OLIVE VIEW-UCLA MEDICAL CENTER
CLINICAL SOCIAL WORK
POLICY & PROCEDURE

NUMBER: 1332
VERSION: 1

SUBJECT/TITLE: **DISCHARGE PLANNING TO HOME HOSPICE OR SKILLED NURSING FACILITY WITH HOSPICE CARE**

POLICY: Social Work will facilitate the placement of appropriate patients into settings providing hospice level care when the patient has financing and desires this service.

PURPOSE: To provide guidelines for staff regarding hospice and discharge requirements.

DEPARTMENTS: All

DEFINITIONS: Hospice Care may be provided in the home or a senior care facility. Services can include pain management and a variety of emotional, spiritual and physical support.

PROCEDURE:

1. Receive referrals from the ward.

2. Confirm the appropriateness for hospice care. The patient's physician must state the life expectancy is 6 months or less. **HOME HOSPICE ARRANGEMENTS ARE MADE THROUGH CONTINUITY OF CARE/UTILIZATION REVIEW DEPARTMENT (EXT. 3352) RATHER THAN SOCIAL WORK.**

3. The patient and/or the family know the prognosis and agree to hospice care.

4. Provide a copy of the "New Lifestyles, the Source for Seniors" Booklet to the patient/family that contains information and community resources available for them.

5. Social Work staff initiates the referral package. This includes: program application, medical information, physician's certification TB clearance form, financial status, and Outpatient DNR form. Follow the requirements of the hospice involved.

6. Social Work staff works with the hospital treatment team, the patient/family and Continuity of Care to facilitate discharge plans and arrangements.

7. A 'Patient Referral and Continuity Plan of Care Form (#76P73S OV1014) is placed on the chart for the licensed physician to complete and sign.

References: VC Policy 262, "Admission / Transfer / Discharge"	
Approved by: Stephanie Johnson (Assistant Hospital Administrator)	Date: 12/15/2010
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