LOS ANGELES GENERAL MEDICAL CENTER POLICY

Subject:	Original Issue Date:	Policy #
DISCHARGE PLANNING	7/14/15	**725**
	Supersedes: 8/23/19	Effective Date: 10/21/22

Policy Owner: Associate Chief Medical Officer/ Chief Quality Officer
Executive Sponsor(s): Chief Medical Officer

Departments Consulted:	Reviewed & approved by:	Approved by:
Quality Improvement Nursing Services Clinical Social Services Regulatory Affairs	Attending Staff Association Executive Committee Senior Executive Officer	(Signature on File) Chief Medical Officer (Signature on File) Chief Executive Officer

PURPOSE

To provide discharge planning guidance and maintain regulatory compliance.

This policy applies only to patients who are admitted as inpatient and is not applicable to patients within the emergency department, outpatient, or observation status.

POLICY

Discharge Planning Process:
It is the policy of Los Angeles General Medical Center to provide discharge planning to all inpatients at an early stage of their hospitalization. The discharge planning process must also be integrated into our hospital's Quality Assessment and Performance Improvement (QAPI) Programs.

Depending on the patient's needs, hospital discharge planning may be completed by registered nurse, social worker, or other qualified personnel.

Discharge Evaluation:
All patients admitted to the hospital shall be screened for conditions that identify them as needing complex post discharge care management and this should be documented in the patient medical record. Staff must initiate discharge planning activities as soon as possible after admission and update the plan prior to discharge based on the patient's condition. The patient or patient's representative must be involved in the discharge planning process.

Patients identified as homeless upon discharge must be offered the following:

- A medical screening examination and evaluation
- Referral or follow-up care
- Infectious Disease screening
- Vaccination
- Meal
- Clothing
- Discharge Medication, if applicable
- Transportation
- Assist patient in enrolling in an affordable health coverage

If the patient refuses any of the above offered, document in the electronic health record.

Discharge Plan:
The hospital's discharge plan should match the identified needs. The patient should be offered a range of realistic options to consider for post-hospital care. The hospital must arrange initial implementation of the discharge plan, by arranging necessary post-hospital services and care, and documenting in the patient's medical record,

The hospital should provide the patient and family/caregivers information and instructions in preparation for the patient's post-hospital care. Individuals who will be providing care should know and be able to demonstrate or verbalize the patient's care needs. This plan must also be re-assessed based on any significant changes in patient's condition, changes in available support, and/or changes in post-hospital care requirements, and updated accordingly.

QAPI:
The hospital's QAPI Program must include a mechanism for ongoing re-assessment of its discharge planning process.

Transfer:
For patients transferred to a post-acute care setting other than home, a transfer summary signed by the provider along with the necessary medical information must be ready at time of transfer and sent to the receiving facility with the patient or electronically at time of transfer.
The transfer summary must include the following:

- Patient's diagnosis or diagnoses
- Hospital course
- Allergies
- Medications
- Treatment plan

When applicable, the following elements should also be included in the Transfer or Discharge Summary:

- Pain treatment and management
- Dietary requirements
- Rehabilitation potential
- Time and location of next appointment/testing, if scheduled, or recommended appointment time, if next appointment/testing is not scheduled
- List of other appointments and tests the patient needs to schedule, including contact information
- Recommended patient decision aids
- Laboratory and other diagnostic test orders
- Test/laboratory results, if received within 24 hours after the visit

REFERENCES

Department of Health and Human Services, Center for Medicare and Medicaid Services, "Discharge Planning" booklet, October 2014.
Agency for Healthcare Research and Quality, "Re-Engineered Discharge (RED) Tool Kit", March 2013
State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning
California, Health, and Safety Code 1262.5 (a-g)
California Hospital Association (2019). Discharge Planning for Homeless Patients

REVISIONS

June 29, 2018; August 23, 2019, October 21, 2022