Discharge Planning for the HF Patient.

Outcome Management Guidelines.
Discharge Planning for the Heart Failure (HF) Patient.

**Title:** Discharge Planning for the HF Patient.

**Responsibility:** Outcome Management (Social Worker and Resource Utilization Coordinator).

**Purpose of Guidelines:** The Social Worker (SW) will forward Summary of Care/Discharge Instructions to the accepting agency to communicate transitions in care.

**Procedure:**

1. The SW will do a discharge planning assessment on each HF patient.
2. The SW will discuss discharge planning with each patient and will determine if the patient will have a need upon discharge.
3. The patient will be given a list to determine the agency that they will choose for follow up care.
4. After the agency is chosen, the SW will provide all appropriate paperwork, Summary of Care and Discharge Instructions to the agency. This process will provide continuity of care.
5. The Clerical Specialist will make follow-up appointments with the specific physicians/clinic and place them on the discharge instructions. All follow up appointments will be made within 7 days of discharge.
6. After discharge, the Resource Utilization Coordinator will forward the HF patient list to the secretary of Outcome Management who will then forward the discharge paperwork to the patient’s primary care physician.

Reviewed by: Greg Shannon, MSN, RN, Staff Development Coordinator & Angela Ackerman BSN, RN Director of Outcome Management.

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Outcome Management