Discharge/Transfer of Patient

POLICY

The patient/legal representative will be given a copy of the discharge/transfer policy upon initial evaluation, the patients selected representative will be given a copy within four days of initial evaluation, and will also be informed in a timely manner of the need for planning discharge, transfer to another facility or agency, or discontinuation of home health services either planned or unplanned.

PURPOSE

- To establish the criteria for transfer or discharge.
- To assure patients are discharged appropriately.
- To protect the organization from liability when a patient no longer meets home health criteria and requires discharge.
- To ensure that OASIS requirements are met for skilled Medicare or Medicaid patients.

GENERAL INSTRUCTIONS

1. The discharge criteria include, but are not limited to the following:
   - Physician responsible for the home health Plan of Care and home health agency agree that the patient no longer needs home health services because the patient's health and safety have improved or stabilized sufficiently, or goals for treatment are achieved.
   - Patient or family request discharge, or refuse home health services, or elects to be transferred.
   - Physician no longer authorizes plan of care.
   - Patient moves outside geographic area.
   - Patient dies.
   - When there is cause, such as if patient's (or other persons in home) behavior is so disruptive, abusive, or uncooperative that the delivery of care to the patient or the ability of the home health agency to operate effectively and safely is seriously impaired.
   - Agency is unable to carry out physician's plan of care.
• Agency does not have the resources to meet the patient’s needs, based on patient acuity.
• Patient no longer meets aspects of admission criteria.
• Patient or payer can no longer pay for the services provided by the home health agency.
• Patient is admitted to Long Term Care Facility.
• Agency ceases to operate.
• Pediatric and Psychiatric patients will follow the same criteria for discharge as other patients.
• Medicaid/Medicare patients who are in the hospital on the 60th day of the present PPS episode or those that do not resume care by the first day of the next 60 day period should be discharged.
• Medicaid/Medicare patients who are admitted to the hospital prior to any service visits being made in the new 60 day episode will be discharged. When the patient returns to the agency after discharge from the hospital, a new admission and SOC will be needed.
• Medicaid/Medicare patients who do not return to the agency following an inpatient stay will be discharged from agency.
  ➢ Discharge OASIS not needed. Transfer OASIS acts as the endpoint OASIS.

2. The agency discharge date for all patients will be the date of the last visit to the home by any discipline.
• The visit does not have to be a billable visit.
• If a Discharge OASIS is completed with a visit, the agency discharge date will be the same date as MO903.

3. The RN/Therapist will be responsible for completing the following discharge-related activities:
• Identify and document potential discharge plans and communicate plan to patient/family, other disciplines in the home and the physician. All communication should be documented in the medical record.
• Provide Notice of Non-Coverage (Expeditied Determination) no later than two days before effective date of patient’s discharge as outlined in the Notice of Medicare Provider Non-Coverage policy.
• At the time of discharge, perform an evaluation of the patient record and relevant documents to ensure that discharge criteria and identified goals have been met.
- Evaluate the need for continuing care and provide written and/or verbal information regarding available resources when indicated to patient/family.
- Provide the resource facility with pertinent patient information when patient warrants a referral for follow-up or a transfer to another service.
- Provide patient with appropriate written and verbal discharge teaching relative to continuing self care needs.
- Provide the appropriate Medicare discharge notice to the Medicare patient as outlined in the Home Health Change in Care Notice policy (HHCCN), or the Advanced Beneficiary Notice Policy (ABN).

4. A discharge summary will be completed that accurately reflects the current health status of the patient at the time of discharge. Submit the discharge summary to the physician or health care professional responsible for providing care and services to the patient after discharge, within 5 business days of discharge.
   - The discharge summary in Horizon will be completed on all patients in addition to the visit note and/or OASIS assessment if a discharge visit was made.
   - If a patient is discharged without a visit being made, the discharge summary will be completed in the office in Horizon.
   - If the discharge visit was documented on paper, the discharge summary will be completed in the office in Horizon.

5. A Transfer Summary will be completed that accurately reflects the current health status of the patient at the time of the transfer. Submit the transfer information to the receiving facility/physician within two working days of notification.

6. Discharge and Transfer to Inpatient OASIS regulations for Medicare and Medicaid skilled patients:
   - Complete the Transfer to Inpatient Facility OASIS Assessment for an inpatient stay of 24 hours or more for any reason other than diagnostic testing within 48 hours of knowledge of the occurrence.
     - Complete Transfer to Inpatient (Without Discharge) for Medicaid/Medicare patients.
     - For Transfer to Inpatient Facility OASIS, MO90 will reflect the date that you learned of the occurrence and completed the OASIS. MO906 is the actual date patient went into the hospital.
   - Complete the Discharge/Death at Home OASIS assessment for patient deaths occurring in the home. MO90 will reflect the date that you learned of the occurrence and completed the OASIS. MO906 is the date that the patient died.
• “Death at home” includes: Death which occurs while being transported to an inpatient facility and before being admitted to the facility or treated in the emergency room (i.e. DOA).

• The Discharge OASIS must be completed during a home visit. If the discharge is unexpected and the patient is unavailable for a home visit, the Discharge OASIS will be completed in the office based on documentation of previous visits. MO90 will reflect the date that you learned of the occurrence and completed the OASIS.

• If the MO90 date is more than two days after the date indicated in MO906, you will get a warning in the OASIS validation and submission software as the regulations require completing within two days of the discharge date. The warning will not hinder locking and transmission of the data, but the nurse who completed the OASIS should document in the record why the situation occurred.

7. In the event the agency initiates termination of services, the following steps will be taken:

• The Clinical Manager/Home Health Manager will be consulted for concurrence of plans to terminate services and a case conference of all staff providing care will be held to discuss available patient options.

• The RN/Nurse Care Coordinator will identify the ongoing patient care needs and report the needs and the plan to terminate services to the physician.

• The patient will receive written notification from the home health program stating the need to terminate care and the scheduled time frame for the discontinuation of services.

• The HHCCN policy or the ABN policy will be followed for all Medicare patients.

• Agency should communicate patient information to all available resources, agencies and services and document communication in the patient’s medical record.

• Notify the physician in writing concerning the patient’s discharge, i.e. Continuation/Conference Note.

• Submit a Discharge Summary to physician.

• Appropriate Discharge Assessment will be completed.

• Patient will sign the HHCCN should they not have Face to Face visit made within the time frame per CMS regulations.