HOME HEALTH CARE SOLUTIONS, LLC.

Transfer and Discharge of Services

Policy Number: C334

POLICY

To delineate the process by which services are discharge, reduced, or transferred.

The patient and/or family member as well as the primary physician, should participate in discharge planning and be informed about the Agency's decision to discharge, reduce or transfer services.

DEFINITIONS

Termination/Discharge: Discontinuance of all agency services.

Reduction of Services: A change in the patient's service plan in which one or more existing services are discontinued.

Transfer/Referral: Patients whose needs change significantly and who require care that cannot be provided by the agency.

CRITERIA FOR DISCHARGE OF SERVICES

When the Agency reduces or discharges services provided to a patient, it must be based on the following circumstances:

A. Patient welfare.
    - A change in the patient's condition requires care or services other than that which can be provided by the Agency.
    - Requires more than intermittent service
    - Transfer for specialized services that the agency cannot provide
B. Reimbursement no longer available
    - Part or all needed services by the patient will not be reimbursed by Medicare or other insurance type. If the patient is a Medicare Beneficiary, the appropriate Home Health Notice of Non-coverage will be presented and explained to the patient and/or patient's representative prior to the discontinuation of services.
    - Lack of ongoing medical necessity
C. Agency and physician agree that goals have been met or maximum potential has been reached
D. Patient or patient representative refuses services or elects to be transferred, or physician discontinues care.
E. The patient or family refuses to cooperate in attaining the objectives of home care.
F. Discharge for cause
    - Abusive or disruptive behavior of patient or caregiver

- Threats – both verbal and non-verbal by patient or caregiver
- Sexual harassment or other incidents involving the safety of staff by patient or caregiver
- Conditions in the home are no longer safe for the patient or Agency personnel
- Other impediments to safe delivery of care
- Repeated declination of service or persistent and counterproductive hostile attitudes and behavior of patient and caregiver.

G. The patient moves from the geographic area served by the agency
H. The patient's physician has failed to renew orders or patient has changed physicians and orders cannot be obtained from the new physician to support needs.
I. The physician gives orders which are not consistent with the stated diagnosis as required by law or fails to give needed orders when requested by Agency
J. Patient death

The physician will be made aware of the agency's discharge plans. The patient and/or family will be notified of discharge plans and the Medicare Notice of Discharge will be given and explained to the patient and/or representative at least Fifteen (15) calendar days prior to the planned discharge date unless patient or caregiver is unavailable to receive notice.

1. For patients or families requiring continuing care or assistance in order to manage care needs after Agency services are discontinued:

A. Discharge planning shall identify needs the patient may have.

B. Arrangements for services will be coordinated by the Agency as completely as possible prior to discharge.

C. A complete list of medications will be provided to the patient.

2. The decision to terminate or reduce services must be documented in the clinical record, citing the circumstances and notification to patient and/or responsible family and/or patient representative at least fifteen (15) calendar days before services are stopped. Medicare Notice of Non-coverage form and the Home Health Change of Care Notice forms will be used for Medicare and Medicare supplement patients.

3. Fifteen (15) day calendar period Prior notice is not necessary when services are discontinued in the following circumstances:

i) The health and safety, or welfare of the home health agency's employees would be at immediate and significant risk if the Agency continued to provide services to the patient.
ii) The patient refuses home health agency's services and/or physician orders to stop home care services.
iii) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the Agency has informed the patient of community resources to assist the patient following discharge.
iv) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the Agency informs patient of community resources to assist the patient

following discharge.
However, Agency will continue, in good faith, to attempt to provide services during the fifteen (15) day calendar period described above. If Agency cannot provide such services during that period, its continuing attempts to provide services will be documented in the clinical record. The OASIS DATA Set for discharge will be based on the condition of the patient at the last skilled visit and will be completed by the appropriate discipline.

4. The OASIS DATA Set for discharge will be done by the discipline who is designated as the case manager at the time of discharge. A discharge DATA set is not required on patients who are discharged for prolonged hospitalization or those patients who have expired.

5. Physician will be notified upon discharge of home care services.

CRITERIA FOR TRANSFER OR REFERRAL TO ANOTHER AGENCY

Home health care services to a patient are not arbitrarily terminated. They may be transferred or referred to another Agency for reason including but not limited to:

A. Medical reasons; the Agency does not provide the services necessary for meeting the patient's needs.

B. Request of patient, patient representative, or the patient's physician.

C. The Agency no longer has the resources to provide needed care or services to the patient.

D. The Agency has determined that all or part of the services the patient requires will not be reimbursed by Medicare or other insurance type. If the patient's insurance is Medicare, the appropriate Medicare Notice of Non-Coverage or the Home Health Change of Care Notice will be presented and explained
to the patient prior to services being transferred.

E. The patient moves out of the geographic area the Agency services.

1. Patients are given immediate notice and assistance in selecting other health care services appropriate to their change needs.

2. When a patient is referred to another organization, the patient is informed of any financial benefit to the referring home care organization.

3. A physician's order must be obtained to transfer a patient.

4. The case manager or clinical supervisor shall make transfer arrangements with the primary physician at his/her request

5. The case manager or a clinical supervisor:

A. Informs the patient and his/her family of the physician transfer order.

B. Involves the patient and family in the transfer.

C. Serves as liaison between the patient, the family and the physician relative transfer arrangements.

D. Verbally confirms the transfer arrangements with and gives appropriate information to the receiving health care clinician.

6. The receiving organization is provided with relevant written or verbal information of transfer. All communication with the receiving facility is to be documented in the clinical record. Transferring information will include current medical status of patient, care and treatment, services received, a complete list of the patient's medications, relevant laboratory results, the presence of an active infection and caregiver information or the assistance patient receives in home.

7. Transfers to hospital settings will be coordinated with the designated admissions coordinator or case manager for the facility and if possible, clinical staff members involved in the patient's care. Transferring information will include current medical status of patient, care and treatment services received, a complete list of the patient's medications, relevant laboratory results, the presence of an active infection, and caregiver information / or assistance patient receives in home. A transfer OASIS DATA Set will be established for patients who are transferred as an inpatient to a facility and will serve as the final data set for patients who are discharged for prolonged hospitalization.

DOCUMENTATION

Relevant information includes at least:

1. Consistent information which will facilitate patient service coordination will be documented in the clinical record. When a patient is discharged, transferred or referred to another organization, relevant information includes at least:

A. Reason for transfer or discharge.

B. Physical and psychosocial status at time of transfer or discharge.

C. Summary of the care/service provided and progress toward achieving goals.

D. Instruction and/or referrals provided to the patient.

E. A complete list of medications was provided to the patient.

2. Information will be documented on appropriate discharge/transfer forms. The form will be completed within seventy-two hours of the action taken.

3. The date of discharge is the date the last visit was made.

4. A copy will be forwarded to the attending physician at his/her request.

5. All discharge paperwork is due in the office within seventy-two hours of discharge date. This includes the discharge summary, OASIS DATA SET, nursing plan of care and any communication documents or physician orders.

6. The discharge record is organized according to the agency policy regarding clinical record contents. Documentation is reviewed by the Clinical Supervisor and completed within thirty days of the discharge at which time it is removed from the active files.