The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

UNDERSTANDING FACILITY-INITIATED TRANSFER AND DISCHARGE REQUIREMENTS

A webinar by the National Consumer Voice for Quality Long-Term Care in coordination with the Utah State Long-Term Care Ombudsman Program

Presenters: Robyn Grant, Director of Public Policy and Advocacy, Consumer Voice &
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Project Overview: Background & Purpose

Purpose

Create a comprehensive manual

- To help providers, ombudsmen, legal services providers and other stakeholders gain a deeper more comprehensive understanding of state and federal laws, regulations, CMS guidance around transfer and discharge, and the appeal process.

Create a consumer booklet

- To educate and inform residents and their families of their rights including appeal rights, their options, and where to go for assistance when facing transfer or discharge.

State of Utah

Alianne Sipes, State Long-Term Care Ombudsman

Greg Bateman, Manager, LTC Survey Section

Accessing Resources

- Contact your local ombudsman program:
https://daas.utah.gov/ombudsman-locations/

- Contact Alianne Sipes, UT State Long-Term Care Ombudsman, if can't connect with local program:
Asipes@utah.gov

- Access resources electronically by going to:
https://daas.utah.gov/long-term-care-ombudsman/

Pre-Test: True or False?

Project Tools and Materials

- Consumer Booklet
- Resource Manual

Consumer Booklet

- Resident rights
- Six reasons for discharge
- Long-Term Care Ombudsman Program
- Written notice requirements
- Resident options
- Information and support

INTRODUCTION TO THE RESOURCE MANUAL

Resource Manual

- Divided into four sections
  - **Section 1** – is an overview of transfer/discharge provisions
  - **Section 2** – covers federal nursing home regulations pertinent to transfer/discharge issues
  - **Section 3** – discusses a range of federal/state laws, regulations, and federal regulatory tools, and how they apply to situations involving discharges
  - **Section 4** – lays out the general fair hearing procedures

Resource Manual

- **Appendices**
  - Utah and Federal Regulations Pertaining to Facility-Initiated Transfers or Discharges in Nursing Homes: A Side-by-Side Comparison
  - Facility-Initiated Transfers or Discharges: Information Required to be Conveyed to Receiving Provider by Transferring/Discharging Provider Checklist
  - Discharge Notification Facility Guidance State of Utah Long-Term Care Ombudsman Program
  - Sample Notice of Transfer or Discharge
  - Completing the “Form to Request a State Fair Hearing:” Directions for Residents When Appealing a Notice of Transfer or Discharge

TRANSFER/DISCHARGE PROVISIONS

Definitions

⇆ **Transfer** - the movement of a resident from a bed in one certified facility to a bed in another certified facility **when the resident expects to return to the original facility.**

⟶ **Discharge** - the movement of a resident from 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.**

Definitions

- **Facility-initiated** – a transfer or discharge which:
  - The resident objects to
  - Did not originate through a resident's verbal or written request
  - Is not in line with the resident's goals or preferences

  An emergency transfer to the hospital is also considered to be facility-initiated.

- **Resident-initiated** – a transfer or discharge in which the resident or their representative has provided verbal or written notice of intent to leave the facility

Once admitted, the facility becomes the resident's home. For this reason, the expectation is that residents should be able to remain except under certain very limited situations.

Permissible Reasons for Transfer or Discharge

- Necessary to meet resident's welfare and resident's needs cannot be met in the facility
- Resident's health has improved and no longer needs facility services
- Safety of others endangered due to clinical or behavioral status
- Health of individuals endangered
- Nonpayment after reasonable notice
- Facility ceases to operate

Reason #1: Needs Cannot Be Met

- Before proceeding to transfer or discharge a resident, the facility must try to meet those needs. This includes:
  - Assessing the resident
  - Revising the care plan to include different approaches/interventions
  - Implementing the care plan consistently across all shifts
  - Evaluating how interventions are working, continuing to revise the care plan

- Documentation must be made in the resident's record:
  - The need the facility cannot meet
  - Facility attempts to meet the resident's needs
  - The service available at the receiving facility to meet the need(s) (why the receiving provider can meet the resident's needs while the facility can't)

Reason #2: Health Has Improved

End of Medicare coverage ≠ End of nursing home stay

Notice that Medicare is ending
(Notice of Medicare Noncoverage-NOMNC) ≠ Notice of Transfer or Discharge

Notice that Medicare will no longer pay
(Skilled Nursing Facility Advance Beneficiary Notice – SNFABN) ≠ Notice of Transfer or Discharge

Reason #3: Safety of Individuals is Endangered Due to Clinical and Behavioral Status
Reason #4: Health of Individuals is Endangered

Before proceeding, the facility must try to meet those needs by:	Assessing the resident
	Revising the care plan to include different approaches/interventions
	Implementing the care plan consistently across all shifts
	Evaluating how interventions are working, continuing to revise the care plan

If resident is transferred to a hospital or other acute care setting: facility cannot base a decision to not permit a resident to return on the condition of the resident at the time of transfer.

Reason #5: Nonpayment

Only occurs if a resident or representative

- Does not pay for stay
- Does not have their stay paid for by Medicare, Medicaid, or other third-party payor

Applies if the resident

- Does not submit necessary paperwork for third-party payment
- Denial from third party payor and resident refuses to pay for their stay

Does not apply if the resident

- Has a pending Medicaid application
- Appeals the denial of their Medicaid application

Reason #6: Facility Ceases to Operate

- CMS or the State Medicaid Agency decertifies the facility
- State Survey Agency revokes license
- Facility chooses to close voluntarily

When a Transfer Becomes a Discharge

A transfer becomes a discharge if the facility decides not to permit the return of a resident who was transferred with the expectation of returning.

The reason for the discharge must be one of the 6 permissible reasons, and the facility must meet all facility-initiated discharge requirements.

Other Key Components

- Documentation requirements
- Information to be shared with the receiving provider
- Notice of transfer or discharge
- Orientation of the resident
- Notice of bed-hold policy
- Right to return to the facility from hospital or therapeutic leave
- Right to remain in the facility during an appeal

NURSING HOME OBLIGATIONS PERTINENT TO TRANSFER/DISCHARGE

Resident Rights

What regulations impact transfers/discharges?

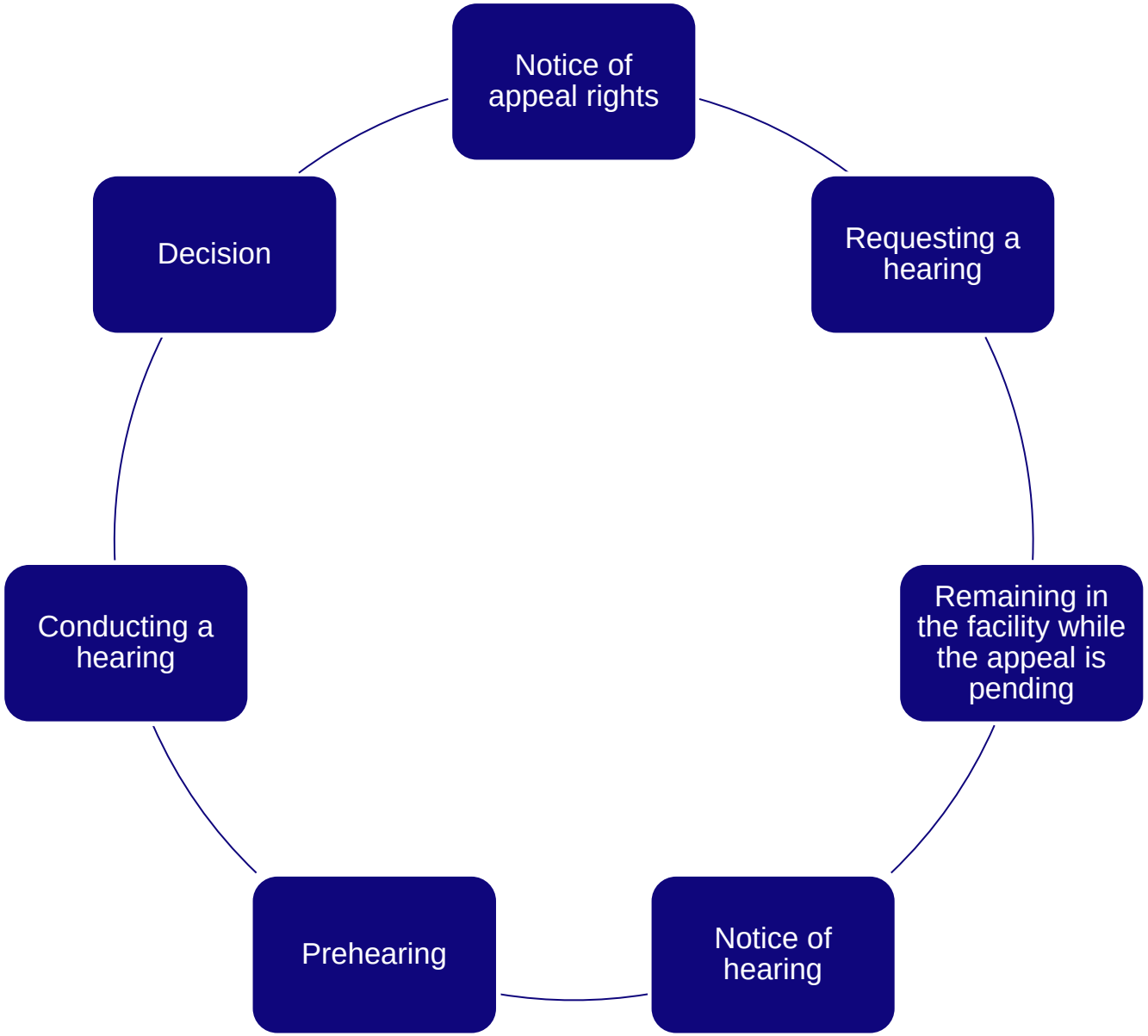
- Refusal of treatment
- Reasonable accommodation of needs and preferences
- Right to self-determination
- Right to be informed
- Freedom from abuse, neglect, and exploitation

What regulations impact transfers/discharges?

- Special Characteristics or Service Limitations
- Assessment
- Comprehensive Person-Centered Care Planning
- Discharge Planning
- Nursing Services
- Behavioral Health Services & Sufficient Staff to Provide
- Administration – Facility Assessment
- Training Requirements

FAIR HEARING PROCESS

Fair Hearing Process



Post-Test: True or False?


Thank you!

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www.theconsumervoice.org

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