Summary

Discharge planning begins at admission. The patient/caregiver will be informed of the need for discharge planning, transfer to another facility or agency and discontinuation of services either planned or unplanned. Regardless of the reason, when at all possible, the patient and caregiver must be given the reason and advanced notice of the discharge.

Role

It is the responsibility of the Nurse Care Coordinator or the RN managing the patients' care to coordinate and document the discharge summary. If the nurse care coordinator or RN managing the patients' care is not available the Supervisor or another nurse on the Home Health Management Team should document the discharge/transfer.

Process

Planned Discharge

- Identify and document the potential discharge plans and communicate the plan to the patient/caregiver. All discharge planning should be documented in the medical record.
- With the planned discharge, the Discharge OASIS must be completed during a home visit.
- A discharge summary will be completed that accurately reflects the current health status of the patient at the time of discharge.
- Provide appropriate Medicare discharge notice to the Medicare patient as outlined in the <u>Home Health Advanced Beneficiary Notice (HHABN)</u> Policy. The policy is located on the Internal Home Care website's Home Health Administrative Policies and Procedures page.
- Provide a complete comprehensive assessment utilizing the Discharge OASIS for skilled patients and the Service note for unskilled patients.

Planned Discharge Continued

- Evaluate the need for continuing care and provide written and/or verbal information regarding available resources, when indicated, to patient/caregiver.
- Provide the patient with appropriate written and/or verbal discharge teaching relative to continuing self-care needs.
- > If the patient continues to require care at discharge:
 - If the patient is discharged to a facility or another agency, provide pertinent patient information.
 - If the patient requires community resources, utilize a medical social worker to assist with the resources.
- Perform an evaluation of the record to assure there is documentation the identified goals were met. If the goals were not met there should be documentation why the goals were not met.

Transfer

- Complete a 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 a Transfer to Inpatient Facility
 (Without Discharge) for Medicare Patients.

 For Transfer to Inpatient Facility OASIS, M0090 will
 reflect the date that you learned of the occurrence and
 completed the OASIS. M0906 is the actual date the
 patient went into the hospital.
 - Complete a Transfer to Inpatient Facility (With Discharge) for Skilled Medicaid patients. M0090 will reflect the date that you learned of the occurrence and completed the OASIS. M0906 is the actual date the patient went into the hospital.

Transfer Continued

- A Transfer Notification will be completed on all patients 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 2 working days of notification using the <u>Transfer Notification Form</u> (HBS 101) located on the Internal Home Care website's HBS Forms page.
- If the patient will not return to our agency or will be re-admitted to a different payor source, complete the Discharge Summary in the Profile section in Horizon.
- Medicare patients who do not return to the agency following an inpatient stay will be discharged from the agency.
 - Discharge OASIS is not needed.
 - Transfer OASIS acts as the endpoint OASIS.

Be sure that all orders are **discontinued** at time of Transfer.

• The new orders will begin with the date of the first billable visit post hospital and will continue until the last date of the current 60 day episode.

Unplanned Discharge

- The Discharge OASIS must be completed during a home visit. If the discharge is unexpected we are still required to make a home visit unless the patient is not available (moved, etc.) or refuses. We must document the reason the visit was not made. The Discharge OASIS will be completed in the office based on previous visits. M0090 will reflect the date that you learned of the occurrence and completed the OASIS.
- If the M0090 date is more than 2 days after the date indicated in M0906, 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.

Unplanned Discharge Continued

Complete the Discharge/Death at home OASIS assessment for patient deaths occurring in the home. M0090 will reflect the date you learned of the occurrence and completed the OASIS. M0906 is the date that the patient died.

Death at Home Includes:

- Death which occurs while being transferred to an in-patient facility **and before** being admitted to the facility or treated in the Emergency Room (i.e. DOA).
- Death that occurs in the patient's residence.

Discharge Summary

- The Horizon Profile discharge section (Discharge Information and Discharge Summary) must be completed regardless of the type of discharge (planned or unplanned.)
- More details regarding discharging the patient can be found in the <u>Discharge/Transfer of Patient</u> policy located on the Internal Home Care website's Home Health Administrative Policies and Procedures page.

Unskilled Discharge Requirements

- > No OASIS is required.
- Complete the Discharge Information and the Discharge Summary

Provide the discharge summary to the physician upon request.

Please see the CMS regulation below:

Interpretive Guidelines

§484.48 - The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.