Sullivan County Department of Public Health

Title: Discharge Process **Number**: AG-18 **Page Number:** 1 of 2	Original Approval: 12/92 Reviewed/ revised: 9/99, 9/01, 8/04, 5/15, 10/18, 11/22, 4/24

Statement/ Purpose:
To provide guidelines for discharging a patient from home health care.

Authority:
CoP 484.50 (d), NYS Home Care Regulations, Title 10, Section 484.110(a)(6)

Application:
All SCDPH staff

Terminology:

Responsible Party:
Director of Patient Services

Cross-Reference:
Quality Standards, Advanced Beneficiary Notice

Procedure:
1. Services are discontinued when:
    a. The physician and/or patient request discontinuation.
    b. The patient no longer meets admission criteria.
    c. The patient's health status no longer requires skilled care.
    d. The patient and/or patient's support system is able, willing, and capable of providing the necessary care to meet the patient's health care needs in the absence of home care staff.
    e. The patient and/ or patient's support system is unable, unwilling, or incapable of providing necessary care to meet the patient's therapeutic goals.
    f. The patient fails to comply with the Plan of Care contract. The care can no longer be delivered in the home care setting for safety reasons. When conditions are known to exist in or around the home that would imminently threaten the safety of personnel or the patient habitually declines visits, compromising the ability of the agency to safely and effectively deliver care to meet the patient's needs.
    g. The patient or payor will no longer pay for the services provided by the home care agency.
    h. The patient expires
    i. The agency ceases to operate.
2. In the event that the patient no longer meets the criteria for continuation of services, the following steps are taken, providing access to a more appropriate level of care:
    a. Patient no longer meeting homebound criteria is offered a choice of self-pay for services, or immediate

discharge with referral to their physician. They are given an appropriate advanced notice of discharge (see Advanced Beneficiary Notice policy).

b. Patients who are deemed medically stable for their condition are discharged from services.
c. Patients who are not medically stable and who can not safely receive services in their home:
    i. The patient, representative, physician(s) issuing orders for the home health care and the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the agency are notified that a discharge for cause is being considered.
    ii. Agency staff make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the home, or situation, and document the problems and efforts in the medical record.
    iii. Patients and their representative(s) are provided with information about alternatives to home health care and contact information.
    iv. If the patient chooses to seek alternative care, the agency provides continued care until arrangements are finalized, within a timeline that is determined by the agency.
    v. If the patient refuses to seek alternative care, the situation is discussed with the Director of Patient Services or his/her designee, and agency staff takes the following steps:
        1. After obtaining the patient's approval, a staff member notifies the next of kin or representative or the person listed as emergency support in the absence of the next of kin.
        2. A staff member contacts the Adult Protective Services (APS) unit. If the agency believes there will be a substantial risk to patient health and safety, the agency will reassess if APS intervenes, takes action, and declares problem resolved.
        3. A staff member notifies the physician and it will be determined if action to discharge should be discontinued or patient readmitted.
    vi. For patients who continue to refuse alternative care, the Director of Patient Services is responsible for serving the patient with official notice within the guidelines of the agency's legal counsel.
d. The patient's physician is notified.

3. Discharge and discharge summary must be completed by COB and sent to the Physician, patient and their representative within 5 days of discharge. Documentation includes the following:
    a. Completion of OASIS discharge form
    b. Completion of Discharge in patient profile.
    c. Completion of Discharge Summary. Email to intake staff to notify of patient discharge/ completion of documentation.
        i. Summary is sent to physician or health care professional that will be providing care and services to the patient after discharge, and the patient, within 5 business days of discharge.
    d. Documentation in the Discharge Summary must include:
        i. Admission and discharge dates
        ii. Name of physician responsible for the home health plan of care
        iii. Reason for admission to home health agency
        iv. Type of services and frequency provided
        v. Laboratory data
        vi. Medications patient is on at time of discharge
        vii. Patient's discharge condition
        viii. Patient outcomes in meeting the goals in the plan of care
        ix. Patient and family post-discharge instructions.