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Policy: Discharge and Transfer

DO NOT DISTRIBUTE BEYOND YOUR OWN FACILITY

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If you have any questions, please contact

Carolyn St.Charles
Chief Clinical Officer
HealthTech
Phone: 360-584-9868
Email: carolyn.stcharles@health-tech.us

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Policy: Discharge or Transfer from Swing Bed

PURPOSE

Identify the required notices and information required to be provided to the patient at the time of transfer or discharge.

POLICY

Name of Hospital will provide patients the appropriate and required notices at the time of transfer or discharge.

Name of Hospital will permit each patient to remain in the facility and not transfer or discharge the patient from the facility except as allowed by regulatory statutes.

Name of Hospital will not transfer or discharge a patient when the patient exercises his or her right to appeal, and the 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.

Name of Hospital will provide patients with sufficient preparation and orientation to ensure safe and orderly transfer or discharge.

Name of Hospital will provide receiving facilities and providers with the necessary information to provide continuity of care when a patient is transferred or discharged.

DEFINITIONS

Transfer and Discharge: Transfer and discharge include the movement of a patient to a bed outside of the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge do not refer to the movement of a patient to a bed within the same certified facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

Facility-initiated transfer or discharge: A transfer or discharge which the patient objects to, did not originate through a patient's verbal or written request, and/or is not in alignment with the patient's stated goals for care and preferences

Patient-initiated transfer or discharge: Means the patient or, if appropriate, the patient representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of patients with cognitive impairment).

PROCEDURES

1. ***Name of Hospital*** will permit each patient to remain in the facility, and not initiate a transfer or discharge of the patient from the facility unless one of the following occurs:
    - The transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the facility
    - 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
    - The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient
    - The health of individuals in the facility would otherwise be endangered
    - 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. Non-payment applies if the patient does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the patient refuses to pay for his or her stay. For a patient who becomes eligible for Medicaid after admission to a facility, the facility may charge a patient only allowable charges under Medicaid
    - The facility ceases to operate

2. When a facility-initiated transfer or discharge is necessary for any of the following reasons listed below, the transfer or discharge documentation in the patient's medical record will be completed by the patient's physician and appropriate information will be communicated to the receiving health care institution or provider:
    - When the transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the facility
    - When 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. When facility-initiated transfer or discharge is necessary for any of the following reasons listed below, the transfer or discharge documentation in the patient's medical record will be completed by a physician and appropriate information will be communicated to the receiving health care institution or provider:
    - When the safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient
    - The health of individuals in the facility would otherwise be endangered

4. When a facility-initiated transfer or discharge is necessary for the reasons outlined in #3, physician documentation in the medical record will include:
    - The reason for the transfer
    - The specific patient needs that cannot be met
    - Facility attempts to meet the patient needs
    - Services available at the receiving facility to meet the needs

5. Care Management will deliver a Notice of Non-Coverage (NOMNC) to Medicare patients no later than two (2) days before termination of services, except when the beneficiary transfers

to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

- The notice must be validly delivered, which means the patient must be able to understand the purpose and contents of the notice in order to sign for receipt of it, including the right to appeal the termination decision. If the patient is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.
- A copy of the signed NOMNC will be given to the patient
- The original signed NOMNC will be placed in the patient's medical record

6. If the patient exercises his or her right to appeal the discharge or transfer, and the appeal is pending, the patient will not be transferred or discharged unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility. If the patient is transferred while the appeal is in process, Care Management or designee, and the physician will document the danger that failure to transfer, or discharge would pose.

7. Before a facility-initiated transfer and discharge of a patient, Care Management or designee will:
   - Notify the patient and the patient's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner, the patient can understand. The notice will include:
     - The specific reason for the transfer or discharge
     - The effective date of the transfer or discharge;
     - The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged;
     - An explanation of the right to appeal the transfer or discharge to the State;
     - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
     - Information on how to obtain an appeal form;
     - Information on obtaining assistance in completing and submitting the appeal hearing request; and
     - The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman (Example Attachment 1)

8. The Notice of Discharge will be provided at least 30 days before the patient is transferred or discharged, or as soon as practical under the following circumstances:
   - When the safety of individuals in the facility is endangered
   - The health of individuals in the facility would otherwise be endangered
   - When the transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the facility
   - The patient's health has improved sufficiently to allow a more immediate transfer or discharge
   - An immediate transfer or discharge is required by the patient's urgent medical needs

- The patient has not resided in the facility for 30 days

9. Care Management will ensure that the reasons for the transfer or discharge are documented in the medical record.

10. A copy of the notice will be sent to a representative of the Office of the State Long-Term Care Ombudsman

11. If the patient is being discharged to a post-acute-care setting or will be using in-home services, Care Management will assist patients, their families, or the patient's representative in selecting a provider by using and sharing Post-Acute Care data on quality measures and resource use measures. The data must be relevant and applicable to the patient's goals of care and treatment preferences. The information provided and the patient's choice will be documented in the medical record.

12. Care Management or RN will provide and document sufficient preparation and orientation for the patient to ensure safe and orderly transfer or discharge. The orientation will be provided in a form and manner that the patient can understand. The form and manner of this orientation and preparation will take into consideration factors that may affect the patient's ability to understand, such as educational level, language and/or communication barriers, and physical and mental impairments. This orientation will be documented in the medical record, including the patient's understanding of the transfer or discharge.

13. When the facility anticipates discharge (a discharge is planned and not due to the patient's death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation)), a discharge summary will be completed that is available for release to authorized persons and agencies, with the consent of the patient or patient's representative that includes, but is not limited to, the following:
    a. 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, including any pending lab results.

    b. A final summary of the patient's status at the time of the discharge which includes the items from the patient's most recent comprehensive assessment to accurately describe the current clinical status of the patient, including:
        - Identification and demographic information
        - Customary routine
        - Cognitive patterns
        - Communication
        - Vision
        - Mood and behavior patterns
        - Psychosocial well-being
        - History of traumatic events
        - Physical functioning and structural problems
        - Continence
        - Disease diagnoses and health conditions

- Dental and nutritional status.
- Skin condition
- Activity pursuit
- Medications
- Special treatments and procedures
- Discharge planning
- Documentation of participation in assessment, including who participated in the assessment process.

c. Reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescribed and over the counter)
   - Facility staff will compare the medications listed in the discharge summary to medications the patient was taking while residing in the facility. Any discrepancies or differences found during the reconciliation will be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes
   - Discharge instructions and accompanying prescriptions provided to the patient will accurately reflect the reconciled medication list in the discharge summary

d. A post-discharge plan of care that is developed with the participation of the Interdisciplinary team and the patient and, with the patient's consent, the patient representative(s), which will assist the patient to adjust to his or her new living environment. The post-discharge plan of care will indicate where the individual plans 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 post-discharge plan of care will detail the arrangements that facility staff have made to address the patient's needs after discharge, and include instructions given to the patient and his or her representative, if applicable
   - The post-discharge plan of care will show what arrangements have been made regarding:
     - Where the patient will live after leaving the facility
     - Follow-up care the patient will receive from other providers, and that provider's contact information
     - Needed medical and non-medical services (including medical equipment
     - Community care and support services, if needed, and
     - When and how to contact the continuing care provider

14. At the time the patient leaves the facility, the discharge summary will be furnished to the receiving provider assuming responsibility for the patient's care after discharge. If there is no continuing care provider (e.g., patient has no primary care physician in the community), the facility will document in the medical record efforts to assist the patient in locating a continuing care provider.

15. The medical record will contain the discharge summary information and identify the recipient of the summary.

16. Care Management will provide at a minimum, the following information to the receiving provider:
    - Contact information of the practitioner responsible for the care of the patient
    - Patient representative information including contact information
    - Advance Directive information
    - All special instructions or precautions for ongoing care, as appropriate
    - Comprehensive care plan goals
    - All other necessary information, including a copy of the patient's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.

17. For patients discharged to their home, the medical record will contain documentation that written discharge instructions were given to the patient and if applicable, the patient representative. These instructions will be discussed with the patient and patient representative and conveyed in a language and manner they will understand

REGULATORY REFERENCES

State Operations Manual. Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20) §485.645(d)(2), §483.5, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), (c)(9)

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 208;10-21-22) F-623

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711 260.2

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Attachment 1

SWING BED NOTICE OF DISCHARGE OR TRANSFER

Date: **Name:** **Admission Date:**

Your discharge from the Swing Bed program is expected to occur _____ (*When)*

You are being transferred or discharged because: (*Specific reason)*

You are being transferred or discharged to _____ *(Location*) (*If the location is a residence the location must be included)*

If you disagree with the transfer or discharge, you can file an appeal by contacting:

State Division of Health (*name/ mailing address / email address),* or

State-Long Term Care Ombudsman (*name/mailing address/email address/phone)*

You can access an appeal form at**:** *(name/web site/Email/phone)*

If you need assistance in obtaining, completing, or submitting the appeal request you can contact (*name/mailing address/email address/phone)*

Patient Signature / Date