FEBRUARY 2022

MONTANA SWING BED BULLETIN

Discharging the Patient

CAROLYN ST. CHARLES, CHIEF CLINICAL OFFICER
HEALTHTECHS3

This issue:

Discharge Criteria
PAGE 01

Steps to Discharge
PAGE 02

Test Your Knowledge
PAGE 06

Discharging the Patient

Congratulations!

The patient has had a successful Swing Bed stay, met their goals, and are ready for discharge. This newsletter will walk you through the steps and documentation requirements for the discharge process

Discharge Criteria

I'm sure everyone is aware of why you can discharge a patient, but the criteria are listed below just in case a reminder is needed.

The facility is required to allow a patient to remain in the facility and not transfer or discharge unless one of the following occurs:

1. The transfer or discharge is necessary for the patient's welfare, and the patient's needs cannot be met in the facility.
2. The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility.
3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient.
4. The health of individuals in the facility would otherwise be endangered
5. The patient has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.
6. The facility ceases to operate.

Source: C-1610 §483.15(c)(1)

Discharge Criteria Continued...

The physician responsible for the patient is required to complete the transfer or discharge documentation if (1) or (2) occurs. Any physician can complete the documentation if the transfer or discharge occurs because of (3), (4), or (5).

When the patient is transferred because their needs cannot be met, the physician must document in the medical record the following information:

- The patient need(s) that cannot be met
- Facility attempts to meet the patient's needs, and
- Services available at the receiving facility to meet the need(s) of the patient

Source: C-1610 483.15(c)(2)

Discharge Appeal

Again, this is probably information you already know. The facility may not transfer or discharge when an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility. If transfer or discharge does occur under these circumstances, there must be documentation that failure to transfer or discharge would endanger the health or safety of the resident or other individuals and the danger that failure to transfer or discharge would pose.

Roles & Responsibilities

Many things need to be done at discharge and it's important to identify who will have responsibility for each of the tasks and/or ensure that each is completed.

The discharge processes can all be assigned to one person – or – divided among multiple individuals. It's essential, however, to ensure that the person assigned understands their responsibilities and that there is someone available seven days per week.

Step 1: Discharge Plan

The discharge plan starts at admission by identifying the patient's goals for discharge and where they would like to be discharged. The discharge plan of care is intended to help the patient adjust to a new living environment. The plan must include where the individual intends to reside, any arrangements that have been made for the patient's follow-up care and any post-discharge medical and non-medical services.

The discharge plan should be reviewed at least weekly as part of the multi-disciplinary planning meetings, with input from the patient, and updated as needed.

It's important to note that even if the patient is returning to their prior place of residence, including home, and may or may not have additional services such as home health, a discharge plan of care is still required.

Step 2: Choice of Post-Acute Care Provider

Part of the discharge planning process is providing the patient with a choice of post-acute care providers.

If the patient is being discharged to a Skilled Nursing Facility, Long Term Care Facility, Independent Rehab Facility, or receiving Home Health Services, they must be provided with data on quality measures and data on resource use measures so that they can make an informed choice. This topic, including examples of quality measures and resource use measures, was covered in the October 2021 newsletter. Please refer to the newsletter for more detailed information.

Source: C-1425

Step 3: Discharge Documentation

When a patient is transferred or discharged, specific information must be communicated to the receiving health care organization or provider, including:

- Contact information of the practitioner responsible for the care of the patient
- Patient representative information, including contact information
- Advance Directive information
- Comprehensive care plan goals
- Final summary of patient status including all elements of the comprehensive assessment
- Discharge summary that includes a recapitulation of the patient's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results
- Reconciliation of all pre-discharge medications with post-discharge medications, both prescribed and over the counter.
- Post-discharge plan of care (Step 1)
- All special instructions or precautions for ongoing care and any other necessary information to ensure a safe and effective transition of care

Source: C-1610 §483.15(c)(2), C-1620 §483.21(c)(2)

Step 3: Continued

So, that's a pretty long list. Let's break it down and hopefully make it a little easier. Many of the elements are pretty self-explanatory, but let's concentrate on those that might not be quite so obvious.

Comprehensive Care Plan Goals
The Care Plan goals are the goals developed, with the patient's participation, as part of the multi-disciplinary care planning process. At the time of discharge, the status of the goals must be part of the communication to the receiving health care organization or provider.

To ensure the goals are updated before discharge, a final care plan meeting should be held with the multi-disciplinary team and the patient, and a final summary completed.

Summary of Comprehensive Assessment
This one is a little tricky. The summary of the comprehensive assessment includes the same elements that were assessed at admission, including: Identification and demographic information, Customary routine, Cognitive patterns, Communication, Vision, Mood and behavior patterns, Psychosocial well-being, Physical functioning and structural problems, Continence, Disease diagnoses and health conditions, Dental and nutritional status, Skin condition, Activity pursuit, Medications, Special treatments and procedures.

The easiest way to do this is to summarize each of these elements at the final care plan meeting and document in the medical record.

Step 4: Patient Required Notices

Two patient-required notices are required: Notice of Medicare Non-Coverage (NOMNC) and Notice of Patient Discharge.

NOMNC
The requirement for the NOMNC to be provided for patients receiving skilled services under a part A stay can be found in the Medicare Claims Processing Manual Chapter 30. Section 260.2 clarifies that the NOMNC must be given to patients in a Swing Bed. Section 260.3.4 requires the notice to be given at least two calendar days before Medicare-covered services end.

Step 4: Patient Required Notices (Continued)

Notice of Discharge

There is no Medicare form for the Notice of Discharge. The Notice of Discharge must include:

- The reason for transfer or discharge
- The effective date of transfer or discharge
- The location to which the resident is transferred or discharged
- A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request
- The name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman
- For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000
- For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

Source: C-1610 §483.15(c)(3), C-1610 §483.15(c)(5)

The notice of transfer or discharge must be made at least 30 days before the patient is transferred or discharged unless one of the following applies. However, if one of the following does apply, the notice must be provided as soon as practicable:

- The safety of individuals in the facility would be endangered.
- The health of individuals in the facility would be endangered.
- The resident's health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident's urgent medical needs.
- A resident has not resided in the facility for 30 days.

Source: C-1610 §483.15(c)(4)

Step 5: Ombudsman Notification

The notice of transfer or discharge provided to the patient must also be sent to the Office of the State Long-Term Care Ombudsman. The information should be sent as soon as possible after the notice is given to the patient.

Source: C-1610 §483.15(c)(3)

Montana State LTC Ombudsman:

https://dphhs.mt.gov/sltc/aging/longtermcareombudsman/

For More Information Contact:

1-800-332-2272: State Long Term Care Ombudsman - Office on Aging, Senior and LTC Division
1-800-551-3191: Regional or Local Ombudsman - Area Agency on Aging
Note: These Help Lines are only available during normal business hours. For all emergencies, call 911.

Test Your Knowledge

Answer each T (true), F (false), M (maybe).

1. A Discharge Plan of Care must be developed for every Swing Bed patient.
2. A summary of the patient's stay, including a review of the patient's goals, must be completed and provided to the next provider of care at discharge.
3. A Notice of Medicare Non-Coverage does not need to be provided to patients discharged from Swing Bed.
4. The Notice of Discharge can be provided at the time of admission.
5. Discharge notices sent to the ombudsman can be sent at the end of the month for all Swing Bed patients discharged that month.

Answer Key

1. True
2. True
3. False
4. False
5. False

March Issue

Marketing your Swing Bed Program

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $806,474 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by MT DPHHS, Montana Health Research & Education Foundation (MHREF), HRSA, HHS, or the U.S. Government.