Arizona, notice will be provided to the client at least 72 hours in advance of the discharge.
        2) For agencies located in Colorado, notice will be provided to the client verbally and in writing at least 15 business days in advance of the discharge unless emergency discharge is necessary to protect the safety and welfare of staff. This emergency discharge must be reported to the Department of Public Health and Environment within 48 hours of the occurrence.
        3) For agencies located in Texas, written and verbal notice will be provided to the client at least 5 calendar days (8 business days of the notice is mailed) in advance of the discharge. This notice requirement does not apply if:
            - The client request discharge;
            - The client's medical needs require transfer (such as a medical emergency);
            - The physician orders the client's discharge;
            - The client fails to pay for his/her services;
            - In the event of staff or client safety after multiple attempts to notify the client, the client's family, and/or the client's physician and appropriate state or local authority, and;
            - In the event of a disaster in which the client's health is at risk.
12. In the case of a client continues to require care and/or services upon discharge, the agency will:
    a. Show continuing and documented efforts to resolve conflicts unless the safety of the staff is placed at an immediate risk
    b. Provide evidence that ongoing efforts were made to recruit staff or place client with an alternate agency.
13. For agencies located in Colorado:
    a. The agency will notify the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment before it initiates

discharge of any client who requires and desires continuing paid care or services when there are no known transfer arrangements to protect the client's health, safety and welfare.

b. The agency will notify the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment if any emergency discharges are necessary to protect the safety and welfare of staff within 48 hours of occurrence. Once admitted, the agency will not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggered such discontinuation or refusal to provide services.

14. Criteria for discharge may include, but is not limited to the following:
    a. The client has reached defined goals and is no longer in need of homecare.
    b. The client's care has become such that it is unsafe and medically inappropriate to maintain the client in his/her home.
    c. Client is non-compliant with the established plan of care. Client/Caregiver consistently refuses to cooperate in attaining treatment goals or tasks associated with plan of care.
    d. Medical approval or supervision has been terminated. Or the physician fails to give or sign orders in a timely manner.
    e. The contracting payer terminates authorization for service.
    f. The client terminates payment for service.
    g. The client chooses to use another home health care company.
    h. The client is hospitalized and the hospitalization period is greater than sixty (60) days or exceeds the current home care episode of care.
    i. Client moves out of the agency's service area.
    j. Services needed by the client are not provided by the agency.
    k. No funding is available to provide the care.
    l. The client and/or family have threatened agency staff, have weapons in the home or the home is in some other way an unsafe environment for agency staff.
15. Criteria for transferring a client to an acute or sub-acute care facility:
    a. If the client's condition deteriorates and he or she requires care beyond the capabilities of the agency.
    b. The client has demonstrated deterioration, appearance of acute symptoms, adverse effects of medical treatment, or other change in status.
    c. There is a threat to client safety due to unsafe home environment, absence of physician, family, or caregiver involvement.
    d. The client and caregiver will be informed of the change in status and be encouraged to provide input to the physician regarding the Plan of Care.
    e. The physician will order the client to be transferred, as appropriate.
    f. Refer to the Client Transfer (Policy C-840) for additional information on the transfer referral process.
16. Agency staff will complete a discharge summary that includes the following information:

a. Client status at the time of admission to the agency.
b. Statement of care and interventions provided and outcomes of care.
c. Status at discharge/last visit/current medications, therapies, and continuing care needs.
d. Name of person or organization assuming responsibility for care.
e. Instructions and referrals given to the client/family/caregiver.
f. Reason for discharge and date of discharge.

17. A copy of the discharge summary is mailed to the physician upon request.
18. Discharge assessment (OASIS as applicable) will be conducted within 48 hours of (or knowledge of) discharge to the community or death at home.
    a. The discharge comprehensive assessment and OASIS data collection is required for all situations that result in an agency discharge except to an inpatient facility or client death at home and should be performed in conjunction with a visit, if possible.
    b. If the discharge comprehensive assessment and OASIS data collection cannot be completed in conjunction with the last (discharge) visit, responses to the OASIS data items must be based on the clinical findings documented at the time of the last skilled visit and completed by the clinician who performed the last skilled visit. The visit date used to complete the OASIS assessment must be documented on the discharge comprehensive assessment.
    c. In cases with multiple disciplines and different discharge dates, there is only one agency discharge on the date of the last skilled visit, and the agency discharge is the only one that requires a comprehensive assessment and OASIS data collection.
    d. If both a Registered Nurse and a therapist see the client on the same day of discharge either can perform the discharge comprehensive assessment and OASIS data collection.