A-1 HOME HEALTH CARE
POLICIES AND STANDARD PROCEDURES

POLICY #: CC-10 PCTT 18 PCTT 19 APC 19

SUBJECT: CLIENT TRANSFER/DISCHARGE AND SUMMARY

POLICY: It is the policy of the home health Agency that the Director of Patient Care Services/Clinical Manager initials transfer/discharge of a client from home care services when patient is transferred to an inpatient facility, goals are met, services are no longer medically justified or services have been interrupted fourteen (14) or more days. The patient and representative (if any), have a right to be informed of the HHA's policy for transfer and discharge. This policy should be included in patient's initial admission packet.

PURPOSE:

1. To document the transfer/discharge of the client from home care services and the present or final disposition of the client.

2. To communicate the transfer/discharge of the client to the physician and various departments of the agency.

PROCEDURE: The organization may only transfer or discharge a patient if:

1. The transfer or discharge is necessary for the patient's welfare because the organization and the physician who is responsible for the home health plan of care agree that the organization can no longer meet the patient's needs, based on the patient's acuity.

2. The patient or payer will no longer pay for the services provided by the organization.

3. The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the organization agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the organization and the physician who is responsible for the home health plan of care agree that the patient no longer needs the organization's services.

4. The patient refuses services, or elects to be transferred or discharged.

5. The organization determines that the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired.

6. The patient dies.

7. The organization ceases to operate.

1. The Director of Patient Services/Clinical Manager must complete the transfer/discharge Summary form for all home care clients after consultation with the Physician.

2. The transfer/discharge Summary will be sent to the physician within 5 business days of the patient's discharge via fax/mail who are not accessing agency's EMR portal for review.

   The discharge Summary is to be completed within five (5) days of discharge, planned transfers, transfer summary within two (2) days and unplanned transfers, transfer summary within 2 days of becoming aware as follows:
   discharge summaries include necessary medical information for the patient's current course of illness and treatment. Requests for additional clinical information is sent to the receiving facility or health care practitioner.

   1.1 Client name.
   1.2 Entity name.
   1.3 Diagnosis
   1.4 Date of Admission
   1.5 Date of Discharge
   1.6 Disciplines servicing client
   1.7 Physician and date of MD notification
   1.8 Reason for Discharge
      1.8.1 No further skilled care needed
      1.8.2 Admitted to Hospital
      1.8.3 Admitted to SNF/LTF
      1.8.4 Family/friends assume responsibility
      1.8.5 Moved out of service area
      1.8.6 Refused services
      1.8.7 Transfer to another Agency
      1.8.8 MD request
      1.8.9 Death
      1.8.10 Lack of Funds- Others
   1.9 Mental Status
   1.10 Functional Ability (Home bound status)
   1.11 Condition at Discharge
   1.12 Signature of Staff who provided Discharge Instructions, Title, and Date.

2. Prior to termination of services, the reason for discharge and any plans for necessary care shall be discussed with the patient, family, and physician and documented in the permanent medical record. The Agency shall coordinate follow up care with community resources involved as well as MD and/or receiving inpatient facility.

3. Discharge instructions are provided to the patient at the day of discharge.

    1. Advises the patient, the patient's representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization (if any) that a discharge for cause is being considered.
    2. Makes efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or the situation.
    3. Provides the patient and representative (if any) with contact information for other agencies or providers who may be able to provide care; and

    4. Documents the problem(s) and efforts made to resolve the problem(s), and enters this documentation into its clinical records.

4. Various departments of the agency will be notified of the patient's discharge by the Staffing Coordinator or designee.

    4.1 Notification of each Department will be logged in the Discharge Patient – Routing Sheet.
    4.2 The Discharge Patient – Routing Sheet will be kept in a log book and will be stored in the Staffing Coordinator's Office.
    4.3 The Billing Department is to be notified of all discharges every 15th and end of the month.
    4.4 The computer clerk will update the Agency's census upon a patient's discharge.

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ADDENDUM TO CC-10 TO INCLUDE PCTT 18 AND PCTT 19

When signs and symptoms indicate the likely imminent death of the patient, the IDT:

1. Evaluates the best care setting, considering the patient's wishes and the family's care giving capacity;
2. Prescribes medication and recommends supplies that may be needed for symptom management;
3. Provides education and instruction to the family or other caregivers in preparation for the patient's death, including what to expect regarding symptom changes and what will happen after the patient's death.

If present at the patient's death, the IDT member(s):

1. Acts in accordance with local and state law and regulation regarding the declaration of death;
2. Provides instruction about appropriate opioid and other drug disposal per federal, state, or local law and regulation as well as Program policy and procedure.

The IDT provides information regarding bereavement support services and recommends community resources for bereavement follow-up as indicated.