MERRIMACK VALLEY HOSPICE

DISCHARGES, TRANSFERS & REVOCATIONS

1

DISCHARGES

- Under Medicare regulations, a patient may be discharged from hospice for the following reasons:
  - The patient moves out of the hospice service area or transfers to another hospice
  - The hospice determines that the patient is no longer terminally ill
  - Discharge for cause – This is when the behavior of the patient/family is disruptive, abusive or uncooperative to the extent that the delivery of care to the patient or hospice operations are seriously impaired.

2

PATIENT MOVES OUT OF AREA OR TRANSFERS TO ANOTHER HOSPICE

- If the patient is moving out of the area, but *not* transferring to another hospice, the following steps are followed:
  - Discharge planning by IDT
  - Discharge order by MVH Medical Director
  - RN Case Manager:
    - Notify attending physician
    - Send pertinent medical information to next provider of care, per patient/caregiver request
    - Update home medication list and review discharge instructions with patient/caregiver
    - Complete discharge/transfer summary

3

PATIENT MOVES OUT OF AREA OR TRANSFERS TO ANOTHER HOSPICE

- <u>Transfers to another hospice</u>
  - Discharge planning by IDT
  - Discharge order by MVH Medical Director
  - RN Case Manager:
    - Notify attending physician
    - Send information to receiving hospice to include:
      - Referral
      - Discharge summary
      - Certification & Recertification forms*
      - Hospice Election Form*
      - Current POC
      - DNR Status
      - Current Medication Profile
      - Change of designated hospice form**
      - Any additional information requested by receiving hospice

*** Scanned – need to be printed ** Paper form – will need to be signed and scanned**

4

DISCHARGE – NO LONGER TERMINALLY ILL

- If the IDT determines that the patient's prognosis has changed and that the patient is no longer terminally ill (6 months or less) the following steps are taken:
  - The medical director/NP will make a visit to confirm the patient's status
  - Discharge planning by IDT
  - Discharge order by MVH Medical Director
  - Notify attending physician

5

DISCHARGE – NO LONGER TERMINALLY ILL

- Prepare "Notice of Non-Coverage" to be given to patient/caregiver no later than two (2) days before the proposed end of services.
  - If the span of time between visits exceeds 2 days, the Notice must be given no later than the next to last visit.
  - The patient's name, Medicare number and the effective date are filled in.
  - The "effective date" is the last day of covered services.
  - Use appropriate Massachusetts or New Hampshire Notice of Non-Coverage form, depending on where patient lives.
- The Notice of Non-Coverage may be delivered by the RN Case Manager, LPN, Social Worker, Chaplain, Medical Director/NP
  - Staff delivering the Notice explains the appeal process to the patient/caregiver

6

DISCHARGE – NO LONGER TERMINALLY ILL-continued...

- Staff obtains the signature of the patient/caregiver
  - If the patient/caregiver refuses to sign the notice, the date/time of the delivery and to whom it was delivered is documented on the Notice, with the signature of the person who delivered it.
- *Tip – You need to make a copy of the notice for the patient/caregiver to bring with you. Make sure you bring the copy with the signature back to the office. If the patient/caregiver wants a copy of the signed form, you can mail it to them.*

7

DISCHARGE – NO LONGER TERMINALLY ILL-continued...

- If the notice cannot be delivered in person to the patient caregiver:
  - Make direct telephone contact with patient/caregiver – **voicemail won't do!**
  - Explain the nature of the call and the appeal process
  - Document the telephone conversation on the form section "additional information" and sign
  - Mail a copy of the Notice to the patient/caregiver <u>via certified mail</u>
  - Keep a copy of the Notice for the patient's medical record
  - Signed delivery receipt is attached to the medical record copy of the Notice

8

DISCHARGE – NO LONGER TERMINALLY ILL-continued...

- If the Notice cannot be delivered in person, nor can telephone contact be made, the Notice may be sent via certified mail
  - Attempts at delivery and telephone contact are documented on the form in the "additional information" section and the form is signed
  - A copy of the Notice goes in the medical record
  - Signed delivery receipt is attached to the medical record copy of the Notice

9

DISCHARGE – NO LONGER TERMINALLY ILL-continued...

- Make sure the medication list is updated, print and leave a copy in the home and review discharge instructions with patient/caregiver – document on discharge summary
- Complete discharge summary
  - Send updated medication profile to attending physician with discharge summary

10

DISCHARGE FOR CAUSE

- This is when the behavior of the patient/family is disruptive, abusive or uncooperative to the extent that the delivery of care to the patient or hospice operations are seriously impaired.
  - Discharge for cause must be discussed by the IDT and all discussion must be documented in the medical record
  - The attending physician is informed of the situation
  - The patient/caregiver must be notified that "discharge for cause" is being considered
    - The patient/caregiver should be told exactly why this is being considered
    - This conversation needs to be documented in detail in the medical record

11

DISCHARGE FOR CAUSE

- Efforts must be taken to resolve the issues which have prompted consideration of "discharge for cause."
- Examples of reasons for discharge for cause are:
  - Patient/caregiver or family member who has become hostile – including threats of physical harm
  - Patient or person in the home is uncooperative to the point that services cannot be delivered – refusing to open the door, not being home at time of scheduled visits, refusing to schedule visits

12

DISCHARGE FOR CAUSE

- If the situation involves illegal activity – have local authorities been notified?
- If the situation endangers the safety of the patient or protected persons in the home, have appropriate agencies (Elder Services, Disabled Persons Protection Commission, Department of Social Services, etc.) been notified?

13

DISCHARGE FOR CAUSE

- CMS requires that hospices consider "discharge for cause" as a last resort
  - "Discharge for cause" must be due to behavioral issues, not time or effort or cost factors in providing services
- Care must be taken for "discharge for cause" for patients/families who go outside the POC for services not approved by the hospice

14

DISCHARGE FOR CAUSE

- One unapproved emergency room visit or hospitalization should not result in "discharge for cause."
  - A pattern of repeatedly not following the POC needs to be established
- Rather than discharge, patient/family member should be counseled that they will be responsible for the cost of care outside of the POC
  - An "Advance Beneficiary Notice" or ABN should be utilized when services are obtained outside the POC

15

DISCHARGE FOR CAUSE

- The State Survey Agency and the Fiscal Intermediary must be notified when "discharge for cause" is being considered.
- If discharge is the only recourse, then:
  - Discharge planning by IDT
  - Discharge order by MVH Medical Director
  - RN Case Manager:
    - Notify attending physician of discharge plan
    - Send updated medication profile to attending physician with discharge summary
    - Update home medication list and review discharge instructions with patient/caregiver, if feasible
    - Complete discharge/transfer summary

16

REVOCATION

- A patient "invokes" or elects the hospice Medicare or Medicaid benefit on admission
- The Medicare/Medicaid election forms explain the patient's right to "revoke" the benefit at any time
  - If a patient seeks aggressive treatment outside the POC, MVH can explain the revocation process and encourage revocation, but cannot pressure a patient to sign

17

REVOCATION

- The MVH Revocation Form is used
  - MassHealth patients need to sign the MassHealth Revocation, on the back of the MassHealth Election Form
- A revocation cannot be verbal
- The effective date of the revocation cannot be earlier than the date the revocation is made
  - If the decision to revoke is made and discussed with MVH staff prior to the actual signing date, the *date of the decision* is reflected on the form – this discussion must be documented when it occurs
  - The form and process must be done timely – forms cannot be backdated to cover unplanned hospitalization or other services
- A patient does not have to give the reason for revoking, although it is encouraged

18

REVOCATION

- The attending physician is notified of the revocation
  - Copies of relevant medical information, including the list of current medications and discharge summary, is faxed or mailed to the receiving facility, attending physician or other provider of care
- For patients not in a facility (at home, assisted living, rest home, etc.) Update home medication list and review discharge instructions with patient/caregiver
- The discharge summary is completed

19

DISCHARGE PLANNING

- Discharge planning
  - The IDT is responsible for developing a discharge plan
    - Discharge planning includes communication with the attending physician or next provider of care
    - Referral to other agencies or community resources,
    - Patient/family teaching
    - Arrangements for durable medical equipment or other supplies

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COMPLETING THE DISCHARGE SUMMARY

- Best clinical practices & regulations require that we provide relevant medical information to the next provider of care when a patient is discharged
  - For most patients, a copy of the current medications and the discharge summary is adequate
  - Transfers to another hospice have specific information that must be sent

21

COMPLETING THE DISCHARGE SUMMARY

- In some cases, additional information may be useful, if the case has been either medically or psycho-socially complex
  - A phone call to the next provider of care, asking "what information can we send you to help you care for this patient?" should be made
- The RN case manager has primary responsibility to coordinating the sharing of relevant medical information with the next provider of care

22

Medications at discharge/transfer-Med List

- Medications lists are checked at discharge and transfer to make sure they are up to date
  - The list is also checked to make sure that all changes are reflected such as meds that have been d/c'd, any changes in orders
- Medications in the home are checked against the list
- The discharge summary reflects the sharing of medication information with the next provider of care, and that a copy of the medication list was left in the home and reviewed with the patient/caregiver at the time of discharge

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MERRIMACK VALLEY HOSPICE - DISCHARGE/REVOCATION/TRANSFER CHECKLIST

DISCHARGE (medically stable, moving out of area – not transferring to another hospice)

- Clinical Manager documents IDT discussion regarding discharge on IDT update tab
- Primary nurse and/or social worker discuss discharge with patient/family & documents
- Primary nurse informs attending physician of IDT discharge decision & documents
- Discharge planning identifies next provider of care (VNA, attending, Elder Services, etc.)
- Referrals made to appropriate agencies & documented
    - May need to obtain prescriptions from attending physician for DME
- Obtain discharge order from medical director
- For medically stable discharges only, if Medicare:
    - MassPro letter is completed and given to patient/legal representative no later than 2 days before the proposed end of services, or if the span between visits exceeds 2 days, at next-to-last visit
- Review medication list
- Review discharge plan with patient/caregiver, including review of medications – patient/caregiver may require assistance in obtaining medications that have been provided by hospice. Document on discharge summary.
- Leave copy of medication list in home
- Provide continuity of care information to next provider of care – attending physician, VNA – to include at least current medication information. Document on discharge summary.

REVOCATION

- Obtain signed revocation
- Primary nurse informs attending physician of revocation decision & documents
- If patient is not in hospital or LTC, referrals made to appropriate agencies & documented
    - May need to obtain prescriptions from attending physician for DME
- Review medication list
- If patient is <u>not</u> in hospital or LTC, review discharge plan with patient/caregiver, including review of medications – document on discharge summary
- If patient is in hospital or LTC, give report to nurse-in-charge – document on discharge summary
- Provide continuity of care information to next provider of care – attending physician, VNA – to include at least current medication information. Document on discharge summary.
- Complete discharge summary

TRANSFER

- Complete transfer of hospice form, obtaining patient/legal representative signatures
- Primary nurse informs attending physician of transfer decision & documents.
- Contact receiving hospice to set up transfer
- Review medication list
- Complete discharge summary & document information listed below to be sent to receiving hospice
- Provide continuity of care information to receiving hospice to include:
    - Referral
    - Certification/Recertification of Terminal Illness
    - Hospice Election Form
    - Current Plan of Care
    - Medication list
    - Change of hospice form
    - Any additional information requested by the receiving hospice
    - Discharge summary