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Owner: Nick Walters

Area:
URMHC Certified Services, Inc.
UR Medicine Hospice
Signature Care

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Discharge or Transfer from Agency, 511

Applies to:

This policy applies to all UR Medicine Home Care employees who work in URMHC Certified Services, Inc., UR Medicine Hospice and Signature Care.

Policy:

It is the policy of UR Medicine Home Care to ensure patients are discharged or transferred after the patient, patient's representative, caregiver, and all medical practitioners (physician licensed in accordance with article 131 of the New York State Education Law, a physician's assistant or a specialists assistant registered in accordance with article 131-B pf the New York State Education Law, or a nurse practitioner certified in accordance with article 139 of the New York State Education Law) issuing orders for the plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency involved in the plan of care are fully informed of the intent to discharge or transfer the patient.

Description:

Description: Discharge shall be appropriate when:

A. Therapeutic goals have been attained and the patient can function independently or with other types of community support services.
B. All Agency services are terminated by the patient or the patient moves out of the service area.

C. The patient's attending medical practitioner discontinues medical orders for all services.
D. Death occurs.
E. The patient's medical practitioner does not return signed medical orders necessary for the care of the patient after repeated attempts by Agency personnel to acquire the orders. Director of Patient Services or designee will speak or write to the medical practitioner prior to the patient's discharge and may involve the Agency Medical Director. Patient will be discharged when a safe plan of care has been identified.
F. The availability of home health services or community support services is no longer sufficient to meet the patient's changing care needs, or the patient refuses medical care when Professional Home Visiting (PHV) staff and the Medical Director agree that medical care is necessary. The Agency will advise the patient/caregiver of alternatives for care as appropriate with social work involvement as needed. If after assessment and advising, the Agency believes that a substantial and imminent health or safety risk continues, referral will be made to Adult/Child Protective Services
G. Discharge for Cause: Conditions in the home imminently threaten the safety of staff providing services or jeopardize the Agency's ability to provide care as described as follows:
    1. When conditions are known to exist in or around the home that would imminently threaten the safety of staff, including but not limited to:
        a. Actual or likely physical assault that the individual threatening such assault has the ability to carry out;
        b. Presence of weapons, criminal activity or contraband material which creates in staff a reasonable concern for personal safety;
        c. Continuing severe verbal threats which the individual making the threats has the ability to carry out and that would create, in staff, a reasonable concern for personal safety;
        d. When the Agency has valid reason to believe that Agency personnel will be subjected to continuing and severe verbal abuse which will jeopardize the Agency's ability to secure sufficient personnel resources or to provide care that meets the needs of the patient; or
        e. Patient repeatedly refuses to comply with a plan of care or others interfere with the patient's ability to comply with a plan of care agreed upon as appropriate, by the patient; the patient's family; any legally designated patient representative; the patient's medical practitioner; Agency personnel and/or any case management entity, and such non-compliance will lead to an immediate deterioration in the patient's condition serious enough so that home care will no longer be safe and appropriate.

H. Discharge for Cause: The patient, the patient's family, informal or any legally designated patient representative interferes with implementation of the patient's plan of care and the scope and effect of such renders the agency unable to safely and/or effectively implement the plan of care.
    1. Has led to or will lead to an immediate deterioration in the patient's condition serious enough that home care will no longer be safe and appropriate.
    2. Has made attainment of reasonable therapeutic goals at home impossible.

3. The likely outcome of such non-compliance or interference has been explained to the patient, or the patient's legally designated patient representative, family or informal supports, and any case management entity, as appropriate, and the patient continues to refuse to comply with, or others continue to interfere with the implementation of, the plan of care.
4. A case conference is held with the patient, family (if any), appropriate Agency staff, medical practitioner if needed, and known community agencies to explore an alternate care plan if patient does not continue to meet admission criteria. If there is no resolution to the impediment of the care plan, Adult/Child Protective Referral is made.
5. Prior to discharge for cause the Chief Medical Officer, VP of Clinical Operations, Director of Quality, Director of CHHA Services, and/or an Agency attorney is informed and consulted as indicated. The Department of Health for the Region may be contacted in some situations.

I. A 48-hour notice of intent to discharge has been provided to the MD and to any 3rd party payors for all LHCSA patients.

(COP -G452) Transfer and Discharge: The HHA may only transfer or discharge the patient from HHA if:

A. (COP-G454) necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patients needs based on patient's acuity. The HHA must arrange a safe and appropriate transfer to the other care entities when the needs of the patient exceed the HHA capabilities. The HHA must assure that documentation of alternate provider's agreement to admit and admission date confirmation is retained in the patient's record.
B. (COP- 462) for the purpose of addressing DC for cause that the patient's behavior (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired: The HHA will
    a. (G464) Advise patient, representative (if any), the physician issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care to the patient after dc from the HHA that a discharge for cause is being considered
C. Appropriate discharge summary is completed and sent to signing provider upon discharge from HHA. When patients are transferred, appropriate medical records are sent to the receiving facility.

Exception:

Licensed Agency reserves the right to discharge for reasons, including but not limited to, non- payment and/or availability of staff.

Regulatory Reference(s):

New York Department of Health Regulations: *http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9f785256538006c3ed7/852565 2c00680c3e8525652b0061dd90?OpenDocument&Highlight=0,home,care,standards*

http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/0/8525652c00680c3e8525652b00609e5b?Op enDocument

Center for Medicaid & Medicare (CMS) Code of Federal Regulations: http://www.ecfr.gov/cgi-bin/text-idx?SID=4340bab411663aded5d3de80afa2e2e5&node=pt42.5.484&rgn=div5#se42.5.484_130

Related Procedure:

Discharge from Agency Procedure

Status: Approved	Approver: Senior Leadership	Date: 1/21/2025
	Professional Advisory Committee	2/06/25