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| Discharge (Home Health Care) | **Last Revision**: | March 2018 |
| **Last Reviewed:** | March 2018 |
| **Applies to the following THA Group of Companies:** | * Island Health Care * RightHealth® |
| **Included in the following THA Group Manual:** | Administrative Policy & Procedure Manual  Provision of Care, Treatment, & Service |

#### POLICY

Discharge planning is initiated at the time of admission and involves the patient and/or caregiver. Services are discontinued when identified goals are met or when the patient no longer meets the criteria for services.

The physician, patient and/or caregiver are notified prior to discontinuation of services. If additional or ongoing care is indicated, efforts are made to assist with patient transfer to the appropriate agency or facility.

**PURPOSE**

1. To outline the criteria for discharge from home health and hospice services.
2. To define appropriate action when the patient no longer meets Medicare Conditions of Participation for homebound status or medical necessity, or chooses to discontinue (revoke) services.
3. To describe appropriate action when the patient refuses to seek alternative care or services at discharge.
4. To list the required documentation to be included in the discharge summary.

# PROCEDURE

**DISCHARGE CRITERIA:**

1. The patient’s health status no longer requires the skills of the home health care staff as determined by the assessment of a professional clinician.
2. 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.
3. The organization is unable to provide services due to lack of appropriate staff or significant change in the patient’s acuity to meet the patient’s special needs. The organization must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the organization’s capabilities.
4. The organization is unable to meet the Face to Face Encounter requirements for Medicare patients.
5. The patient refuses services or elects to be transferred or discharged and/or physician requests discontinuation of services.
6. The patient no longer meets admission criteria.
7. The patient and/or caregiver are unable to demonstrate adherence to instructions, procedures, or physician follow-up visits.
8. The caregiver is unable, unwilling or incapable of providing the care necessary to meet the patient’s therapeutic goals in the absence of home care staff.
9. The organization determines that the patient’s (or other persons in the patient’s home) behavior 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. The organization follows established protocols before it discharges a patient for cause:

a. Advise the patient, 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 that a discharge for cause is being considered and document in the client’s record;

b. Make efforts to resolve the problem(s) presented by the patient’s behavior, the behavior of other persons in the patient’s home, or situation;

c. Provide the patient and representative, if any, with contact information for other agencies or providers who may be able to provide care; and

d. Document identification of the problem(s), assessment of the situation, communication with the clinician’s leader and physician responsible for the plan of care, and efforts, with corresponding results, made to resolve the problem(s), and enter this documentation into the clinical record.

1. The patient is no longer homebound (under regulatory guidelines).
2. The patient expires or the organization ceases to operate.
3. The patient is no longer under a physician’s care.
4. The patient or payer will no longer pay for the services provided by the organization.

**DISCHARGE PROCESS:**

1. Patient/caregiver is notified in advance of discharge.

2. For Medicare & Medicare Replacement Plan patients, the CMS Notice of Medicare Non-Coverage (NOMNC) is given to the patient/caregiver at least 2 business days before date of discharge. Signature is acquired & the document is filed in the medical record. A copy of the signed form is left in the home. If a discharge visit cannot be made, the Notice of Medicare Non-Coverage (NOMNC) is mailed to the patient with return receipt requests notice. The returned receipt signature card is placed in the medical record.

3. The primary care physician is notified and is in agreement with the discharge plan.

4. Planned discharges are discussed by the Health Care Team, including Telehealth to coordinate discharge plans with all disciplines. The State Director assures tht the current Medication Profile for the planned discharge is printed.

5. The last discipline visitng the patient provides the current Medication Profile & reviews the Discharge Instructions and follow up appointments.

6. The clinician keys the visit type as “Discharge.”

7. The clinician charts in the discharge summary narrative all the documents given to the patient.

8. If a discharge visit cannot be made, the clinician documents in the electronic health record the circumstances of the discharge and the mailing of the Medication Profile and CMS Notice of Medicare Non-Coverage (NOMNC).

9. The discharging clinician completes the Discharge Summary as a “Team/Case Note” in the electronic health record. The summary should include:

a. Summary of all care provided in the entire course of Home Health Care.

b. Review of goals—which were met, which were not, and why.

c. Trends, complications, rehospitalizations

d. Patient status at discharge and plan for care going forward, including outpatient services

and follow up appointments.

e. Report that an up-to-date medications list was left with the patient.

f. The physician has been notified of the discharge.

g. If the NOMNC form has been mailed to the patient, this should be noted here.

10. If a telemonitors is still in the home, the last discipline in confirms with Telehealth whether the monitor should be picked up or remain in the home for continued monitoring. If a monitor remains in the home, collaboration between the discipline and Telehealth will continue until the time specifies for re-evaluation. If a monitor is to be returned, Telehealth will be notified and the last visitis clinician will take the monitor with them and return it to the appropriate community office. The discharge summary, current medications likst and discharge fax cover sheet are sent to the patient’s physician by the Scheduler/Office Coordinator.

11. The State Director reports any difficulty in acquiring signed orders to the President/CEO. The designated discharge date is the date of the last billable visits.

**MEDICARE PATIENTS**

1. If the physician orders home care services and the patient no longer meets Medicare conditions of participation for homebound status or medical necessity:

a. The physician is notified that the patient no longer qualifies for Medicare coverage.

b. The patient/caregiver is notified that Medicare will no longer reimburse home care services.

c. An Advance Beneficiary Notice (ABN) is given to the patient/family or significant other(s)

with a complete explanation during a home visit.

d. If a home visit to explain the Advance Beneficiary Notice is refused, the ABN is sent to the

patient by certified mail.

2. Patients no longer meeting homebound criteria are offered a choice of self-pay for services or

immediate discharge with referral to their physician or an outpatient clinic.

3. If the patient is no longer homebound but continues to require assistance with health care, the home care agency assists with referral to outpatient and/or physician office care.

**REFUSAL OF ALTERNATIVE CARE**

If a patient refuses to seek alternative care or services on discharge, the agency:

1. Notifies th emergency contact or responsible party that was identified by the patient on

admission.

2. Collaborates with the physician to assess the need for protective services.

3. Follow our policy for contacting the protective services division of the local organization on

aging when indicated.

**FORMS**

The Advance Beneficiary Notice of Non-Coverage (ABN) and Notice of Medicare Non-Coverage forms referenced in this policy are found in G:\Approved Forms\Patient Notifications.

Also see the **Patient Notifications (ABN, HHCCN, NOMNC) Policy** for more information on the Advance Beneficiary Notice, Home Health Change of Care Notice, and Notice of Medicare Non-Coverage.