OPTIMAL HOME CARE
www.optimalcareinc.com
(248) 723-9613

Optimal Care Home Care
Discharge, Transfers and Referral policy

Conditions for discharge or transfer from Optimal Care:

1. Your care levels exceed that of what we can safely provide you in the home and discharge/transfer is necessary for your safety; this is agreed upon by the physician and the agency; we will help coordinate other care options
2. You or your payer will no longer pay for home health services
3. It is agreed upon by the physician and the agency that your medically necessary care is no longer medically necessary because you have achieved your measurable goals/outcomes or have reached your maximum potential with home care services.
4. You choose to cancel services or you wish to transfer to another agency
5. Optimal Care closes
6. Optimal Care determines, based on our policy, that your behavior or the behavior of other persons in your home are not safe (disruptive, abusive, uncooperative etc) to the extent that the delivery of your care or the ability of the agency to effectively operate is at risk. Prior to discharging the agency must
    a. Advise you, your representative, your physician(s) issuing orders for you home health plan of care, your primary care practitioner or any other health care professional who will be responsible for providing care and services to you after discharge from our agency that a discharge for cause is being considered.
    b. Make efforts to resolve the problem (with you or the person causing the problem)
    c. Provide you and your representative with, if any, contact information for other agencies or providers who may be able to provide your care
    d. Document in the medical record the problem and the efforts made to resolve the problem(s)
7. Your death occurs while receiving home health services

Discharge Planning

1. Begins when you are admitted to the agency and is based on the comprehensive care assessment performed
2. You and your representative with receive education and training throughout your home care episode to facilitate timely discharge.
3. Any revision related to your plan of care are communicated to you, your representative, all physicians related to your care, your primary care provider, your caregivers and any physician or other health care professionals assuming your care after home health discharge.

Active Discharge

1. You will be given advanced notice of your discharge or transfer to another agency in accordance with applicable state regulations, except in the case of an emergency
    a. You or your authorized provider will receive and be asked to sign and date a Notice of Medicare Non-Coverage (NOMNC) at least two days before your covered Medicare home care services will end.
    b. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice (if requested)

   c. If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) no later than noon of the day before your services are to end ask for an immediate appeal:
      i. **Livanta, LLC; 10820 Guilford Rd Suite 202, Anapolis Junction, MD 20701-1105. Toll Free: 1-888-524-9900; TTY: 1-888-985-8775. Weekdays: 9:00am to 5:00pm Eastern, Central, and Mountain Time. Weekends and Holidays: 11:00am to 3:00pm Eastern, Central, and Mountain Time.**

2. Your discharge or transfer will be documented in the medical record
3. When your discharge occurs, an assessment will be done (if not a cancellation of care and request for no visit is made).
4. At discharge you will receive an updated medicine list with instruction on how to take those medicines.
5. At discharge you will review and receive updated illness management tools
6. At or prior to discharge we will coordinate referrals to available community resources as needed.
7. Following your discharge, we will send a discharge summary within five business days to your primary care practitioner and any other physician/NPP involved in your post-home health care.
   a. Your discharge summary will include
      i. Medically necessary information related to your illness and current course of treatment
      ii. Post-discharge care goals and treatment preferences
      iii. Any additional information that may be necessary

Active Transfer

1. If you transfer to another home health agency, long-term care facility, skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital we will assist you and your caregivers in selecting the facility that best meets your needs by using and sharing information that includes, but is not limited to, data on quality measures and resource use measures that is relevant and applicable to your care goals and treatment preferences.
   a. Following your transfer, we will send a transfer summary within state/federal guidelines to your primary care practitioner, any other physician/NPP, and to the transferring facility involved in your post-home health care (note the follow up physician/NPP may be at the facility as well).
      i. Your discharge summary will include
         1. Medically necessary information related to your illness and current course of treatment
         2. Post-transfer care goals and treatment preferences
         3. Any additional information that may be necessary

2. If you elect transfer from the agency, Medicare requires us to coordinate that transfer. Our services will not longer bill for home care services effective the date of transfer.

If you have any questions or concerns related to the agency discharge, transfer or referral policies please contact Erik Wilson – 248-723-9613 or email: ewilson@optimalcareinc.com