Exhibit OO12.bq

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Vice President and Chief Executive Officer of the Medical Center

MEDICAL CENTER POLICY NO. 0025

A. SUBJECT: Discharge Planning

B. EFFECTIVE DATE: October 1, 2012 (R)

C. POLICY:

Discharge planning is a continuous, multidisciplinary process applied to all patients admitted to the University of Virginia Medical Center regardless of length of stay. Discharge planning shall begin at the time a planned admission is scheduled or when the need for an unplanned admission is determined. The process is initiated through a multidisciplinary screening assessment to identify potential continuing care needs after discharge. Discharge planning includes appropriate health care team members to identify and address the patient's needs as well as involvement of and collaboration with the patient, family and community agencies as indicated. A Registered Nurse (RN), Nurse Case Manager, or Social worker shall coordinate the development of the discharge plan.

D. PROCEDURE

1. Expected length of stay and patient care needs shall be identified and documented in the LIP Admission Navigator section of the medical record. The information shall be updated daily and documented by an LIP[1] member of the service team and shall be available for review by all members of the patient's health care team.

2. Admitted patients shall be initially assessed for risk factors, such as functional status, cognitive ability and family support, psychosocial needs and external factors, such as availability of home care post-discharge, which may impact continuing care needs. This assessment shall be completed by the multidisciplinary team that shall include, but not be limited to, physicians, nurses, social workers and/or nutritionists. The assessment shall be documented in the patient's medical record. Timeframes for patient assessment are delineated in Medical Center Policy No. 0094 "Documentation of Patient Care (Electronic Medical Record)".

3. Discharge planning that includes needs assessment, potential treatment or care after discharge, patient education, benefits coordination, referral to community resources and/or services, and projected discharge dates shall be among the topics included in daily multidisciplinary patient care planning conferences or rounds. In addition, plans for patients scheduled for discharge the following day shall be reviewed, confirmed and revised as needed, and communicated to designated unit personnel responsible for pending discharge information. All participants in the conference are responsible for documenting their discharge planning and patient education activities pertinent to their discipline in the patient's medical record.

[1] For the purpose of this policy, LIP (Licensed Independent Practitioner) shall include physicians, nurse practitioners, and physician's assistants

4. The expected date of discharge shall be based on when the patient is medically ready and has a safe discharge plan in place. The patient and family shall be active participants in the discharge planning process and shall be kept informed of the expected date of discharge and reasons for any modification of that date. The patient and family and/or caregivers shall be provided information and instructions in preparation for post-hospital care. When the date of discharge is determined, the patient and family shall be notified and an expected departure time shall be agreed upon. All team members shall prioritize work to ensure timely completion of the discharge plan.

5. If it is determined that the patient requires extended post-hospital care in a skilled care, acute care, rehabilitation or psychiatric facility, or referral to a home health agency, a nurse case manager, social worker or RN shall collaborate with the patient, family and physician to identify the appropriate level of care.

    a. The patient and/or patient's family shall be informed of his/her right to select an appropriate facility or agency. A list of available and appropriate facilities or agencies shall be provided to them. A nurse case manager, social worker or RN shall include in the medical record that the list was provided and the decision that was made.

    b. If the patient lacks capacity to make a decision and/or cannot communicate the decision, a surrogate decision maker, who may be a legal guardian or a family member, may state an agency preference. A telephone contact with the surrogate decision maker shall be sufficient to confirm the preference. A nurse case manager, social worker or RN obtaining the surrogate's decision must document the choice in the medical record. See Medical Center Policy No. 0024 "Informed Decision-making" for the description and process for determination of patient capacity for decision-making. Form 070861, Certification of Capacity, must be completed by a physician.

    c. A nurse case manager, social worker or RN shall assist with arranging for follow-up care and exchange of information with sources outside University of Virginia Medical Center, including documentation of the name of the accepting physician and facility name, and coordinate with other disciplines to complete the transfer, arrange transportation and/or order equipment.

    d. At the time of transfer, a unit registered nurse (RN) shall call a detailed hand off of care report to the accepting facility. A copy of the discharge summary shall be sent to the receiving facility.

    e. The patient and/or family shall be further informed that the Medical Center does not endorse the services of any agency or vendor on the list, and advised that the Medical Center has a financial interest in Continuum Home Health Care, UVA Transitional Care Hospital and UVA HealthSouth Rehabilitation. The patient and/or family shall also be informed that the list of available agencies was prepared in compliance with a requirement of the Medicare program. The social worker or staff person presenting this information shall then document in the medical record the selection made by the patient or surrogate decision maker (see Medical Center Policy No. 0151, "Patient Choice in Selection of Home Health Agencies").

    f. The physician shall write the appropriate orders for home health and complete the attestation. A nurse case manager, social worker or RN shall complete the Home Health Referral and provide a detailed report to the accepting Home Health agency.

6. Any patient who disagrees with his/her discharge plan shall be informed that he/she may discuss the concerns with the attending physician and that he/she has the right to contact the Quality

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Improvement Organization (QIO) to file a formal complaint. If the patient wishes to file a formal complaint or grievance regarding the impending discharge, Care Management shall be notified for review and resolution of the complaint/grievance. Medicare patients have the right to appeal a discharge that the patient or family perceives as premature and must be provided a notice of non-coverage by Care Management when a patient disagrees with his/her discharge or when the inpatient stay is no longer being covered by Medicare.

7. The effectiveness and quality of discharge planning is monitored through the Patient Satisfaction Survey process, and other specific performance improvement initiatives such as length of stay data and readmission rates. Reassessment of the discharge planning process identifies whether patients in need of discharge planning are effectively identified and includes a review of discharge plans to ensure they are responsive to discharge needs, are adequate and are effectively executed.

SIGNATURE:

R. Edward Howell, CEO, UVA Medical Center

9/26/12

DATE:

Medical Center Policy No. 0025 (R)
Approved June 1984
Revised May 1993, September 1993, September 1996, November 1999, June 2003, September 2005, September 2008, September 2011, September 2012
Approved by Chief Nursing Officer
Approved by Medical Center Administration