LEGACY HEALTH

PATIENT CARE
Practice Guideline #: 900.4289
Effective Date: DEC 1995
Last Revision Date: SEP 2023

SECTION: TRANSITION PLANNING
TITLE: DISCHARGE OF THE HOSPITALIZED PATIENT

FACILITY:

☒ Legacy Emanuel Hospital and Health Center	(as applicable: ☐ LEMC only ☐ RCH only ☐ Unity only)
☒ Legacy Good Samaritan Medical Center	☐ Legacy Medical Group
☒ Legacy Meridian Park Medical Center	☐ Legacy Urgent Care
☒ Legacy Mount Hood Medical Center	☐ Legacy Visiting Nurse Association (Hospice)
☒ Legacy Salmon Creek Medical Center	☐ Legacy Lab Services
☒ Legacy Silverton Medical Center	☐ Legacy Research Institute
☐ Administrative / System Support Services	☐ Other:

POPULATION: ☒ Adult ☒ Pediatric ☒ Neonate
(Adult > 18 years of age; Pediatric 0-18 and adult patients under care of a pediatric specialty physician at RCH; Neonate 0-28 days and continued hospitalization in the NICU)

PURPOSE: Hospital discharge planning is a process that involves determining the appropriate post-hospital discharge destination for a patient; identifying what the patient requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the patient's identified post-discharge needs (42 CFR §482.43 Condition of Participation: Discharge Planning/Interpretive Guidelines).

RESPONSIBILITIES:
Registered Nurse (RN), Clinical Social Worker (CSW), RN Case Manager (RN CM), Legacy Hospice Home Care Coordinator (HCC), Infusion Services Clinical Liaison, Licensed Independent Practitioner (LIP).

PRACTICE GUIDELINE:

KEY POINT: *Discharge planning applies to identified hospitalized individuals and requires an evaluation of the likelihood of a patient's capacity for self-care. The patient is reassessed, and the plan modified if there are factors impacting continuing care needs and the appropriateness of the established discharge plan.*

A. ASSESSMENT:

1. Patients are screened by one of the above listed responsible members of their care team early in their hospital stay to identify those who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

2. Criteria for screening include:
   a. The patient's functional status and cognitive ability;

b. The type of post-hospital care the patient requires, and whether such care requires the services of health care professionals or facilities;
c. The availability of the required post-hospital health care services to the patient;
d. The availability and capability of family and/or friends to provide follow-up care in the home.

3. The evaluation includes an assessment of the patient's capacity for self-care or of the possibility to be cared for by others in the environment from which patient was admitted to the hospital.

4. The assessment also includes an opportunity for the medical care team to encourage the patient to identify a lay caregiver, defined as an individual who, at the request of the patient, agrees to provide aftercare to the patient in the patient's residence. The lay caregiver is included in the planning process and receives instruction or training to perform needed aftercare.
   a. For patients younger than 18 years of age, the lay caregiver is the patient's parent or legal guardian unless there are clear clinical indications to the contrary.
   b. Patients aged 14 or older, the lay care giver can be an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.675.
   c. Patients over 18 years of age may designate a lay caregiver of their choice, unless there is a clear indication to the contrary.
   d. The care team will ensure the patient is aware of the benefits of designating a lay care giver, and that the patient has the right to rescind this authorization at any time.

KEY POINT: *While the hospital respects and supports a patient's right to participate in decisions about his or her care, treatment, and services received, there are times when patient/family wishes may conflict with the recommended medical plan of care. Consider requesting an Ethics Consult to explore value conflicts and patient/family preferences in the context of legal, cultural and spiritual considerations, and to facilitate communication regarding a framework for healthcare decision-making.*

B. DISPOSITIONAL DECISION MAKING:

1. The discharge planning assessment includes identifying a primary decision maker for planning purposes. Most often, patients and their family members are able to make their own decisions about continuing care plans, based upon their needs, resources and personal preferences.

2. Individuals who have been deemed by a medical professional to not have capacity to make important decisions may be considered 'incapacitated' (that is, unable to make or communicate the decisions needed to provide for basic health care, food, shelter, clothing, and personal hygiene without which serious physical injury or illness is likely to occur.) It is important to note a patient is not incapacitated because he/she disagrees with the health care team concerning medical treatment or because he/she refuses

recommendations for follow-up care. In those cases where the patient is incapacitated and there is no family or identified surrogate decision maker, establishing guardianship may be necessary to facilitate discharge planning, particularly where funding issues exist, or the receiving facility requires patient/family agreement to the discharge plan.

KEY POINT: *In some cases, a public guardian may be available when there are neither family members nor resources available to engage a private guardian. Not all counties have public guardians, however. Consult with Care Management staff for assistance.*

3. Establishing guardianship is a legal process, requiring a court order. Discharge decisions for adults are generally not considered 'emergent' by the courts; therefore, it is unlikely temporary guardianship will be granted to expedite a discharge plan. Based off of medical providers determination on capacity the Care Management staff will assess the availability of surrogate decision makers and the necessity of involving community resources such as Protective Services and/or public or private guardians.

KEY POINT: *Refer to* ***LH 900.4058 Informed Consent*** *for guidance regarding surrogate decision makers and authorized consenters for both minors and incapacitated adults. Consult with the Legal Services Department when considering the need to establish private guardianship.*

C. PRACTICE GUIDELINE:

1. Admission to Nursing Facility
    a. Care Management staff make an initial determination of level of care needs based on medical and functional recommendation, anticipated continuing care needs, resource availability and input from the health care team.
    b. Resource information, including facility options, availability, costs, and benefits, is reviewed with patients and/or family members.

KEY POINT: *The CMS website (www.Medicare.gov) is a source of information regarding specific nursing facilities.*

    c. Care Management staff facilitate authorization of needed services, as well as referrals for Medicaid eligibility determination when appropriate.
    d. Reasonable efforts are made to accommodate patient/family preference related to facility options.
    e. A Preadmission Screening Assessment is completed for patients requiring nursing facility care in accordance with state requirements.

2. Admission to Residential Facility
    a. *In Oregon*, the Social Worker or RN CM makes a determination of the patient's care needs and appropriateness for admission to the level of care provided in foster care, assisted living, or residential care facility.
    b. *In Washington*, all private pay patients who are candidates for adult foster home care must receive an assessment by a private qualified assessor to determine

level of care. Medicaid patients cannot be placed in an Adult Foster Home until an assessment is completed by Home and Community Services. The Medicaid patient may be placed in a SNF or be discharged to home until the HCS assessment is completed.

c. Care Management staff assess for appropriate level of care based on medical and functional recommendation, anticipated continuing care needs, resource availability and input from the health care team.
d. Resource information, including facility options, availability, costs, and benefits, is reviewed with patients and/or family members.
e. Care Management staff collaborate with Medicaid caseworkers to confirm eligibility for services when appropriate.
f. Reasonable efforts are made to accommodate patient/family preference related to facility options.

3. Admission to Inpatient Rehabilitation
    a. Patients in the following diagnostic groups should be considered for evaluation of eligibility for Inpatient Rehabilitation treatment (refer to pg. 2 of the CMS Criteria for reasonable and necessary Inpatient Rehabilitation treatment)
    b. The Rehabilitation Admissions Coordinator collaborates with the multi-disciplinary team, reviews the EHR and assesses the patient to determine appropriateness for patient admission to the inpatient rehabilitation setting.
    c. In some cases, the decision may be to delay patient admission to inpatient rehabilitation. A delayed admission is defined as a patient who is not able to be admitted directly from the referring acute medical hospital, or a patient who is in another setting (home or nursing home) and not admitted within 30 days. A patient whose admission is delayed is expected by the Rehabilitation Admissions Coordinator to meet admissions criteria in the near future. In the case of a patient who is being admitted to a nursing home, Care Management will inform the nursing home that the patient will be followed by the Rehabilitation Admissions Coordinator for potential future admission to Rehabilitation after a review of progress.

4. Admission to Skilled Home Care/Hospice/Home Infusion

KEY POINTS: *Hospice:*
In Oregon, Legacy Hospice will provide an on-site representative to coordinate Hospice referrals.
In Washington, there are no contracted on site Hospice representatives.

Infusion Services:
The Infusion Services Clinical Liaison coordinates admissions to home infusion services.

a. Care Management staff assess feasibility of home care based on care needs, resources and available informal and formal supports.

b. Resource information, including skilled and non-skilled home care resource options, costs, and benefits, is reviewed with patients and/or family members.
c. Care Management staff provides patients/families a list of available Home Health Agency providers, with information regarding health plan benefits, limitations and preferred providers. In cases where patients elect to have services provided by Legacy-affiliated infusion services or Legacy Hospice, the Infusion Services Clinical Liaison, Legacy Hospice Care Coordinator and/or Care Management personnel are responsible for informing the patient that Legacy has a financial interest in these services.

KEY POINT: *The CMS website (www.medicare.gov) is a source of information regarding Medicare-certified Home Health Agencies.*

d. Care Management staff facilitate referrals to community providers or, when appropriate, provide patients/families with resource and contact information for their follow-up.

5. Transfer to another Acute Care Hospital

KEY POINT: *In most adult cases transfers to acute care hospitals will be handled by nursing. Care Management may be called on to assist when patients are transferring to Veterans Administration, Kaiser hospitals, or a hospital outside of the immediate area, or when funding, transportation, or patient preference issues need to be addressed. Care Management will coordinate transfers to long term acute care hospitals (LTACHs).*

6. Referral and/or Admission to Alcohol and Drug Treatment Programs
    a. Care Management staff are available to assess patients referred for substance abuse treatment. Assessment includes patient's substance use history and readiness to engage in treatment.
    b. Resource information, including available options, benefits, and referral processes, is provided to patients.

7. Referral to County Health Department

KEY POINT: *In most cases the county health department and Community Health Nurses (CHNs) will not be able to provide immediate post-discharge follow-up services to patients. If the patient requires immediate services that meet criteria for skilled care, they should be referred for home health services.*

a. Patients may require the services of the county health departments for a variety of services. Clinics provide services to patients needing family planning, well-baby care, STI, immunizations, as well as general health care for patients who meet financial eligibility guidelines. CHNs make home visits to provide newborn and post-partum instruction, investigate home care situations other than those needing skilled care and refer patients to community resources.

b. Care Management staff provide patients/families with information about services available via the County Health Department and facilitate referrals as appropriate.

8. Admission to Psychiatric Inpatient Units

   Refer to the policies and procedures specific to the operating unit.

9. Referral to Outpatient Mental Health Treatment from Inpatient Mental Health Treatment
   a. Follow all preceding practice guidelines. Care Management staff will provide the additional following services as part of this discharge process.
      i. CSW to conduct assessment of patient's risk of suicide.
      ii. Schedule a follow-up appointment no later than seven days after discharge.
         1. If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's EHR.
      iii. Coordinate the patient's care and transition to outpatient treatment by sharing the post-discharge treatment plan with the patient and lay caregiver and provide an explanation of the next level of care and what the patient should expect from outpatient treatment.
      iv. Provide instructions or training to the patient and lay caregiver prior to discharge. Instructions should address how to provide assistance to the patient and may include securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.

D. DOCUMENTATION:

1. The assessment of discharge needs, including discussion of the results of the assessment with the patient, lay caregiver or individual acting on patient's behalf, is documented in the patient's EHR. A copy of the discharge policy or a version of the policy that is clear and easily understood will be given to each patient and their designated lay care giver.

2. Designation of a lay caregiver is documented in the patient's EHR.
   a. If a lay caregiver is identified, a signed authorization to disclose relevant protected health information is encouraged and documented in the EHR. (see addendum A)
   b. To the extent a parent or legal guardian is not designated as the lay caregiver for a patient aged 14 to 18 due to clinical indicators, those reasons should be noted in the EHR.
      To the extent that a lay caregiver for a patient over the age of 18 is not designated due to clinical indicators, those reasons should be noted in the EHR
3. Once established, the discharge plan is also documented in the patient's EHR, including final discharge arrangements, referrals made and transportation plans.

a. The plan is reassessed as needed.
b. Recommendations and resource information discussed, including lists of skilled nursing facilities and home health agencies available and presented to patients or the individuals acting on their behalf, are documented.

4. Necessary medical information related to the care, treatment, and services provided is shared with appropriate facilities, agencies, or outpatient services as needed and as otherwise consistent with law and regulation. Protected health information shall not be disclosed without obtaining a patients consent as required or permissible by state and federal law.

5. Physician-to-physician and/or nurse-to-nurse communication with next service site is completed to provide hand-off information and to ensure continuity of care.

Key Words: TRANSFER, DISCHARGE, GUARDIANSHIP
References: CMS (42 CFR § 482.43), 2015 ORS § 441.198, The Joint Commission, PASARR, Oregon Association of Hospitals and Health Systems “Discharge Planning for Patients Hospitalized for Mental Health Treatment,”

Approval: CSR
NEC
Medical Executive Committees
MQ&C

Originators: PFM Transition Planning Design Team

ADDENDUM A (SEE NEXT PAGE)

LEGACY HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.
Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? Yes No
Patient's Mailing Address		

Healthcare Provider to **Release** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Person or Agency to **Receive** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Purpose of release: _____
If such information exists, I authorize the disclosure of □ the entire medical record **or** □ the following specific documents, dates of service, and/or information about the following injury/illness/disease:

_____

The following items **must be initialed** to be released:

_____HIV-positive test results and HIV diagnosis
_____Mental health information and/or records (Oregon only)
_____Genetic testing information and/or records (Oregon only)
_____Other sexually transmitted diseases (Washington only)
_____Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire in one year from the date of signing or on _____ , whichever is later.

I am requesting the following records in electronic format:

☐ Discharge Instructions ☐ Available Electronic Medical Record

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (If other than the patient, proof of authority is required). Relationship to Patient

A copy of this signed form will be provided to the patient or personal representative. (11/19)

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