Vancouver
HOME HEALTH CARE
Agency

DISCHARGE, TRANSFER AND POLICY

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 Home Health Advanced Beneficiary Notice (HHABN) 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. We may only discharge or transfer you from this agency if:

- It is necessary for your welfare, and your physician who is responsible for your home health plan of care and our agency agree that we can no longer meet your needs based on your

acuity level. We must arrange a safe and appropriate transfer to another care provider when your needs exceed our agency capabilities;

- You or your payer will no longer pay for the home health services;

- Your physician who is responsible for your home health plan of care and our agency agree that the measurable outcomes and goals of your plan of care have been achieved and you no longer need home health services;

- You refuse services or elect to be transferred or discharged;

- Our agency closes;

- Our agency determines, based on our policy, that your behavior or the behavior of other persons in your home is disruptive, abusive, or uncooperative to the extent that delivery of your care of the ability of our agency to effectively operate is seriously impaired. Prior to discharging for cause, our agency must:

- Advise you, your representative, if any, your physician(s) issuing orders for your home health plan of care, your primary care practitioner or any other health care professional who will be responsible for providing care and services to you after discharge from our agency that a discharge for cause is being considered;

- Make efforts to resolve the problem(s) presented by your behavior or the behavior of other persons in your home or situation;

- Provide you and your representative, if any, with contact information for other agencies or providers who may be able to provide your care; and

- Document in your medical record the problem(s) and efforts made to resolve the problem(s). Discharge planning will be begin when you are admitted to the agency based on the findings of the comprehensive assessment performed at admission. You and/or your representative will receive education and training to facilitate a timely discharge.

  Any revisions related to plans for your discharge will be communicated to you, your representative, your caregiver, all physicians issuing orders for our agency plan of care, your primary care practitioner and any other health care professionals who will be providing care and services to you after discharge from our agency.

You will be given advance notice of your discharge or transfer to another agency in accordance with applicable state regulations, except in the case of an emergency. All discharges or transfers will be documented in your medical record. When a discharge occurs, an assessment will be done. You will receive an updated list of your current medications along with any instructions needed for ongoing care or treatment. We will coordinate referrals to available community resources as needed.

Following your discharge or transfer, we will send a discharge or transfer summary within the time frames specified by federal regulations to your primary care practitioner or other health care professional who will be providing care and services to you after discharge or transfer from our agency. The summary may include, but will not be limited to, a list of your current medications and information necessary for your continued care, including pain management. If you elected to transfer from another agency and were under an established plan of care,

Medicare requires us to coordinate the transfer. The initial home health agency will no longer receive Medicare payment on your behalf and will no longer provide you with Medicare covered services after the date of your elected transfer to you agency.

You or your authorized representative will receive and be asked to sign and date a Notice of Medicare Non-Coverage (NOMNC) at least two days before your covered Medicare services will end. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice. If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) at the phone number listed on the form no later than noon of the day before your services are to end and ask for an immediate appeal.

At Vancouver Home Health Care Agency, caring and compassion is our business...