



OHSU HEALTHCARE

Policy # HC-PC-116-RR	Title: Patient Discharge Process	
Effective Date: 10/29/2018	Category: Provision of Care	
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PURPOSE:

This policy describes OHSU Healthcare processes for use throughout a patient's hospitalization to assess and plan for discharge needs.

PERSONS AFFECTED:

This policy applies to OHSU Healthcare workforce members who provide ongoing assessment and planning for patient discharge needs.

POLICY:

OHSU Healthcare workforce members identify patient discharge needs as early as possible during hospitalization in order to ensure planning for continuity of care and safety. Discharge planning must be appropriate to the condition of the patient and interpreted in a manner and as necessary to meet the needs and acuity of the patient and the abilities of the lay caregiver if needed

RESPONSIBILITIES:

The patient care team is responsible for understanding the patient discharge process and complying with this policy.

DEFINITIONS:

1. **Aftercare:** The following activities after a patient is discharged from hospital or procedural areas
 - a. Assistance with activities of daily living or instrumental activities of daily living.
 - b. Medical or nursing tasks such as wound care, the administration of medications and the operation of medical equipment.
 - c. Other assistance provided by a caregiver to a patient, following the patient's discharge that is related to the patient's condition at the time of discharge.
2. **AOD:** Administrator On-Duty – pager 12241. The AOD is the front line hospital administrator responsible for daily administrative coordination of patient care and other hospital activities in conjunction with Nursing and Hospital Administration. The AOD is responsible for administrative activities during off shifts/weekends and holidays with appropriate Administrative backup.
3. **Behavioral health crisis:** means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate treatment to prevent a serious deterioration in the individual's mental or physical health.
4. **Discharge:** The release of a patient from the hospital following an admission to the hospital.
5. **Lay Caregiver:** For a patient who is younger than 15 years of age (except as otherwise indicated below), a parent or legal guardian of the patient. For a patient who is at least 14 years of age and is hospitalized for mental health treatment, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted by law (see ORS 109.640 and 109.675). For patient who is at least 15 years old and not

hospitalized for mental health treatment, an individual designated by the patient or a parent or legal guardian of the patient to extent permitted by law (see ORS 109.640 and 109.675).

6. Lethal means counseling: means counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.
7. LIP or Licensed Independent Practitioner: An individual permitted by law to provide care, treatment and services without direction or supervision. An LIP refers to a Physician, Nurse Practitioner, Certified Nurse Midwife or other provider with prescribing privileges. A LIP operates within the scope of his or her license, consistent with individually granted clinical privileges.
8. FMS: Financial and Medicaid Services. This is an OHSU Healthcare department section that assists patients and their families to participate in available healthcare reimbursement programs when possible.
9. SNF: Skilled nursing facility.
10. Suicide prevention measure: means measures that include, but are not limited to: (A) lethal means counseling; and (B) providing information about a suicide intervention hotline.

PROCEDURES:

1. Patients shall be discharged only on a written or verbal order of an LIP. The "Discharge Summary" and "Discharge Order" provide vital information for proper care of discharged patients in an emergency, return visit to the outpatient clinic, visit to the primary care physician's office, or continued treatment orders for post acute care locations
2. The interdisciplinary patient plan of care is designed to provide optimal care after discharge. (Physicians are expected to help plan a patient's medical course after hospitalization.) The case manager can assist the interdisciplinary team in planning and coordinating a safe and appropriate discharge plan. This plan is reviewed and updated by the interdisciplinary team and lay caregiver throughout the patient's hospital stay. The patient plan of care shall include an assessment of the patient's ability to provide self-care after discharge.
3. The case manager will facilitate discharge from the hospital for patients who are in need of assistance at home or are unable to return home.
4. The patient and patient's lay caregiver will receive as part of the discharge plan:
 - a. Appropriate referral to health team members for teaching regarding aftercare when indicated
 - b. Assessment of preferred learning methods and any barriers to learning
5. Discharge preparation
 - a. **Lay Caregiver**
 - i. Patients who can consent to medical treatment shall be asked whether they want to designate a lay caregiver. If the patient designates a lay caregiver, RN must document in the EHR the name and contact information for the lay caregiver.
 - ii. The lay caregiver shall be given the opportunity to participate in discharge planning and be notified of the patient's discharge or transfer, except where the patient objects to the lay caregiver being provided this information and the law does not allow the provision of this information.
 - iii. A family member involved in the patient's care may also be given information about discharge planning and be notified of the patient's discharge or transfer, except where the patient objects to the disclosure and the law does not allow for the provision of this information.
 - b. **Teaching**
 - i. The patient and lay caregiver will be given multidisciplinary instruction on aftercare.
 - ii. The patient and lay caregiver will be given appropriate and timely teaching on aftercare based on their readiness to learn at each teaching episode.
 - iii. Resources such as teaching protocols, the Integrated Health Record, videos and brochures or handouts will be used.
 - iv. Skill demonstrations and time for the patient and caregiver to practice skills will be provided.
 - v. The patient and lay caregiver's understanding of aftercare and skill performance will be evaluated and clear feedback will be provided at each teaching episode.
 - c. **Discharge supplies**

- i. The RN provides patients discharging to home a 24-hour supply of essential supplies (non-pharmaceuticals).
 - ii. In limited circumstances, a maximum three-day supply may be provided if it would be a hardship for patients to obtain necessary supplies for continued care.
 - iii. If more than a three-day supply is needed, consult with the nurse case manager for additional problem solving.
 - d. **Transportation**
 - i. Before contacting Care Management for patient transportation assistance, verify that the patient is unable to provide transport. Verification should include calling on family, friends, lay caregiver and local community services to help with transport. Once all options exhausted, RN is to call the Care Management Department for resources.
 - ii. Care Management, or bedside RN in the ED, should receive all medical transport requests for patients being discharged without their own transportation resources. During hours when Care Management is unavailable, requests should be made to the AOD.
 - iii. Care Management will arrange all transportation arrangements for patients being transferred to other facilities.
 - e. **Early, on time and late discharge or transfer**
 - i. Early discharge (Release against medical advice): If the patient's condition is potentially dangerous to self or others according to the criteria for a physician hold, a hospital hold should be initiated. If a patient wishes to be released from the hospital against medical advice, the patient should sign a "Discharge of Patient From Hospital Against Medical Advice (Form 6.A-18 / CO-1414)" acknowledgment. If the patient refuses to sign, document this in the medical record and release the patient.
 - ii. On time discharge: An expected discharge date and time will be identified by the multidisciplinary team early in each patient's admission. Every effort should be made to have discharge orders completed the evening before in order to expedite the process.
 - iii. Late discharge: If a Medicare patient refuses discharge, and initiates the Medicare appeal process, please notify the Case Manager covering the patient to begin the appropriate paperwork or call 4-2273 after hours.
 - f. **Discharge of patient following admission for mental health treatment.** To comply with Oregon law, the process for discharging a patient following an admission for mental health treatment shall include the steps outlined below. The other processes outlined in this policy also apply to patients discharged following an admission for mental health treatment, unless they conflict with the steps outlined in this subsection.
 - i. A social worker working with a patient shall encourage the patient to sign an authorization for the disclosure of the patient's health information to the lay caregiver so that the lay caregiver can participate in the patient's discharge planning and provide appropriate support to the patient following discharge. The social worker shall document in the EHR that a discussion about the authorization took place with the patient. Please note that a lay caregiver involved in the patient's care prior to discharge may receive patient medical information (including information about discharge planning and post-discharge care) without the patient signing an authorization for the release of patient information, except if the patient has specifically asked that medical information not be shared with the lay caregiver.
 - ii. The LIP treating the patient shall assess the patient's risk of suicide with input from the lay caregiver if appropriate. The LIP shall document the assessment in the EHR.
 - iii. A social worker, with input from nursing and the LIP(s) caring for the patient as appropriate, shall assess the mental health acuity and the level of recommended mental health care for the patient including: (A) the patient's need for community-based services; (B) the patient's capacity for self-care; and (C) to the extent practicable, whether the patient can be properly cared for in the place where the patient was residing when the patient presented at the hospital. The social worker shall document the assessment in the EHR.
 - iv. The case manager, with input and assistance from LIPs, nurses and social workers caring for the patient as appropriate, will help with the initial coordination of the patient's care after

discharge. The coordination may include setting up treatment at a community-based provider, identifying peer support for the patient, connecting lay caregivers with resources that may assist with the care of the patient post discharge and connecting the patient or lay caregiver to others who can execute the patient's care plan post discharge.

- v. If medically necessary, the case manager will schedule a follow-up appointment for the patient to receive outpatient treatment within seven (7) days after discharge or as soon as practical thereafter. The case manager shall document the details of the appointment in the EHR (e.g., date, time, provider and location). If a follow-up appointment cannot take place within seven (7) days of discharge, the case manager shall document why in the EHR.

g. Discharge of Behavioral Health Crisis Patient from Emergency Department

- i. In addition to the steps set forth in 5(f) above, a social worker working with a patient who was admitted to the Emergency Department due to a behavioral health crisis, or LIP or physician's assistant when a social worker is not working with such patient, shall ensure that suicide prevention measures are provided to such patients prior to discharge.
- ii. The social worker, physician's assistant or LIP, as applicable, shall document in the EHR and in the discharge summary, as appropriate, that suicide prevention measures have been provided to the patient.

h. Discharge of hospitalized patient to other facility: To facilitate transfers of hospitalized patients to another service site, appropriate information on the patient's care, treatment and services received at OHSU will be exchanged with receiving providers. This information will include:

- i. Reason for transfer or discharge
- ii. Patient's physical or psychosocial status
- iii. Summary of care, treatment and services
- iv. Community resources or referrals provided to the patient
- v. Name of lay caregiver (if one has been identified)

i. Transfer to nursing home:

- i. When a patient is identified as requiring nursing home placement, the case manager will be involved in communicating that recommendation to the patient, lay caregiver and family. The case manager in collaboration with the multidisciplinary team will identify determination of the patient's need for skilled or intermediate care based on medical criteria and provides patients, lay caregiver and families with information on the levels of care available in different facilities.
- ii. The case manager will provide the patient, lay caregiver and family with a list of nursing homes in the area they have requested. Families and lay caregiver(s) are encouraged to visit facilities prior to making a choice.
- iii. The case manager will review the patient's insurance benefits to determine if there is coverage for nursing home care, if prior authorization is required for placement and if there are preferred providers for nursing home care. Case Management will relay co-pays or additional costs of the nursing home placement with patients, lay caregiver and families.
- iv. If a patient requires intermediate care and does not have insurance coverage for care, the case manager will make a referral to FMS, which will assess the patient's financial status to determine if the patient is eligible for Medicaid coverage. If the patient is eligible for Medicaid, the FMS worker will refer the Case Manager to the appropriate Medicaid branch office for an evaluation, and completion of a Preadmission Screen Form (PAS).
- v. A preadmission screening assessment is required for patients entering a skilled nursing care facility or transitioning to an intermediate care facility for long-term care funded by Open Card Medicaid. The Case Manager will request this screening from the FMS worker assigned. FMS will coordinate the intermediate care evaluation screening with the appropriate county case worker.
- vi. The case manager is responsible for coordinating the patient's nursing home admission and transfer.
- vii. The direct care RN will provide a verbal report or warm video handoff at participating locations; on the patient's nursing care to the receiving RN.

j. Transfer to foster care home, assisted living, residential care facility or intermediate care facility:

- i. The case manager determines the patient's care needs and the suitability of foster care, assisted living or residential care. Patients receiving Medicaid cannot be placed in an adult foster home without approval from their county case worker
 - ii. The case manager determines the patient's ability to pay privately for care. If the patient cannot pay privately, an assessment for Medicaid eligibility must be made. If the patient is eligible for Medicaid, refer the patient, lay caregiver and family to FMS for application assistance.
 - iii. The case manager will refer Medicaid-funded patients requiring assisted living or residential care to the Medicaid caseworkers for placement. The case manager will coordinate with the county case worker to locate an open bed for patients who require admission to adult foster care.
 - iv. If the patient can pay privately for care, the case manager will refer the patient, lay caregiver and family to placement-finding agencies or provide them with a list of licensed facilities.
- k. Providing hospice and home health care:**
- i. The case manager will coordinate admissions to hospice and home health care when patients are referred to home health agencies.
 - ii. The case manager will discuss home care needs with the patient, family, lay caregiver, physician and staff. The case manager will discuss with the patient, lay caregiver and family the physician orders for skilled home care and assess their ability and willingness to manage the discharge care plan at home.
 - iii. The case manager will provide the patient, lay care giver, and family a list of certified home health agencies to choose a home care agency to provide services. Patients will be advised if their insurance coverage specifies a particular home health agency.
 - iv. If the patient's level of need justifies skilled care, the case manager will obtain a physician's orders and pre-authorization from the insurance representative as necessary.
 - v. The case manager will communicate with the patient, lay caregiver and family and document the home health plan in the patient's medical record, and after visit summary.
- l. Transfer to another acute care hospital**
- i. The attending physician identifies patients who may be appropriately transferred to another acute care hospital and consults with patient, lay caregiver and family about transfer when appropriate.
 - ii. Follow the hospital to hospital transfer policy
 - iii. The LIP collaborates with the case manager, who contacts the receiving hospital's admissions coordinator about bed availability and accepting the patient. The case manager can assist the physician to call their transfer center consultation and acceptance of patient.
 - iv. The direct care RN reports specifics of the patient's nursing care to the receiving RN, once the patient is accepted for transfer.
 - v. The LIP completes the hospital transfer form. The patient or patient's representative signs this form, and a copy is sent with the patient.
 - vi. In all patient transfers, appropriate medical documentation is copied and sent with the patient.
 - vii. The case manager arranges appropriate transportation per recommendations of the provider.
 - viii. The case manager and LIP will communicate with patient, lay caregiver and family and document the transfer plan in the patient's medical record.
 - ix. Lists of county health clinics, primary care physicians and community health nurse contact information are available through Care Management.
- m. Discharge summary**
- i. OHSU Healthcare encourages physicians to complete the discharge within 48 hours of discharge as part of providing good patient care. All discharge summaries must be completed within 30 days of the patient's discharge or before the patient is transferred, for both outpatient surgery and inpatient stays.
 - ii. Even if a patient leaves the hospital against medical advice or dies during the hospital stay, the discharge summary and a discharge order must be completed with principal and secondary diagnoses, major procedures during the admission and a brief statement about any complications or problems during the hospital stay.

n. **Discharge follow-up:**

- i. Reports to referring physicians: Communication with referring physicians is expected according to OHSU Healthcare policy as appropriate after admission of their patients, following surgical procedures (during hospitalization) and upon discharge.
- ii. The resident (house) physician should consult with the attending faculty physician to determine whether he or she wants to communicate personally with the patient's referring physician, or desires the house staff to do so. At discharge, the referring physician should always be given a brief summary of the following:
 1. Patient's current condition
 2. Important aspects of his or her hospital care
 3. Recommendations for follow-up care
 4. Notification that a complete written summary will be mailed shortly
- iii. OHSU clinic follow-up care: If the patient is to be followed in an OHSU clinic, the Health Unit Coordinator will make the appointment for the patient with the clinic designated in the discharge order, if the appointment is not already in the system.

6. Factors to consider when referring patients: Patients admitted to OHSU Hospital are returned to the care of the referring physician as soon as appropriate. Specific Medicare or other billing regulations may need to be considered. In some instances, the referring physician may desire that a patient's treatment be continued at an OHSU clinic. Such a patient may be referred to the clinic the same way as other clinic patients.

7. Care team responsibilities

a. **Nurse case manager responsibilities**

- i. Assess all assigned patients for continuing care needs using case management and high risk screening tools and methods, to identify patients with potential discharge planning needs.
 1. Methods used may include:
 - a. Care conferences
 - b. Review of daily unit or service census
 - c. Review of case management work list
 - d. Review of surgery schedules
 - e. Review of electronic medical records
 - f. Participation in interdisciplinary rounds
 - g. Referral information from community resources and third-party payers
 - h. Referral information from interdisciplinary team members
 - i. Interviews with the patient's family, lay caregiver or significant other
- ii. Document assessment findings in the EHR and develop discharge plan of care based on the findings.

b. **Social worker responsibilities**

- i. Assess all referred patients for the wide range of psychosocial challenges related to illness
- ii. Support patients in overcoming barriers to discharge by offering counseling and assistance with issues such as:
 1. Coping with illness and hospitalization
 2. The impact of illness on family members and loved ones
 3. Grief, loss and end of life experiences
 4. Care conferences
 5. Trauma
 6. Family challenges or conflicts
 7. Communication with the medical team—Social worker can help enhance this in order to help patients, lay caregiver(s) and families be active partners in the patient's health care
 8. Advance directives
 9. Parenting or caregiving concerns
 10. Adoption or foster care
 11. Violence in the home or community
 12. Depression, anxiety and other mental health concerns
 13. Substance misuse

14. Financial difficulties
 15. Housing problems
 16. Behavioral challenges
 17. Vocational needs
 18. School or educational concerns
 19. Access to community resources
 20. Support needs related to social determinants of health
 21. Referral or admission to alcohol and drug treatment programs
 - a. The social worker receives physician order for evaluation and referral to alcohol or drug abuse treatment.
 - b. The social worker meets with the patient to assess the patient's interest in receiving resource information or referral to treatment programs. The social worker also assesses the availability of financial or insurance resources to cover the desired treatment.
 - c. The social worker partners with the patient in facilitating admission to alcohol and drug treatment programs as indicated.
 - iii. Document assessment findings in the EHR and partner with the case manager to develop a discharge plan of care based on those findings.
- c. Registered nurse responsibilities**
- i. Assess and provide for patient, lay caregiver and family educational needs related to aftercare. Examples of this include, but are not limited to, wound care, tube flushing or catheterization.
 - ii. Document educational assessment in the EHR and develop a care plan that addresses any educational needs identified.
 - iii. Review discharge instructions and consult with patient to determine where the patient would like prescriptions filled. Note: Prescriptions for investigational drugs must be filled at the OHSU Pharmacy.
 - iv. Review the complete After Visit Summary and have patient sign it. Keep a copy for scanning into the EHR.
 - v. Check all prescriptions for correct and complete information and verify against medications ordered.
 - vi. Ensure that case management services arranged are complete and documented on AVS
 - vii. Ensures that medical documentation packet is sent with patient when medically transferred to another facility
- d. LIP responsibilities**
- i. Complete appropriate portion of interdisciplinary discharge instructions and orders.
 - ii. Complete discharge summary.
 - iii. Enter prescriptions into electronic medical record. Print a hard copy for the patient and fax prescriptions to patient's preferred pharmacy.
 - iv. Order post-hospital supplies, equipment, services or alternative level of care placement for safe discharge. Consult with case manager for necessary documentation.

RELEVANT REFERENCES:

- NIAHO Standards
- ORS 441.196-441.198; HB 3090 (2017)

RELATED DOCUMENTS/EXTERNAL LINKS:

- High Risk Preadmission Screen: Adult (Form #8.2-9J)
- Newborn Order for Discharge and Discharge Summary (Form DC#1802)
- High Risk Newborn Order for Discharge and Discharge Summary (Form DC#1803D)
- Discharge of Patient From Hospital Against Medical Advice (Form CO-1414)
- Patient Transfers: Hospital to Hospital Transfer Communication

TITLE, POLICY OWNER:

Care Management Director

APPROVING COMMITTEE(S):

Patient Care Operations

FINAL APPROVAL:

Policy Steering Committee

Supersedes: Discharge and Discharge Planning (R&R II.B) August 6 1998, July 1989; Order for Discharge and Discharge Summary (ODDS) FORMS (ADM 4.03) May 1997; Healthcare Plan Assessment (ADM 1.58) Effective Date: October 1998; Discharge: Discharge Planning - Nurse Role (d-01) Effective Date: March 1998; Discharge: Patient/Family Education - Nurse Role (d-03) Effective Date: March 1998; Discharge: Transportation For Patients Being Discharged (d-04) Effective Date: March 1998; 8/20/2001; 11/2013; 8/27/2014 policy updated to include patient teaching and patient discharge supplies; 11/11/2014 updates from Genevieve (plain language); 1/2017; 10/2018;