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;
Subject: Discharge Planning

- 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.
Subject: Discharge Planning

• Rehabilitation services:
  o Inpatient;
  o Outpatient; and
  o Partial.
• Nursing facilities:
  o Skilled Nursing facility;
  o Extended care facility;
  o Transitional care facility;
  o Sub-acute; and
  o Convalescent/long-term care.
• Transfer to another acute care facility:
  o Acute care hospital; and
  o 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:
  o Equipment;
  o Personnel;
  o Facilities; and
  o Supportive services/agencies.
• Document and communicate the discharge plan in a timely manner.
  Communication with:
  o Patient and family;
  o Attending physicians;
  o Nursing and ancillary services; and
  o 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.
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:
     o Assess timeliness of screening;
     o Ensure appropriateness of assessments;
     o Determine effectiveness of interventions; and
     o Assess for preventable readmission.
   • Monitor outgoing feedback from:
     o Community resources and facilities;
     o Patients and families; and
     o Physicians and nursing.
   • Communicate outcomes through appropriate channels:
     o Financial;
     o Clinical; and
     o Satisfaction indicators.

References: 42 CFR 482.43
Formulated: August 1995
Reviewed: June 1999
February 2012
February 2014
Revised: March 1997
June 1998
January 2003
February 2006
December 2009

THA Plan Director

THA Medical Director