

Institutional Handbook of Operating Procedures
Policy 09.01.13

Section: Clinical Policies	Responsible Vice President: EVP and CEO Health System
Subject: Admission, Discharge, and Transfer	Responsible Entity: Care Management

I. Title

Discharge Planning

II. Policy

Discharge planning services are provided to patients with the involvement of an interdisciplinary team including the patient, the patient’s family/caretaker, and licensed medical providers and staff involved in the patient’s care, treatment, and services (i.e., nursing, therapy staff). Care Managers (CMs) and/or Social Workers (SWs) will educate and provide patients and families with information about discharge options available in the community in preparation for key points in the transition of a patient’s care (i.e. transition/discharge to a lower level of hospital care, transition/discharge out of the hospital system, etc.). This process will ensure that patients are informed of their options regarding post-discharge needs and will have the ultimate and final choice in selecting the Provider/Service unless designated by the patient’s managed care insurance carrier or other payer source. The policy also serves to reduce avoidable readmissions and comply with all regulatory guidelines and governing entities.

III. Procedures

Screening

1. All inpatients are screened as close to time of admission as possible to determine which patients may be likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. A discharge planning screening shall be initiated upon admission, utilizing the initial Nursing Admission Assessment.
2. The admitting RN will complete the discharge planning screening to identify those patients identified as being at risk for adverse health consequences upon discharge without adequate discharge planning
 - a. If the patient is identified to be at high risk from the discharge planning screening, Care Management will be notified for further evaluation.
 - b. Reassessment of a patient’s discharge needs and associated risks using the screening criteria will occur during multi-disciplinary rounds and the nurse’s daily patient assessment.
 - c. A referral to Care Management may be requested by a member of the patient’s care team, family, or provider at any time during the course of their hospitalization.

Evaluation

1. The CM will perform an evaluation of an inpatient’s post-discharge needs as indicated through the primary RN’s admission screening. The discharge planning assessment will be completed in a timely manner to ensure that appropriate arrangements for post-hospital care will be made before discharge, and to avoid unnecessary delays in discharge.

2. As part of the discharge assessment, the CM will complete the 8 P's Risk Assessment Tool to determine the patient's risk for readmission. The below risk factors will be identified and addressed for all hospitalized patients:
 - Problem medications-Is the patient on anticoagulants, insulin, digoxin, narcotics, or aspirin & clopidogrel dual therapy?
 - Psychological-depression screen positive or h/o depression diagnosis, anxiety disorders, and substance abuse?
 - Primary Diagnosis-cancer, stroke, diabetes, COPD, heart failure, or liver failure?
 - Polypharmacy-10 or more routine meds?
 - Poor Health Literacy-inability to do teach back?
 - Patient Support-absence of caregiver to assist with discharge and home care/poor physical condition?
 - Prior Hospitalization-Non-elective within the last 6 months?
 - Palliative Care-Does this patient have an advanced or progressive serious illness?

A score of 3 or more identifies the patient as a potential high risk for readmission and will trigger a specific intervention or group of interventions to decrease the risk of readmission.

3. Discharge planning needs are reassessed during the patient's stay in collaboration with all disciplines involved. Revisions are made to appropriately meet the needs of the patient, including changes in the patient's condition, support system, and/or changes in discharge care needs.
4. An evaluation may be requested at any time by the patient and/or family, and/or by a physician or other members of the patient's care team. Referrals for patients in an outpatient setting should be routed to the Department of Care Management for assignment.
5. The CM may request assistance from a Social Worker to assist with complex discharge planning needs or concerns as follows:
 - Patients with the diagnosis of a catastrophic illness requiring placement or alternative after-care arrangements and/or major changes in life-style
 - High Risk patients needing psychosocial assessments and discharge planning
 - Patients who need help with state or federal programs for medical care or financial support
 - Patients living in suspected situations of abuse or neglect
 - Complex patients needing coordination of patient/family physician conferences
 - Patients needing Child Protective Services or Adult Protective Services
 - Patients with alcohol/drug addiction and discharge issues
 - Patients needing mental health services and/or crisis intervention
 - Patients who are homeless and/or lack adequate housing to accommodate medical needs
6. The CM or SW evaluation of the patient's post-discharge needs is determined by the assessment and evaluation of the patient's medical record, interviews and/or conferences with patient/family, and multidisciplinary rounds.

7. The evaluation also incorporates the patient's need for post hospitalization services such as home health, hospice or palliative care, respiratory services, rehabilitation services, dialysis services, pharmaceutical related supplies, nutritional consultation and related supplies, and durable medical equipment (DME). Non-traditional services essential to the patient's ability to continue living at home are also considered, such as transportation services, meal services, housekeeping, or shopping services.

Development

1. The patient and/or family shall be notified as soon as possible regarding the identified discharge needs, as appropriate, so the patient and/or family can be involved in the decision making and ongoing discharge planning. The discussion must disclose to the patient the relationship, if any, between the transferring provider and any entity affiliated with the Hospital before the patient makes his or her decision as to who the receiving service/provider will be.
2. The CM and SW will collaborate on developing a coordinated discharge plan using the evaluations and assessments of the interdisciplinary team, along with the goals of the patient and/or family/representative.
3. Patients requiring post-acute home health, hospice, or skilled nursing services will be offered a list of geographically-appropriate services/facilities located where the patient resides or in the area requested by the patient, for their selection. The patient, or the patient's representative, will be informed of their freedom to choose among providers for post hospital services and when possible, the Hospital shall respect patient and/or family preferences when they are expressed.
 - a. The patient's, or the patient's representative's choice will be documented in the medical record.
 - b. Patients with Medicare will be informed of their freedom to choose among participating Medicare providers for post hospital services.
 - c. For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post hospital extended care services through individuals and entities that have a contract with the managed care organization.
 - d. For patients without a funding source, or where the insurance does not cover post-acute care services, options may be limited to available charity services or local agreements.
4. If, prior to the hospital admission, the patient was a resident in a facility that he or she wishes to return to, such as an assisted living or nursing facility or skilled nursing facility, the discharge evaluation shall address whether the facility has the capability to provide the post-hospital care required by the patient.
5. If a patient/family exercises the right to refuse to participate in the discharge planning or to implement a discharge plan, documentation of the refusal will be recorded in the patient's medical record and the physician will be made aware of the refusal.

6. If a patient and/or family/representative choose a discharge plan that is considered to be unsafe or suboptimal, the CM/SW shall discuss the risks associated with the plan. Documentation shall include the patient and/or family teach back regarding their understanding of the risks discussed.
7. Care Management will communicate regularly with the attending physician regarding the status of the current discharge plan and update other members of the healthcare team as necessary.

Implementation

1. The interdisciplinary team will communicate with patient and/or family/representative as early as possible regarding the patient's expected discharge date.
2. Care Management will facilitate the patient's transfer of care to appropriate facilities, agencies, or outpatient services, as ordered. For patients who are transferred from UTMB, medical information that is necessary for the transfer will be sent with the patient to the accepting facility or agency. The necessary medical information includes, but is not limited to:
 - Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;
 - Brief description of hospital course of treatment;
 - Patient's condition at discharge, including cognitive and functional status and social supports needed;
 - Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal supplements. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);
 - List of allergies (including food as well as drug allergies) and drug interactions;
 - Pending laboratory work and test results, if applicable, including information on how the results will be furnished;
 - For transfer to other facilities, a copy of the patient's advance directive, if the patient has one.

For patients discharged home:

- Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);
 - If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date, and time.
 - If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.
3. The transition plan will be updated as needed during the hospital stay based upon changes to the patient's health, psychosocial, financial status, and the availability of services post discharge.

Reassessment

1. As part of the Quality Assessment & Performance Improvement (QAPI) program, UTMB’s Care Management department will reassess the effectiveness of the hospital’s discharge planning process on a quarterly basis. The following reassessment processes will be performed to ensure that the discharge plans are responsive to the patient’s discharge needs:
 - Immediately identify those patients who are readmitted within 30 days of their index stay and complete a focus assessment to identify potential reason for readmission.
 - Refer readmissions to UTMB’s Outpatient Care Management Programs or other community programs, as appropriate, for continued assessment of health care needs and monitoring of the need for additional community services.
 - Utilize readmission data tracked by Care Team to conduct an in-depth, closed medical record review of ten percent (10%) of all-cause readmissions within 30 days.
 - Develop action plans for trends identified through the analysis of readmissions, e.g., concentration of readmissions related to post-surgical infections, discharge from a specific unit, or discharges to a specific post-acute extended care facility, and/or discharges with certain primary diagnoses.
 - Action plans shall address factors contributing to potentially preventable readmissions and incorporate improvement strategies and the ongoing (reassessment) monitoring of results to achieve improvements. Action plans may include revisions to the discharge planning process to achieve improvement.

IV. Relevant Federal and State Statutes

- [Centers for Medicare & Medicaid Services; Center for Clinical Standards and Quality/Survey & Certification Group \(2013\), COP 42 CFR 482.43. Revision to State Operations Manual \(SOM\), Hospital Annex A – Interpretive Guidelines for 42 CFR 482.43, Discharge Planning](#), February 28, 2017

V. Related UTMB Policies and Procedures

- UTMB Care Management, Practice Standard: Care Coordination- Transition of Care “Continued Stay Assessment” 42 CFR CoP 482.43
- [IHOP – 09.01.14 – Patient Discharge](#)

VI. Dates Approved or Amended

<i>Originated: 03/23/2017</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
	09/22/2021

VII. Contact Information

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