Subject: Discharge Planning  

Objective:
I. To ensure that each Tuality Health Alliance (THA) member who is identified as high-risk upon hospital/facility discharge has an individualized plan of continuous post-discharge care.

Policy:
I. THA Case Managers utilize national guideline criteria and functional assessment guidelines in the discharge planning process.

II. Accurate assessments are essential to the development of appropriate discharge plans; THA Case Managers review the following criteria/indicators to appropriately develop a discharge plan.

- *Assessment/screening indicators*:
  - Admission review; and
  - Designated high-risk patients will be screened high-risk within the first business day following admission.

- *Continued stay review*:
  - Receipt of an order or referral.

- *Data collection sources*:
  - Patient and family interviews;
  - Clinical/medical record;
  - Physicians and nurses; and
  - Other healthcare professionals.

- *Patient components*:
  - Age – elderly (high risk \( \geq 65 \)) or pediatric;
  - Diagnosis (high-risk patients may have HIV, cancer, stroke, substance abuse, chronic illness, psyche diagnosis);
  - Medical history, prognosis;
  - Response to treatment;
  - Functional capacity and ability to safely perform daily living activities (e.g., feeding, bathing, mobilizing, ambulating, vision, hearing, communicating, toileting, shopping, housekeeping, using the telephone, sleeping);
  - Medications;
  - Nursing care/therapy needs;
  - Nutritional status;
  - Skin integrity;
  - Pain; and
  - Exercise and activity tolerance.

- *Emotional/cognitive needs*:
  - Level of consciousness, orientation, memory competence, and judgment;
  - Motivation and readiness for self-care;
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- Learning ability;
- Presence of confusion, dementia, depression, and anxiety;
- Communication;
- Coping mechanisms; and
- Self-help perception.

- Psychosocial needs:
  - Adequacy of living arrangements/caregivers;
  - Familial and social support systems;
  - Availability and access to community resources;
  - Values, beliefs, cultural/spiritual preferences;
  - Designated party for health care decisions;
  - Advanced Directives;
  - Pets, possessions; and
  - Roles, relationships, ability to socialize.

- Financial needs:
  - Insurance/benefits and contractual considerations;
  - Medicare, Medicaid;
  - Income, occupation, employment; and
  - High-risk patients may be homeless, indigent, etc.

III. The discharge plan will be a multidisciplinary effort, including input from the medical record review, primary care provider and/or attending physician(s), the facility Case Manager/Discharge Planner, and the patient and the family. The following will be addressed in the discharge plan.

- **Home with no after-care needs identified.**
- **Home Health Care:**
  - Nursing services/attendant care;
  - Home Medical equipment;
  - Therapy services (e.g., OT, PT, ST);
  - Social Services;
  - Nutritional Support; and
  - Clinical laboratory and Radiology.

- **Transportation needs:**
  - Frequency;
  - Distance; and
  - Cost/financial feasibility.

- **Financial assistance:**
  - Availability of third party coverage;
  - Family resources; and
  - Public assistance.

- **Board and Care/assisted living.**
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- **Rehabilitation services:**
  - Inpatient;
  - Outpatient; and
  - Partial.
- **Nursing facilities:**
  - Skilled Nursing facility;
  - Extended care facility;
  - Transitional care facility;
  - Sub-acute; and
  - Convalescent/long-term care.
- **Transfer to another acute care facility:**
  - Acute care hospital; and
  - Long-term acute care hospital.
- **Hospice care/palliative care program.**

IV. The healthcare team will be knowledgeable about the discharge plan and the responsibilities to meet the ongoing needs of the patient.

- **Prioritize identified discharge plan needs.**
- **Identify available resources:**
  - Equipment;
  - Personnel;
  - Facilities; and
  - Supportive services/agencies.
- **Document and communicate the discharge plan in a timely manner.**
  - Communication with:
    - Patient and family;
    - Attending physicians;
    - Nursing and ancillary services; and
    - Community resources.

V. Individualized patient plan of care will be implemented in a timely, effective manner to ensure that post-discharge needs are met.

- Ensure contact to appropriate and available resources.
- Ensure coordination of placement if necessary.
- Authorize and/or order needed equipment, supplies, and/or transportation services.
- Assist with community referrals.
- Obtain necessary consents for authorization to release medical records as appropriate.
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VI. Patient and appropriate family will be educated about the discharge plan and the responsibilities to meet the patient’s ongoing health care needs.
   - Identify learning needs/barriers.
   - Assess readiness to learn.
   - Identify resources available.
   - Verbal/written discharge instructions.

VII. Conduct periodic program evaluation to meet and exceed patient expectations.
   - Periodic evaluation to:
     - Assess timeliness of screening;
     - Ensure appropriateness of assessments;
     - Determine effectiveness of interventions; and
     - Assess for preventable readmission.
   - Monitor outgoing feedback from:
     - Community resources and facilities;
     - Patients and families; and
     - Physicians and nursing.
   - Communicate outcomes through appropriate channels:
     - Financial;
     - Clinical; and
     - Satisfaction indicators.

References: 42 CFR 482.43

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THA Plan Director ___________________ THA Medical Director ___________________