CLINICAL Policies and Procedures

<table>
<thead>
<tr>
<th>DISCHARGE FROM HOSPICE SERVICES</th>
<th>Policy #: CP219</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHPCO Standard(s): PFC 6.4; CES 9.1, 9.4; IA 1.2</td>
<td>BOD Review/Approval 03/21/17</td>
</tr>
<tr>
<td>Regulatory Citation(s): 42 CFR 418.3, 418.26; 10 NYCRR 793.2(b), (c), and (e), PHL 4002 (5)</td>
<td></td>
</tr>
</tbody>
</table>

POLICY

High Peaks Hospice (HPH) may discontinue hospice services for a patient/family for reasons other than death. A patient may be discharged from HPH services for three reasons:

1. HPH determines the patient is no longer terminally ill,
2. the patient moves out of the service area or transfers to another hospice, or
3. the patient meets HPH’s policy regarding discharge for cause.

The interdisciplinary team (IDT) will make arrangements and referrals for continuing care as appropriate and desired by the patient/family. HPH will provide the patient/family with appropriate notice of its intention to discharge depending on the reason for discharge.

DEFINITION:

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. [42 Code of Federal Regulations (CFR) 418.3]

"Terminally ill" means an individual has a medical prognosis that the individual's life expectancy is approximately one year or less if the illness runs its normal course. [Public Health Law (PHL) 4002, Para 5]

PROCEDURE

A. Discharge Planning:
1. As soon as the IDT is aware of the possibility of a discharge, discharge planning is started. Discharge planning includes:
   a. Regularly reviewing the potential for discharge at IDT;
   b. Informing the patient, family, caregivers and attending physician of the potential for discharge;
   c. Consulting with the attending physician on the possibility of discharge;
   d. Identifying services that will be needed after the discharge and determining openness to those services;
   e. Identifying needed referrals for such services as possible;
   f. Completing a written discharge plan as appropriate
2. If the IDT determines that the patient is to be discharged the discharge planning occurs as follows:
   a. the Registered Nurse (RN) Case Manager consults with the patient’s attending physician regarding the need for other health care services and obtains appropriate discharge and referral orders
   b. the RN Case Manager or Social Worker arranges for these services at the request of the patient or caregiver after acquiring physician approval
   c. the patient/family and/or caregivers are included in the discharge planning process and HPH staff provide appropriate education and support as needed
   d. notification of the discharge date is provided to the patient and to the patient’s attending physician as soon as it is determined.

B. Discharge Process:
   1. When a decision to discharge has been made the attending physician is informed as soon as possible.
   2. A written physician’s order is required from the Medical Director (MD) or Hospice Physician (HP) for any discharge. Consultation with the attending physician and documentation of any comments should be included in the discharge note.
   3. Written notice with the reason for discharge will be provided, in person, at least five days before discharge unless:
      a. the discharge is for cause and the issue is an imminent and significant safety risk
      or
      b. the discharge is caused by a sudden change in location out of the service area or to a site HPH cannot serve.
   4. Notification of Medicare and other beneficiaries. Depending on the reason for discharge, additional notice may be required for Medicare and other beneficiaries. The Medicare contractor must be notified within 5 calendar days of the discharge. Notify the Business Office with the discharge date before it occurs.
   5. A discharge summary will be completed for all discharges regardless of reason; the summary is intended to be informative to attending physicians and other providers. The discharge summary is completed by the day of discharge and is sent to the attending physician and other providers who are assuming care after discharge.
   6. All discharges are reported to IDT and discussed for case review

C. Specific Discharge Processes:
   1. Discharge because the patient is no longer terminally ill:
      a. May be discharged because of improved prognosis or decisions to seek aggressive, curative treatment
      b. The current Medicare beneficiary notice is required at least 2 days before discharge. This is in addition to the HPH discharge notice.
      c. Eligibility for recertification must be reviewed at least one IDT meeting (14 days) prior to the IDT meeting where recertification will be determined. This is to allow sufficient time for notice and discharge planning to occur.
d. Patient/family will be informed that if the patient becomes eligible again, they may re-elect hospice care at any time.

2. Discharge due to moving out of service area or transfer to another hospice:
   a. If the patient/family is moving out of the service area, HPH staff should determine if continued hospice services are desired. If so, the procedure for transfer to another hospice should be used - not a discharge. (Also see Clinical Policy: “Transfer of Patient to Different Hospice Provider CP279”)
   b. If the family is considering admission/relocation to a facility or residence where HPH will not be able to provide hospice services, the family should be informed service is not available as soon as HPH staff is aware. Staff members should respect the need of the family to make their own informed decisions.
   c. The five day notice of discharge should be provided whenever possible. When a sudden decision is made with less than five days remaining, the discharge notice should be provided as soon as possible.

3. Discharge for cause:
   a. Definition: Discharge for cause is a discharge that occurs because HPH determines that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of HPH staff to operate effectively is impaired.
   b. Discharge for cause is not the first reaction to a difficult clinical situation. It is used after significant effort of care planning and intervention by the IDT has been unsuccessful.
   c. Before the patient can be discharged for cause, HPH staff:
      i. advises the patient/family that a discharge for cause is being considered;
      ii. makes a serious, ongoing effort to resolve the problem(s) caused by the patient’s behavior or the situation;
      iii. ensures that the decision to discharge the patient is not related to the use of necessary hospice services
      iv. documents in the clinical record the problem(s) and the efforts made to resolve the situation.
   d. Discharge for cause requires the approval of the Executive Director or designee.
   e. Immediate discharge for cause may be used if there is a likely and immediate risk to HPH staff or other persons. In this event the notice of discharge does not have to be presented in person, depending on the circumstances.