TITLE: DISCHARGE PLANNING

PURPOSE: To define the process by which patients remain in a Harris County Hospital District facility no longer than medically necessary and to facilitate a continuum of care following the patient’s discharge.

POLICY STATEMENT:

The Harris County Hospital District (“HCHD”) will assess and reassess a patient’s need for services following discharge using a coordinated interdisciplinary approach during the patient’s hospital stay.

POLICY ELABORATION:

I. DEFINITIONS:

A. **After Visit Summary:** A clinical summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before twenty-four (24) hours after visit), and symptoms.

B. **Discharge Instruction:** Any directions that the patient must follow after discharge to attend to any residual conditions that need to be addressed personally by the patient, home care attendants, and other clinicians on an outpatient basis.

C. **Discharge Planning:** An interdisciplinary process utilized by the health care professional to formulate and implement a plan to address the needs of patients, either actual or potential, in order to facilitate a positive outcome and potentially decrease length of stay.
D. **Discharge Summary**: Discusses the outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

E. **Interdisciplinary Team**: Physicians, registered and licensed vocational nurses, social worker case managers, nurse case managers and other healthcare professionals who provide care to the patient throughout hospitalization.

II. **General Provisions**:

A. The admitting nurse shall initiate the discharge planning process and shall document the assessment of the patient’s needs in the medical record in the Inpatient Initial Assessment section of the patient’s medical record. The Inpatient Initial Assessment shall provide the basis for the planning processes utilized to identify services required throughout the patient’s hospitalization.

B. Patients who require additional support with discharge plans may also be identified through referrals from the patient’s family, significant other, physician, nurse, social work case manager, nurse case managers, other healthcare providers, and/or the community at large.

C. As indicated, Clinical Case Management (CCM) staff shall ensure that communication with members of the Interdisciplinary Team occurs and that services are coordinated to assist with the identified needs of the patient.

D. Documentation of all pertinent medical, nursing, and social history concerning the patient shall be reflected in ongoing assessments and re-assessments during the patient’s hospitalization.

E. Discharge planning may occur at the unit level and/or at specific service interdisciplinary meetings, e.g., Pediatrics, Medicine, Surgery, Neurology, etc. This process may include, but shall not be limited to, assessment, reassessment, and evaluation of the patient’s discharge needs related to:

1. Cognitive status;
2. Functional status;
3. Family structure;
4. Primary caretaker;
5. Financial status;
6. Transportation availability;
7. Medical supplies/equipment;
8. Living arrangements;
9. Community resources (to include options for alcohol or substance abuse treatment);
10. Referrals to other disciplines within the hospital, i.e., nutrition, physical therapy, occupational therapy, etc.; and
11. Any return to pre-hospitalization activity.

F. A completed Discharge Instruction which include an After Visit Summary (“AVS”) from the patient’s medical record and a patient copy with explanations provided by the nurse shall be given to the patient at the time of discharge. Discharge Instructions and the AVS do not replace or suffice as the Discharge Summary in any manner. The actual Discharge Summary may reference the AVS and/or Discharge Instruction.

G. Patients who require post acute care healthcare services (to be arranged by a HCHD provider) shall provide that facility, through HCHD Health Information Management (“HIM”) Department, with copies of the:

1. Discharge orders; and
2. Discharge Instruction Report that includes an AVS, the patient’s name and address, the phone number of the discharge location, family contact information, and the name of the HCHD provider along with any documentation required by the facility.

H. HIM shall incorporate all paper documentation accumulated during the patient’s stay into the patient’s medical record during or within two (2) days following the patient’s discharge from a hospital stay.

I. HIM may forward a copy of the Final Progress Note, Discharge Summary, and Operative Report, Specialty, and Emergency Center report to the patient’s non- HCHD primary care location, if indicated.
REFERENCES/BIBLIOGRAPHY:

The Joint Commission Leadership Standard 3.140.

The Joint Commission Provision of Care Standards 15.10.

42 C.F.R. § 482.24(c) (2)(vii), Condition of participation: Medical record services.


OFFICE OF PRIMARY RESPONSIBILITY:

HCHD Associate Administrator, Clinical Case Management

REVIEW/REVISION HISTORY:

Record review and revisions below:

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<th>Effective Date</th>
<th>Version# (If Applicable)</th>
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