


Name of Policy: <u>Hospital-Wide Discharge Planning</u> Policy Number: 3364-100-50-30 Department: Hospital Administration Approving Officer: Chief Executive Officer Chief of Staff Responsible Agent: Director Outcome Management Scope: The University of Toledo Medical Center and its medical staff	 Effective Date: 06/01/2021 Initial Effective Date: 9/12/1990
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	
<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy	

(A) Policy Statement

A comprehensive method will be used to provide for the coordination of the patient's continued care after discharge.

(B) Purpose of Policy

To provide an operational definition of discharge planning, to clarify role responsibility, to outline specific procedures of the disciplines concerned and to document compliance with various regulatory/accrediting bodies.

(C) Procedure

1. Definition of Discharge Planning:

Discharge planning is a coordinated program developed to ensure that each patient has a plan for needed continuing care and/or follow-up.

- a. Discharge planning ensures continuity of care and enables the patient to make an appropriate transition from the hospital to another environment: for example, home with home health care, a relative's home, rehabilitation facility, subacute care facility, a group home or an extended care facility. Discharge planning is a multidisciplinary clinical treatment process which evaluates the physical, emotional, social and financial aspects of the patient's situation and that of his or her family. The discharge planning process transfers the responsibility for care to another setting, modality of treatment, or provider, and/or to the patient and his/her personal support system.

2. Process:

- a. All patients admitted to The University of Toledo Medical Center (UTMC) will have a discharge plan screening found on the Nursing Admission History Assessment completed by the admitting RN. This screening will alert the Outcome Management Report located on the Clinical Portal, and will be reviewed by the Social Worker or Social Work Assistant (SW/SWA) for the patient's immediate and emerging physiological, psychological, social, financial, spiritual, and cultural needs. The SW/SWA will complete the discharge assessment to identify the appropriate clinical disciplines and resources needed to implement a successful discharge plan for the patient. The SW/SWA will work with the attending/medical team, nursing staff and multidisciplinary teams (respiratory, dietary, physical/occupational/speech, pharmacy, pastoral care/ethics) to communicate the resources needed for discharge planning during the course of the patient's hospitalization in order to coordinate and facilitate the patient's progression through the continuum of care and into the post-acute discharge setting.
- b. The individual patient's discharge planning process will continue to be refined during the course of the hospitalization and will be a multidisciplinary, collaborative effort. Assessments by a variety of disciplines will occur in a timely manner. Continuity of care meetings, high risk screening criteria and referrals to the appropriate discipline will also be utilized to facilitate the discharge planning process.
- c. Patient and/or family are involved in mutually determining the discharge plan. Support, education and guidance are extended to the patient/family as the plan evolves.
- d. Documentation of the discharge plan occurs in the electronic medical record by the physician, nurse and other clinical care departments as involved.

3. Responsibilities of Disciplines:

- a. **The Physician:** The attending physician is ultimately responsible for the assessment, medication reconciliation (admission and discharge), and care plan. The attending physician is responsible for documenting the recommendations from consultants on the Discharge Instructions/Doctor's Order Form. These responsibilities may be delegated to resident physicians assigned to care for the patient. The physician is cognizant of the patient's medical needs early in the hospital stay and includes consults to the appropriate multidisciplinary teams immediately so that an assessment and treatment plan can be formalized to accommodate a timely discharge. The physician completes the Medication Reconciliation, Discharge Instructions/Doctor's Discharge Order form and indicates the type of services needed. Discharge orders are reviewed and updated as indicated. Potential discharge dates are relayed to the designated Outcome Management and multidisciplinary staff with as much advance notice as possible. A minimum of 24-hour notice of pending discharge is given when care arrangements are required. The Discharge Instructions/Doctor's Discharge Order Form is a State mandated form and a legal document since it constitutes physician orders and must be completed and signed by the physician in a thorough and timely manner in order to expedite discharge. The purpose of the form is to determine the patient care level so that the patient's medical needs and facility/service can be matched.
- b. **Outcome Management Services:** Outcome Management is responsible for coordinating and implementing community agency involvement in the discharge plan. Patients are assessed according to established Outcome Management policy (see Outcome Management department policy number 3364-131-28). The SW/SWA assesses referrals and serves as coordinator in arranging for the various resources, facilities, services and therapies that a patient requires post-discharge. The Outcome Management department works closely with the physician and other multidisciplinary teams to pro-actively facilitate an effective discharge plan. The Resource Utilization Coordinators and the SW/SWA's will help facilitate the completion of the Discharge Instructions/Doctor's Discharge Order form.
- c. **Nursing:** Nursing provides and documents an assessment plan which includes intervention and evaluation for each hospitalized patient from initial contact through discharge. The nursing plan is consistent with the medical plan of care and is available to all hospital personnel involved in the care of the patient. Nursing completes the nursing section of the Discharge Instructions/Patient Discharge Education form in a timely manner. **Every Patient is to receive a Patient Discharge Instruction form, including patients discharged to Extended Care Facilities (ECF), Long Term Acute Care (LTAC), Home Health Care (HHC), Acute Rehab, Rescue Crisis, or other hospitals. Patients discharged with post care services require a physician signature on the Discharge Instructions/Doctor's Discharge Order Form.**
- d. **Respiratory:** is responsible for coordinating and implementing community agency involvement for any respiratory needs the patient may have according to the recommendations for the patient in their care plan.
- e. **Utilization Management:** The Resource Utilization Coordinator monitors the patient's plan of care and provides clinical data to third party payors to support the hospital stay. The Resource Utilization Coordinator works with the Financial Counselors and the RN Denials Coordinator when potential loss of coverage exists.
- f. **Other Multidisciplinary Teams:** Other multidisciplinary teams involved in the discharge planning process may include but not be limited to respiratory, dietary, physical/occupational/speech therapy, pharmacy, pastoral care/ethics, etc. Communication about any ongoing concerns and/or needs of the patient/family regarding the discharge plan are relayed to the appropriate personnel.
- g. **Transfer Agreements with outside Facilities:** All transfer agreements between UTMC and outside facilities (i.e., ECF, subacute care facility, etc.) will be facilitated through the Office of Liability Control.

<p>Approved by:</p> <p><u>/s/</u> Richard Swaine Chief Executive Officer</p> <p><u>06/11/2021</u> Date</p> <p><u>/s/</u> Andrew Casabianca, MD, DMD Chief of Staff</p> <p><i>Review/Revision Completed By:</i> HAS Chief of Staff Outcome Management</p>	<p>Review/Revision Date: 4/8/92 4/14/93 9/11/96 1/13/99 3/13/02 4/29/05 3/15/2007 8/26/2009 10/1/2012 4/1/2016 4/1/2020 5/1/2021</p>
<p>Policies Superseded by This Policy: 7-50-30 - Hospital-Wide Discharge Planning</p>	<p>Next Review Date: 5/1/2024</p>

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.