# Rancho Los Amigos National Rehabilitation Center

# ADMINISTRATIVE POLICY AND PROCEDURE

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| **SUBJECT:** | **DISCHARGE PLANNING**<br>**Non Voluntary Discharge**<br>**Hospital Issued Denial Letter to Non Medicare Recipients** | **Policy No.:**<br>**Supersedes:**<br>**Revision Date:**<br>**Page:** | **B826**<br>**December 29, 2015**<br>**February 5, 2019**<br>**1 of 8** |

## PURPOSE:

To identify components of effective discharge planning.

## POLICY:

All patients receiving services will receive a discharge plan. Discharge decisions are made by the physician in response to the care needs of the patient, regardless of external entities performing utilization review (i.e., peer review organizations, insurance companies, managed care reviewers, federal or state payers).

## DEFINITIONS:

Non voluntary Discharge - When an appropriate discharge plan is established, a discharge order has been written, and the patient is asked to leave but refuses.

Examples of situations which may lead to a non voluntary discharge:
- Patient disagrees with recommended discharge location or date.
- Patient requests ongoing medical or rehabilitation treatment, but attending physician and clinical team have defined that there is no clinical justification for continued inpatient care.
- Patient behavior which may prevent appropriate and safe treatment.

Physician Advisor - Is an advisor to the attending physician. The Chair of the Utilization Review Management committee will function as the physician advisor. In their absence the Program Chief, if not also the patient's attending physician, will be the advisor. If the Program Chief is the patient's attending physician, the Department Chair will be the advisor.

Attending Physician - Is the final authority on the treatment and discharge plan.

## PROCEDURE:

### A. Discharge Planning Process

Discharge planning focuses on meeting the patient's health care needs after discharge and considers the physical, psychological, social, cultural and age-specific needs of the patients. The patient and family are provided with education in understandable terms that enhances their knowledge, skills and the functional abilities needed for discharge. At the time of the admission

interview, Patient Financial Services (PFS) will provide all patients or surrogate with a copy of the patient and family handbook which will include a listing of patient's rights and responsibilities. If the patient is a Medicare Recipient, PFS staff will review with the patient or surrogate the "An Important Message from Medicare" document. After the review, PFS staff will have the patient or surrogate sign and date the document indicating that the document has been provided. PFS staff will provide the patient with the original, retain a copy to be placed in the patient's PFS file, and place a copy in an envelope. PFS staff will place the envelope with the copy in the chart under the miscellaneous section of the chart.

1. Within three (3) business days of admission and after consulting with the admitting physician, the Social Work Staff Member and/or Case Manager will meet with the patients and/or family to discuss discharge planning. Patients will be given an opportunity to identify one caregiver who may assist in post hospital care. The name and contact information will be documented in the medical record. The designated caregiver will be included in the discharge planning process. Information and instruction will be given throughout hospitalization to the caregiver regarding the continuing health care requirements of the patient following discharge. If patients or their representative decline to designate a caregiver, it will be documented in the medical record.

2. Within 10 days of admission, the Case Manager reviews the letter titled Discharge Guidelines, (see attachment) with the patient and/or the patient's representative. The patient or patient's representative is asked to sign the letter. If the patient or patient's representative refuses to sign, the Case Manager documents this in the medical record. The original document is placed in the medical record and a readable copy is given to the patient. For patients being discharged to skilled nursing or subacute facilities, see policy B828.

3. At the first team conference following admission a tentative discharge date is set.

4. Patients, their representative and/or caregiver are kept abreast of all aspects of the patient's treatment program. Discharge arrangements, including discharge time, are discussed at the time of the patient/family conference. When there is no patient/family conference, the social worker will discuss discharge arrangements, including discharge time and transportation one week prior to discharge or as indicated.

5. Within two calendar days prior to discharge, the Case Manager:

    a. Confirms that the patient, family and caregiver are knowledgeable about the 11:00 a.m. discharge time.

    b. Ensures that the (this will change with ORCHID so my suggestion is as follows): the appointments are complete.

    c. Confirms that all equipment and supplies have been received or ordered appropriately.

    d. If the patient is a Medicare/Medicare Advantage recipient, the Case Manager will provide the patient or surrogate with the copy of the original signed "An Important

Message from Medicare" documents and document in the medical record that the copy has been given to the patient or surrogate.

**Key Point:** When the exact discharge date is unknown, the time frame for issuing the follow-up copy can be adjusted but cannot be given less than four (4) hours before discharge.

6. On the date prior to discharge (which applies to both rehabilitation and the medical-surgical units), discharge prescriptions are written and discharge medications are ordered.

    a. Prescriptions being dispensed at Rancho are sent to the outpatient pharmacy by 3:00 pm.

        **i.** Patients with no approved funding will have their prescriptions filled at Rancho

        **ii.** Patients with funding, including approved Medi-Cal, may have their prescriptions filled at any pharmacy.

    b. In the rehabilitation areas, the interdisciplinary staff are to complete all treatments and patient/family education.

7. On discharge day every effort should be made to discharge the patient by 11:00 a.m. (which applies to both the rehabilitation and the medical-surgical units):

    a. The physician or authorized agent of the physician writes a discharge order by 9:00 a.m.

    b. Upon delivery of the discharge medication by the pharmacy beginning at 9:30 a.m. on the scheduled date of discharge, the nurse will:

        i. .

        ii. Place the medications in the designated secured area until released to the patient or returned to Pharmacy.

        iii. Check the label of each medication prior to giving the medication to the patient against

            a. The prescription photocopy placed inside the chart OR

            b. The photocopy of the prescription place in the bag of medications when changes to the original prescription were needed.

            **Key Point:** Any discrepancies will be resolved with pharmacy prior to giving them to the patient.

        iv. Reinforce previously taught information to the patient/family.

c. If discharge medications have not been delivered to the unit at the time of discharge or the prescription was not delivered to the pharmacy by 8:00a.m., the nurse will:

   i. Complete the discharge process.

   ii. Give the prescription to the patient/family (if not yet delivered to the pharmacy).

   iii. Inform the patient or family to pick-up the medications directly from the outpatient pharmacy.

   iv. Document in the medical record that the patient/family was instructed to pick-up the discharge medications from pharmacy..

d. Patients should not be scheduled for any activities other than those directly related to discharge.

e. All equipment, supplies and related instruction not already taken by family are issued.

f. The interdisciplinary team is responsible for completing the Post-Discharge Instructions in the medical record, ensuring that the patient receives a completed copy. Note: Not sure if this will remain as is with ORCHID.

g. The patient is discharged by 11:00.

**B. Requesting Quality Improvement Organization (QIO) Review (for Medicare or Medicare Advantage Beneficiaries only)**

1. If the Medicare or Medicare Advantage beneficiary/representative disagrees with the discharge, the Case Manager advises the patient/representative of their right to appeal. The case manager can assist the beneficiary/representative in filing an appeal by dialing the number of the Quality Improvement Organization (QIO).

2. Once the appeal is filed, the QIO will communicate this to the Case Manager or the Case Management Department.

3. The Case manager reviews with the patient or the patient's representative, the Detailed Notice of Discharge on the same day the QIO notifies the hospital of the review request.

4. Beneficiary cannot be discharged if he/she requests QIO review.

5. Beneficiary is responsible only for coinsurance and deductibles for inpatient hospital services furnished before noon of the day after the QIO notifies the beneficiary of its decision.

6. The QIO will inform the hospital and the beneficiary of their decision regarding the appeal.

7. QIO agrees with the hospital: Case Management Department will issue Non Covered Continued Stay Denial letter. Liability for continued services begins at noon of the day after the QIO notifies the beneficiary, or as determined by the QIO.

8. QIO agrees with beneficiary: No beneficiary liability for continued care, other than coinsurance and deductibles.

9. For all patients who refuse to be discharged after receiving a denial letter, or a notice of non-coverage, follow the process for Non-Voluntary Discharge found in Section E of this policy.

**C. Discharge and continuing care needs for patients under legal and correctional restrictions:**

1. Patients who are prisoners or wards of the legal system have unique discharge planning needs. In addition to the usual and customary discharge interventions, communication with the receiving staff in the correctional facilities will take place prior to discharge.

2. Length of stay shall be determined by the physician treating the patient, in consultation with the courts.

3. Equipment and supplies are issued based upon decision of the court and the patient's clinical condition upon discharge.

4. Persons who are prisoners or wards of the legal system will be supervised by a peace officer at all times during the inpatient stay.

5. Visitation, while an inpatient, shall be allowed based upon decision of the courts.

6. Private room is not mandatory, unless determined by County policy in collaboration with outside police agencies or by the patient's medical condition.

**D. Discharge and continuing care needs of individuals who are considered unstably housed with the possibility of becoming homeless**

1. All attempts to honor our patients' right to self-determination in identifying their discharge destination shall be made. This includes patients who willingly choose to return to their pre-existing unstable living situation (homeless).

2. Patient must be medically cleared by a physician prior to a discharge to an unstable housing. This includes a homeless or shelter discharge.

3. If there is uncertainty about a patient's mental capacity to make discharge decisions, a full capacity evaluation should be completed by psychology.

4. Patients with capacity who request a discharge to unstable housing will be advised by the physician and efforts toward a more appropriate setting will continue. Patients will be referred to social work for an individualized discharge plan (IDP). Social Work will provide assistance and resources to create the safest possible discharge. This includes helping patients find and contact their family. Patients who have capacity but are not medically cleared to be discharged to unstable housing must sign out AMA. Refer to AMA policy B824. Resources will still be given.

5. Patients who do not have capacity to make discharge decisions will be referred to Social Work to assess family involvement in decision making. A referral for conservatorship will be sent to the Office of Public Guardian if appropriate.

6. For all patients who request to voluntarily discharge to an unstable housing including a shelter or the streets, staff must consult the Director of Social Work or the Director of Case Management to determine if there any other alternatives. Transportation cannot be provided for patients who chose an unstable housing discharge against medical advice. The Social Work Department can assist with transportation between the hours of 7:30 a.m. and 4:30 p.m. The nursing resource office should be contacted after hours.

7. If the best possible option is to DC a patient to an unstable living situation and they refuse to leave at the time of their discharge, follow the process for Non Voluntary Discharge.

**Addendum: In Compliance with Senate Bill 1152 effective January 1, 2019, the following services will be provided to homeless/unstably housed patients from any of our inpatient units prior to discharge at Rancho Los Amigos. All relevant disciplines must document in ORCHID that these services were provided to the patient.**

- **Physical Exam(indicating medical stability for discharge)-Physician**
- **Referral for Follow up Care if needed-Medical or Behavioral**

  **If applicable, there will be contact with the patient's PCP,(including if patients are empaneled and will be returning to Rancho Los Amigos for their primary provider) the patient's health plan, or a list of free/low cost clinics will be sent with the patient in the area of their preference-Case Management.**
- **Meal-Nursing**
- **Weather Appropriate Clothing if the patient's clothing is inadequate-Social Work, Nursing(after hours)**
- **Discharge Medications(a prescription, or an appropriate supply of all necessary medications)-Pharmacy, Nursing**
- **Infectious Disease Screening as appropriate-Physician, Infection Control**
- **Vaccinations-Physician**
- **Transportation-30 miles(maximum)from hospital to destination-Social Work**
- **Screening/enrollment in insurance-Patient Financial Services**

**When engaging with social services agencies or shelters to provide linkage, Social Work must document the name of the organization that has agreed to accept the patient, the name of the staff who committed to the agreement and note that patient will have a discharge summary of medical information, medications, treatments, etc.**

**Effective July 1, 2019, there will be a coordinated written plan(updated annually) of homeless services and agencies in the region surrounding the hospital. The coordination plan must contain the following:**

- **List of local homeless shelters including hours of operation, admission procedures and requirements, client population served, general scope of medical and behavioral health services available**
- **The hospital's procedures for homeless patient discharge referrals to shelter, medical care and behavioral care**
- **Contact information for the homeless shelter's intake coordinator**
- **Training protocol for discharge planning staff(Medical Case Workers)**
- **Log of homeless patients discharged and the destination of each patient**

**E. Non Voluntary Discharge of a Patient**

1. When an appropriate discharge plan has been developed and when the discharge date is defined, the patient or surrogate will be informed by the Physician of record or the agent of the physician. The team will reinforce the physician's decision to discharge the patient.

2. When a determination has been made that the discharge destination is a Skilled Nursing Facility or Board and Care, a copy of the Transfer to Alternate Level of Care will be provided to and reviewed with the patient or surrogate by the Social Work staff. The patient or surrogate will be requested to sign the document.

3. If the patient or surrogate decline the discharge plan or do not want to be discharged on the defined date, the Social Work staff will meet with the patient to discuss possible discharge alternatives, and will document this discussion in the medical record,. The Social Work staff will also inform them of the availability of the Patient Advocate.

   **Key Point**: For Medicare or Medicare Advantage beneficiaries follow the steps in Section B.

4. If the patient or surrogate does not identify or select an appropriate discharge plan, the Case Manager will refer the case to another physician (for second level review).

5. The Case Manager will also refer the case to Patient Advocate.

6. The Physician Advisor will review the patient's medical records and if necessary, discuss the case with the attending physician. Following the review, the Physician Advisor will document in the medical record that:

   i. The discharge plan determined by the attending physician is appropriate, or

   ii. Based upon communication with and agreement by the attending physician, the attending physician will revise the discharge plan.

7. The attending physician will inform the patient that he/she is discharged and will write the discharge order on the day of discharge.

8. If the patient or surrogate still declines the planned discharge, the Case Management Department will provide the Letter of Non-Coverage or Denial Letter (Attachment) to the patient or surrogate informing them of the possible financial responsibility which they may incur, and explain any appeal rights which are available to the patient.

   **Key Point:** A copy of the denial letter is forwarded to the Finance Department and a copy is placed in the patient's medical record. A copy is retained by the Case Management Department. The Case Manger will monitor the appeal process and inform the patient/family of the outcome.

9. If the patient or surrogate still declines the planned discharge and does not provide an appropriate and timely alternative, they will be informed that the patient must be discharged.

10. Transportation as required and appropriate will be arranged, and the patient or surrogate will be informed when the transportation is expected to arrive, or the time at which they must leave the rehabilitation center.

11. At the time at which transportation is expected to arrive or the patient is expected to leave, County Sheriff will be asked to be present and stand by on the patient's unit.

12. If the patient or surrogate still refuses to be discharged when transportation arrives or at the time they are to leave, the administrator designee will again inform them that the patient must be discharged an the further possible consequence of refusal.

13. If the patient or surrogate still refuses discharge, the County Sheriff may cite them for trespassing.

    **Key Point:** A discharge order in the chart allows County Sheriff to cite the patient or surrogate for trespassing.

14. If the patient is medically stable and able to provide for their own needs they will be asked to leave the facility and will be escorted off grounds by County Sheriff.

    **Key Point:** Medications, supplies, etc. which are required for the patient's safety will be provided. They will be instructed as to what to do to obtain further medication and supplies.

15. If the patient refuses or resists being escorted off campus, County Sheriff will take appropriate actions which may include placing the patient into police custody.

16. If the patient is not medically stable or unable to provide for their own basic needs and they or a surrogate still refuses the discharge, the case will be referred to County Council.

17. All services necessary to provide for the patient's medical needs and safety will be provided while this process is occurring and until the patient is discharged.

HW:mm

AL:CD

Reference: SB 675 (Liu) Hospitals: Family Caregivers - Chapter 494

Attachments

RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

Los Angeles County
Board of Supervisors

Hilda S. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Aries Limbaga
Interim Chief Executive Officer

Ben Ovando
Chief Operations Officer

Susan Shaw Huang, MD
Interim Chief Medical Officer

Michelle Sterling
Acting Chief Nursing Officer

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Downey, CA 90242

*To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.*

# DENIAL LETTER
# PHYSICIAN CONCURS
# NON MEDICARE BENEFICIARY

**Date:**_____

RLANRC #: _____

**Patient Name:** _____

**Address:**_____

**City/Zip:**_____

Admission Date: _____

Dear (Patient Name):

This letter is to inform you that your insurance (**Name of insurance)** has requested you be **discharge/transfer** from Rancho Los Amigos National Rehabilitation Center to (**designated place)** , effective **Discharge Date**. The medical or rehabilitation services which you now require may be furnished at another facility. Per your Physician, you are stable for transport/ discharge.

You will be financially liable for all costs for the care you receive beginning **Discharge Date**. The minimum cost that you will be charged is **Daily Rate per Finance** per day. If you leave on **Discharge Date** you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by your insurance. If you need to discuss further health care related issues, please speak with your Physician.

Sincerely,

Dr. (**Name of URC Chair**)
Chairperson, Utilization Review Committee