PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3012 (previously UP100312)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Discharge Planning (Non-capitated Members)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/27/1999</td><td colspan="4">Next Review Date: 09/11/2025
Last Review Date: 09/11/2024</td></tr>
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/11/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3020 - Hospice Services Guidelines
B. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
C. MCCP2019 - Identification and Care Coordination for Seniors and Persons with Disabilities
D. MCUG3024 - Inpatient Utilization Management
E. MCCP2024 - Whole Child Model for California Children's Services (CCS)
F. MCUG3011 - Criteria for Home Health Services
G. MCCP2031 - Private Duty Nursing under EPSDT

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Discharge Planning is the coordinated process that evaluates a patient's needs and ensures that each patient has an individualized plan for continuing care, follow-up and/or rehabilitation. It can also be defined as planning for the appropriate continuing care of the patient upon discharge from an acute care facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the process for Discharge Planning. Discharge Planning is part of admission certification and an integral part of daily inpatient utilization management.

VI. POLICY / PROCEDURE:

A. OBJECTIVES OF DISCHARGE PLANNING
   1. To identify prior to or on admission, "high risk" patients with medical, surgical, or psychosocial problems which have potential for increased lengths of stay or possible readmission. Examples of "high risk" patients include Seniors and Persons with Disabilities, children in the California Children's Services (CCS) program, or other populations as identified by Partnership HealthPlan of California (Partnership).
   2. To coordinate post discharge needs and alternative care
   3. To ensure continuity of care throughout inpatient confinement and following discharge
   4. To ensure appropriate utilization of inpatient facilities and services

5. To prevent iatrogenic complications that may require hospital readmission
6. To reduce length of stay by preventing unnecessary inpatient days

B. PROCESS

1. Assessment
   a. Discharge planning begins **prior** to admission by assessing the following areas:
      1) The patient's living arrangements prior to hospitalization
      2) The expected living arrangements post-discharge
      3) Any significant others who would be available to provide assistance at home
      4) The assessment of patient/family psychosocial status
      5) Family, support group status
      6) The patient's socio-economic status
      7) Available community resources and the estimated cost and benefits
      8) The patient's ability to perform activities of daily living
      9) Special nursing procedures, medication administration, other special ancillary care services required
   b. Determination of the need for discharge planning is also determined through use of goal-based criteria. Discharge planning should be considered for all patients admitted to an acute care facility.
   c. The need of all patients for discharge planning should be identified and should commence at the time of admission.
2. Ongoing Assessment
   a. Throughout the patient's confinement, the Nurse Coordinator, facility discharge planner, and/or social worker assess the following:
      1) The patient/family psychosocial, and emotional status
      2) Any change in the patient's physical status that may affect post-discharge well-being (i.e., physical progress or deterioration, new diagnosis, disease or procedure)
   b. Once the alternate care setting has been selected and transfer has taken place, a request is made to the agency or provider for a written progress report when necessary.
3. Identification of Alternate Medical Services
   a. Home health care, pediatric day nursing care, hospice, or a skilled nursing facility is for patients who may require intermittent professional nursing care outside the acute care facility. See Partnership HealthPlan of California's (Partnership's) policies MCUG3011 Criteria for Home Health Services, MCCP2031 Private Duty Nursing under EPSDT, MCUP3020 Hospice Services Guidelines and MCUG3038 Review Guidelines for Member Placement in Long Term Care Facilities for authorization of these services.
4. Attending physician or hospital discharge planner must notify the Nurse Coordinator prior to patient discharge for precertification of that service as part of a patient's discharge plan.
5. An alternate notification process is for the service provider to call and request pre-certification of services for the patient being discharged.

VII. REFERENCES:

A. Centers for Medicare & Medicaid Services (CMS) Standards
B. Medi-Cal Provider Manual/ Guidelines

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

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Applies to:	☒ **Medi-Cal**		☐ **Employees**

X. **REVISION DATES:** 05/05/00; 05/16/01; 05/15/02; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 10/15/14; 01/20/16; 08/17/16; 08/16/17; *09/12/18; 09/11/19; 09/09/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.