

DISCHARGE CRITERIA

✓ CHECK ALL THAT APPLY

LOW RISK DISCHARGE	MODERATE RISK DISCHARGE	HIGH RISK DISCHARGE
<ul style="list-style-type: none"> <input type="checkbox"/> Independent in ADL's <input type="checkbox"/> Caregivers in the home and available to assist <input type="checkbox"/> Lives alone with community support <input type="checkbox"/> Independent with management of chronic disease/meds <input type="checkbox"/> Adherent to treatment plan <input type="checkbox"/> Able to direct medical care <input type="checkbox"/> Consistently followed by MD/Practitioner <p>Discharge to Community</p> <p><i>Refer to home care services (Including patients who reside in Adult Home or Assisted Living Facility)</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Lives alone with limited community support <input type="checkbox"/> Requires assistance with medications <input type="checkbox"/> Issues of health literacy <input type="checkbox"/> History of mental illness <input type="checkbox"/> Polypharmacy (greater than 7 meds) <input type="checkbox"/> Requires temporary assistance with IADL's and ADL's <input type="checkbox"/> Requires assistance in: <ul style="list-style-type: none"> • Ambulating • Wound Care • Transferring • Management of oxygen and/or nebulizer <p style="text-align: center;"><i>If ≥ 2 then refer to home health agency</i></p> <p>Refer to home care services for:</p> <p>Patient received services from home care prior to hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of agency:</p> <hr/> <p><i>Skilled Nursing</i></p> <ul style="list-style-type: none"> • Observation and assessment • Teaching and training • Performance of skilled treatment or procedure • Management and evaluation of a client care plan <p style="text-align: center;"><i>AND/OR</i></p> <ul style="list-style-type: none"> • Physical, occupational and/or speech therapy • Medical social work • Home health aide service for personal care and/or therapeutic exercises • Telehealth Care Management 	<ul style="list-style-type: none"> <input type="checkbox"/> Lives alone with no community support <input type="checkbox"/> Lives with family that is not actively involved in care <input type="checkbox"/> Clinically complex (multiple co-morbidities, repeat hospitalizations or ED visits, needs considerable assistance to manage or is unable to manage medical needs independently) <input type="checkbox"/> History of falls <input type="checkbox"/> Acute/chronic wound or pressure ulcer <input type="checkbox"/> Incontinent <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> History of mental illness <input type="checkbox"/> CHF and/or COPD and/or diabetes and/or HIV/AIDS <input type="checkbox"/> End stage condition <input type="checkbox"/> Requires considerable assistance in: <ul style="list-style-type: none"> • Transferring • Ambulating • Medication management (greater than 7 meds) • Management of oxygen and/or nebulizer <p style="text-align: center;"><i>If ≥ 4 then refer to home health agency upon patient admission to hospital</i></p> <p style="text-align: center;">THIS PATIENT IS HIGH RISK FOR REHOSPITALIZATION REFER TO HOME CARE SERVICES IMMEDIATELY</p>

Other Outpatient Referrals

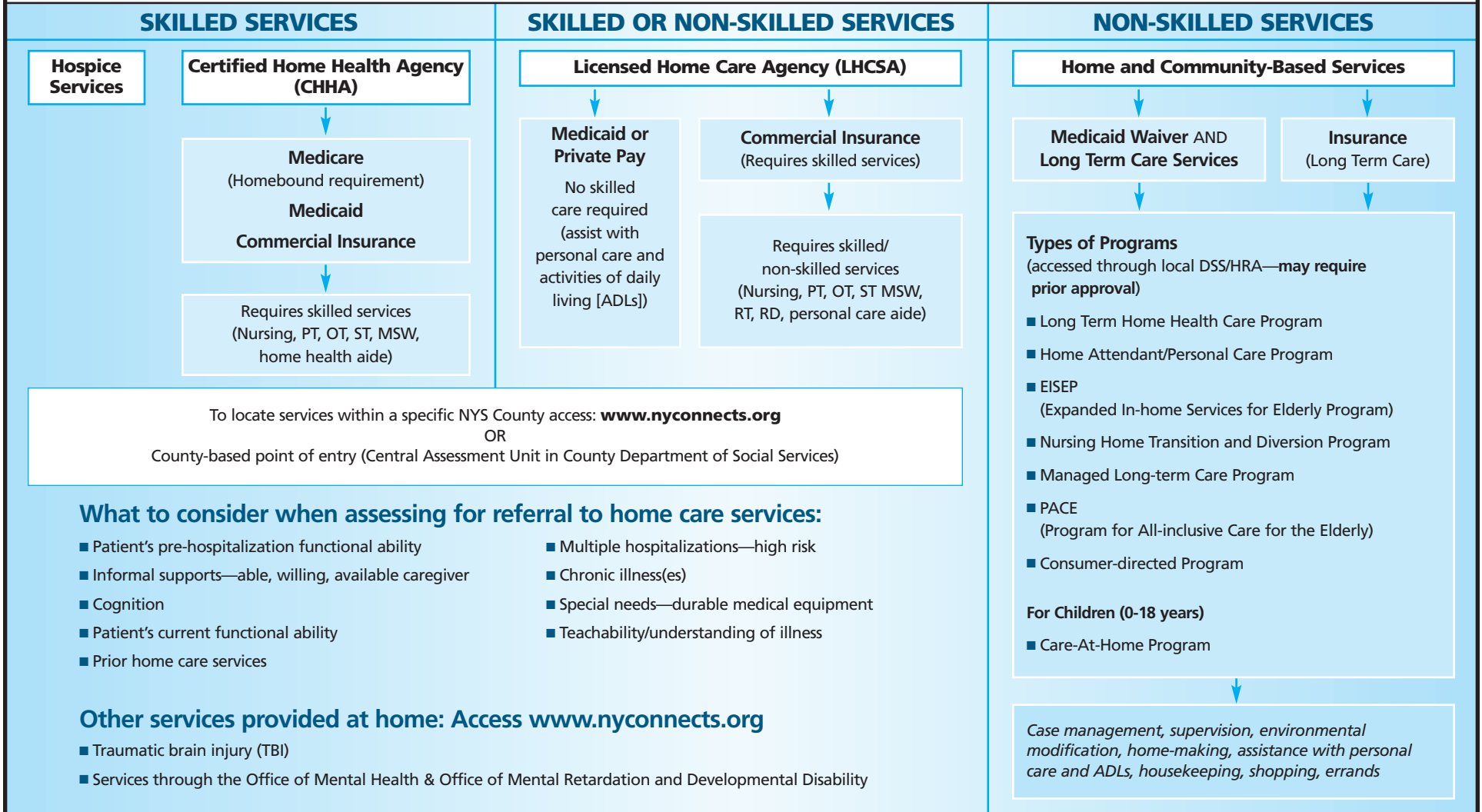
Services not provided by home care agencies: Outpatient mental health Medicaid/Public Assistance Social Security Office

This information is provided as guidance and should not be considered to be an all inclusive list of discharge planning options. Providers need to select and/or develop protocols that apply to their specific patient population and region.

NEW YORK STATE DISCHARGE PLANNING AT A GLANCE

Patient is going home and requires home care services (skilled/non-skilled)

If patient has commercial insurance, call to see if CHHA or LHCSA requirement.



Patient is **unable** to go home; if no able and willing caregiver and requires supervised living—consider Adult Home or Assisted Living residence (Call County Central Assessment Unit (CAP)/point of entry (POE)—New York State: www.nyconnects.org)

Patient is **unable** to go home; if no able and willing caregiver and requires 24-hour skilled care—consider Nursing Home placement (Call County Central Assessment Unit (CAP)/point of entry (POE)—New York State: www.nyconnects.org)

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