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| Subject: Determination of Patient Transfer or Discharge | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
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POLICY:

It is the policy of [program name] to provide a consistent mechanism to determine under what conditions a patient should be transferred or discharged from the skilled program. The purpose of this policy is to provide staff and interdisciplinary team members a framework for such decisions to be made.

The [program name] is professionally and ethically responsible for providing care within its mission, its financial and clinical capabilities, and applicable law and regulation.

For Clarification:

A ***transfer*** is generally considered when a patient either moves from one location to another within the same level of care/reimbursement such as from a swing bed to distinct part SNF or a nursing home SNF.

A ***discharge*** is generally considered when a patient moves from one level of care/reimbursement to another as noted by a facility or program/unit to acute care, acute rehabilitation, psychiatric care, long term acute care, or is formally released from the hospital to home/community; OR patient expires on the unit.

PROCEDURE:

# Prior to admission, a preliminary discharge plan will have been proposed and agreed to by the patient and their family as much as feasible.

# Patients/families will be notified of the process to determine discharge from the short-term program during the admission and patient orientation.

# All patients admitted to the program will be discussed during weekly or more frequent interdisciplinary team conferences. The team shall involve the patient and/or family to the extent possible that they can participate in to assure their involvement in the process.

# Care Management will be the liaison between the team and the payor representative and will communicate with the payor at a scheduled agreed time.

# Transfer or discharge is determined to be appropriate if one of the following criteria exist:

## Patient’s welfare is endangered, or the unit is unable to meet his/her needs.

## Patient’s health has sufficiently improved and the program services are no longer needed.

## Health or safety of individuals in the facility is endangered.

## Patient is self-pay and has not paid for a stay in the program following reasonable and appropriate notice as defined by the hospital and in accordance with applicable law and regulation.

### 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.

## Patient leaves against medical advice. Such patient will sign a form stating that he/she is aware of leaving against medical advice.

## Patient’s death.

## Program ceases to operate.

# When one of the above criteria is met, the attending physician will be notified and an order to transfer or discharge will be written.

# If an external entity performing utilization review, such as insurance companies, managed care reviewers, and peer review organizations recommend a discharge and the team is recommending ongoing care, the [program name] will be responsible to ensure that the patient’s continuing care and follow-up needs are met.

# With the exception of a medical emergency, the patient and if known, a family member, significant other or legal representative of the patient will be notified verbally of the decision to transfer or discharge for medical reasons and/or the other patient’s welfare.

## Notification required for medical emergency is verbal only.

# Written notification to notify the patient of the day of discharge will be submitted in a timely manner to the patient and if known, a family member, significant other or legal representative of the patient within 2 days of the planned discharge given the short length of stay in the [program name].

# Care Management shall document in patient medical record such conversations and maintain a copy of all discharge notices given in the patient’s chart.

# Care Management shall be responsible to inform patient of their rights to appeal. Appeal process shall include but not be limited to provision of information about access to state agency and/or peer review organization.

# The patient will continue to receive care in this facility until sufficient notification has been given regarding discharge placement and reasons for transfer.

# The facility may not transfer or discharge the patient while an appeal is pending, when a patient exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility. The program must document the danger that failure to transfer or discharge would pose.

# When the program transfers or discharges a patient under any of the circumstances specified above, the program must ensure that the transfer or discharge is documented in the patient's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the patient's medical record must include:

## The basis for the transfer

## In the case of transfer/discharge due to needs cannot be met, documentation will include the specific patient need(s) that cannot be met, program’s attempts to meet the patient’s needs, and the service available at the receiving facility to meet the need(s).

# The patient's physician when transfer or discharge is necessary must document such in his/her progress note.

# Information provided to the receiving provider must include a minimum of the following:

## 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.

## Any other documentation, as applicable, to ensure a safe and effective transition of care.