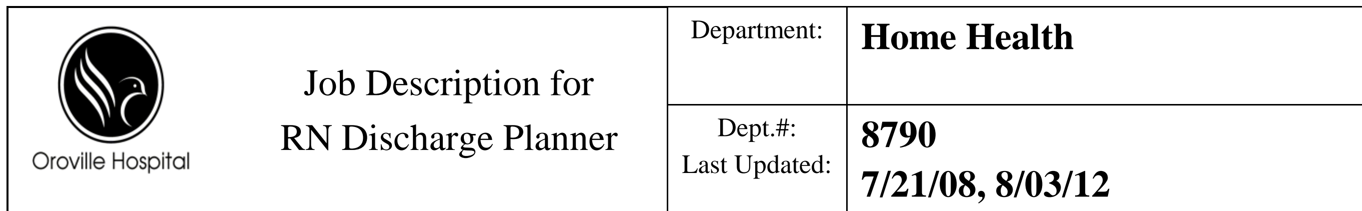

Job Description for RN Discharge Planner	Department:	Home Health
	Dept.#: Last Updated:	8790 7/21/08, 8/03/12

Reports To

Director of Home Health

Job Summary

The registered nurse working in as a Discharge Planning Nurse is responsible for performing case management, utilization review, quality assurance, and discharge planning first.

Responsibilities specific to Discharge Planning includes assessment, identification of specific needs, and social service intervention or referral while in the acute setting. Awareness of services available to patients and their families are an important part of this assessment. Determining patient needs on basis of diagnosis; prognosis and social support system/person information are included in the initial assessment process. Upon individual recognition and staff referral, the discharge planner will contact the appropriate agency to meet the patient's social, emotional and spiritual needs.

Responsibilities specific to Utilization Review include performing admission and concurrent review, and at times retro-review of all in-patients conforming to Medicare and Medi-Cal requirements. These review processes may be applicable also to Contracted Managed Care members who are patients in the acute/ extended care units of the hospital. Issuance of non-coverage letters at time of discharge to the acute/extended care patient is also considered part of the discharge planning process as specified by contracted Health Plans and HCFA.

Responsibilities specific to Quality Assurance include performing surveillance and data collection as directed for trend recognition and development of effective actions/plans.

Duties

1. Demonstrates professional responsibility in the role of Discharge Planner
2. Complies with personnel policies and hospital safety policies
3. Maintains confidentiality when interacting with patients, families, personnel and the public
4. Maintains compliance with State/Federal Guidelines and standards
5. Performs duties as prescribed by the Discharge Plan of the hospital and as directed by the Nurse Manager.
6. Conforms to all requirements of Medicare
7. Conforms to all requirements of Medi-Cal
8. Keeps current on changing laws and requirements of Medicare and Medi-Cal
9. Reports any problems to the Nurse Manager in a timely manner
10. Provides information in response to queries from the public, doctors' offices, families and outside facilities

11. Provides case management, social services, utilization review and discharge planning daily and on weekends as scheduled or assigned by the Nurse Manager
12. Performs morning work according to the written procedure and as directed and scheduled by the Nurse Manager.
13. Reviews information on Medi-Cal/CMSP patients in assigned area(s) necessary for review to Medi-Cal field office according to written procedures daily
14. Participates in Continuing Education and other pertinent and appropriate learning experiences to maintain and increase personal and professional growth
15. Participates in current continuing education that is relevant to the field of expertise of current practice
16. Maintains clinical competency in the DISCHARGE PLANNING /Case Mgt. /DCP field.
17. Utilizes work time appropriately to maximize productivity
18. Minimizes visiting with co-workers, personal telephone usage and avoids unnecessary absence from assigned work areas and tasks
19. Utilizes work space and equipment in an appropriate, professional manner to enhance patient outcome
20. Performs financial assessment to ascertain patients' source of payment for in-patient stay to begin review process and obtain timely payment for services rendered by hospital
21. Begins initial discharge planning assessment within 24 hours of admission
22. Using scoring from initial assessment determines degree of discharge planning needed on an individual basis for each patient
23. Completes the assessment within 72 hours of admission for each patient. Completion of assessment includes interview with the patient, family or other caregivers, and also may utilize chart information from previous stays
24. Begins acuity assessment using Interqual criteria and standards to complete concurrent review requirements and continued acute stay as part of initial assessment
25. Enters daily review information on computer forms. acuity assessment form to document and assess need for continued acute stay
26. Makes additional notes and documents conversations with other members of inter-disciplinary team on computer charting forms. These notes may also include conversations with caregivers, families, and other support systems involved with the care of the patient
27. Refers patients not currently requiring acute or skilled nursing care for discharge with appropriate services to lower level of care, or placement in appropriate facility. Preparation may include speaking with the patient, family, physicians, therapists, nurses, supervisors, intake coordinators, residential care facility managers, insurance companies, reviewers, etc. Also arranges for acute to acute transfers.
28. Physician orders and signatures on transfer sheets, financial verification, insurance approval and transfer permits will need to be obtained, and transportation arranged

29. Checks voice mail periodically throughout the day and before leaving each day. Handles insurance review requests and patient related calls and removes the messages in a timely manner
30. Does inpatient insurance reviews that are requested daily, utilizes the acuity assessment form and notes review outcomes, contacts and requests for further review times for follow-up
31. Provides intervention necessary as indicated by scoring guideline of Discharge Planning assessment. This begins the case management for each patient as indicated by need identified. Case Management/DCP of the acute patient may include, but is not limited to Social Service intervention by outside agencies, such as Adult Protective Services, Child Protective Services, Psychological counseling, or follow-up by either in house MSW/ Psychologist, or County/State provided psychiatric services. Home Health referral based upon patient/ family wishes or needs. Arranging help such as IHSS, or contracted help to allow the patient to remain in their own home, ordering of DME necessary for patient recovery or convenience as ordered by the physician. Services may also include arrangement of placement in either Residential Care Facility, Assisted Living or in Skilled Nursing Facilities based upon patient/ family wishes and doctors order. Discussion of the discharge plan is ongoing from day of admission with the patient, family, interdisciplinary team, and physician staff. DCP acts as a resource person for patients referred from physician's offices. Evaluates and refers appropriate patients to Financial Counseling or appropriate agency for assistance in obtaining Medi-Cal coverage. Contacts the appropriate agency to meet the patient's social, emotional and spiritual needs. Provides continuity of care as the level of care changes
32. Provides information regarding Advance Directives, assists in filling out the forms, and obtaining non-employed witnesses to complete the documentation of Advance Directives. Makes photocopies for the patient and places a copy in the chart or sends it to Medical Records for filing in the chart at any time
33. Enters all discharges on Discharge Planning Activity Log Sheets daily for statistical purposes. Indicates on log all pertinent information regarding patient activity prior to discharge such as DME, Home Health agency referral, etc.
34. Calls appropriate insurance companies for discharge review upon patient discharge. Makes appropriate notes to document final review given
35. Completes retro- review to insurance companies as directed by the Nurse Manager.
36. Performs surveillance and data collection as directed for trend recognition and development of effective actions/plans
37. Assist with Nursing duties as assigned per Nurse Manager.
38. Educate patients upon discharge using the teach back method.

Qualifications

1. Graduate of an accredited school of professional nursing and a current license with the California State Board of Registered Nursing
2. Ability to interact therapeutically with patients, families, physicians, co-workers and community agencies
3. Ability to maintain confidentiality
4. High level organizational skills
5. Excellent communication skills
6. Current Cardiopulmonary Resuscitation Certification (CPR), annual update of Safety, Clinical Competency and annual Interpreter Services
7. Demonstrate compression and empathy with patients.

Lifting Requirements

Lifts up to 100 lbs. with help able to lift 50 lbs.

Dress Code

Follow Nursing dress code.