Community Partners

Minimum Discharge/Transfer Requirement List

Please include the following information when discharging a patient to a facility

Name: _____

Transfer to: _____

Date/Time of pick up: _____am/pm

PATIENT INFORMATION

- ☐ Face sheet/personal demographics
- ☐ Insurance information
- ☐ Referring physician contact information
- ☐ Attending physician for follow-up
- ☐ Primary care provider
- ☐ Other specialists

MD REPORTS

- ☐ History and physical (completed within 7 days or less prior to day of admission; include surgical history/operations)
- ☐ Transfer summary/discharge summary (as required)

IMAGING

- ☐ X-ray/diagnostic/imaging

TB CLEARANCE

- ☐ TB test results (two step or CXR)

ISOLATION PRECAUTIONS

- ☐ *C. diff*
- ☐ MRSA
- ☐ VRE
- ☐ Other

PERTINENT LAB RESULTS

- ☐ UA
- ☐ CBC
- ☐ Immunizations/dates:
  - ☐ Influenza
  - ☐ Pneumococcal
  - ☐ Tetanus
  - ☐ Other
- ☐ Positive cultures
- ☐ Other lab results

THERAPY REPORTS

- ☐ Functional status/ADL/safety awareness
- ☐ Physical Therapy: Evaluation/ discharge summary
- ☐ Occupational Therapy: Evaluation/ discharge summary
- ☐ Speech Therapy: Evaluation/ discharge summary
- ☐ Dysphagia Therapy: Evaluation/ MBS reports/ discharge summary

OTHER

- ☐ Lives alone
- ☐ Guardianship needs/APS
- ☐ DME provider/supplies

ADVANCED DIRECTIVES (IF AVAILABLE)

- ☐ Advanced directives
- ☐ Living will
- ☐ POLST
- ☐ Power of attorney/health care surrogate
- ☐ Code status

FOLLOW-UP APPOINTMENTS

- ☐ MD follow-up appointment
- ☐ Dialysis schedule (if appropriate)
- ☐ Transportation requirements/needs.
  - Agency name/date arranged: _____
    _____

DISCHARGE ORDERS (SIGNED)

List additional information below as available.

- ☐ Activity
- ☐ Allergies
- ☐ Consultations
- ☐ Diagnosis
- ☐ Diet
- ☐ Equipment/supplies/vendors
- ☐ Meds/current medication list/ MAR -7 day (including hold parameters, over the counter meds and last dose given)
- ☐ Medication reconciliation date: __/__/____
- ☐ Discharge medications orders
- ☐ Treatment orders
- ☐ Discharge instructions
- ☐ Referring facility contact information
  - Contact information: _____
  - Nurse-nurse report date: __/__/____

Plus Additional Discharge/Transfer Information Required by Facility Type

Please include the following additional information by facility type

PLUS for RESIDENT CARE FACILITY

- ☐ Approved 1147
- ☐ OHCA ARCH IR35 – MD/APRN - Tuberculosis Risk Assessment and Attestation Screening (for +PPD)
- ☐ OHCA ARCH N2 for E-ARCH – Level of care evaluation for adult residential care home residents
- ☐ ICF level of care orders (use OHCA ARCH N2 for E-ARCH)
- ☐ OHCA ARCH N3 for E-ARCH – Resident admission and personal history (2 pages)
- ☐ Tube feeding orders including flushes and hold parameters
- ☐ Insulin orders including blood sugar checks and hold parameters
- ☐ Complete O2 orders including latest saturation

All discharges shall be coordinated and approved through the case management agency.

PLUS for NURSING FACILITY

- ☐ Long-term care facility transfer form/**Briggs:**
  - ☐ First page – nurse
  - ☐ Second page – MD. Check off level of care (SNF or ICF), date and signature
- ☐ Pre-admission Screening Resident Review (PASRR) form with date, time and signature by MD, APRN, RN. Level 1 (include level 2 if appropriate). *Please note electronic versions of the PASRR cannot be used.*
- ☐ Admission date and reason (recent acute, nursing facility, ARCH, etc.)
- ☐ Approved 1147
- ☐ Transfer form
- ☐ Minimum Data Set (MDS) – most recent for all lateral transfers (nursing facilities)
- ☐ Treatments (including but not limited to tube feeding, ostomy, dialysis, vent or trach care, rehabilitation, etc.)
- ☐ Skin condition, wound care
- ☐ Communication barrier
- ☐ Discharge plans

PLUS for NURSING FACILITY (Continued)

- ☐ Discharge instructions
- ☐ Discharge summary within 48-72 hours
- ☐ Referring facility –contact information

**plus number of remaining SNF days left at discharge*

Any missing or incomplete documents may result in a delay, or cancellation of admission.

PLUS for ASSISTED LIVING FACILITY

Assisted living facility is licensed to provide the level of care required by the patient..

- ☐ Patient must be 18 years of age or older

☐ **A Bed (low level of care):** The resident needs occasional supervision, assistance or reminders to perform some activities of daily living (ADLs) but is independent in other activities. Must be mobile (with or without assistive devices), and be able to feed themselves. May manage own medications upon passing medication assessment and approval from PCP - if this criteria is not met the resident will need to receive medication management.

☐ **B Bed (moderate level of care):** The resident requires more substantial support with some ADLs while needing only minimal assistance with others. Must continue to be mobile (with or without assistive devices), but may need SBA for mobility. Must continue to be able to feed themselves. May manage own medications upon passing medication assessment and approval from PCP - if this criteria is not met the resident will need to receive medication management.

☐ **C Bed (high level of care):** The resident needs frequent and comprehensive assistance with ADLs. Must continue to be mobile (with or without assistive devices), but may need SBA for mobility. Must continue to be able to feed themselves. Staff administers medications. Staff monitors the resident for effects of medications. *The unit for memory care residents have exit alarms ti alert staff*

PLUS for ASSISTED LIVING FACILITY (Continued)

Fax the following documents to the facility:

- ☐ Face sheet/demographics (DOB, SSN, phone, address, payor information)
- ☐ Attending MD or primary care physician
- ☐ History and physical
- ☐ Hard scripts for any opioids
- ☐ Current medication list (medication orders must be signed by MD, DO or APRN. This is particularly important if assisted living nurse is to administer/ manage medications for resident)
- ☐ Facility will contact patient/family to start admission process, including face-to-face health assessment
- ☐ TB skin test (2 step) results must indicate millimeters read. If "negative" documentation, must state "0 mm"
- ☐ Discharge information should include if "home health" is being ordered for resident and indicate the nursing agency contacted to provide home health services along with what services will be provided (e.g., nursing, physical therapy, occupational therapy, speech therapy, wound nurse to follow, etc.)
- ☐ Referring facility
  - Contact information: _____
- ☐ Assisted Living Admission or Readmission forms must be signed by MD, DO or APRN
- ☐ Please make sure that resident has been discharged with necessary supply of medications to be given/started upon move in or readmission to assisted living and referring facility contact information for clarification of orders or questions

Plus Additional Discharge/Transfer Information Required by Facility Type

Please include the following additional information by facility type

PLUS for HOSPICE

- ☐ Certification of terminal illness from attending MD or primary care physician
- ☐ Prescription:
  - Diagnosis
  - Contact name/phone number
  - MD (print name and signature)
  - MD NPI number
- ☐ RN notes for PICC line placement/dressing change
- ☐ Foley- last date changed/size of catheter
- ☐ Ostomy size- product # using
  - Last changed
  - What has patient/family demonstrated with ostomy care (only empty, observed only or assisted with)
- ☐ Nursing discharge summary information and information for patients with wounds/wound care, measurements and onset date
- ☐ Psychosocial assessments (e.g., social work, chaplain)
- ☐ Referring facility

  - Contact information: _____

PHARMACY (FOR Rx SERVICES ONLY)

I. Patient Demographics

- ☐ Name
- ☐ Date of birth
- ☐ Address (*NO* P.O. Box)
- ☐ Phone number
- ☐ Patient ID (driver's license, etc.)
- ☐ Insurance information

II. Prescription Rx Content

A. Non-controlled Rx

- ☐ Legible provider name/signature
- ☐ Call back phone number for provider
- ☐ Allergy

PHARMACY (FOR Rx SERVICES ONLY) (Continued)

B. Controlled Rx (CII-CV)

- ☐ DEA#
- ☐ Quantity number spelled out
- ☐ Resident address (*NO* P.O. Box)

III. Non-Formulary Items

- ☐ Prior Authorization (PA) may be required or an alternate substitute

PLUS for REHABILITATION HOSPITAL of the PACIFIC INPATIENT REQUIREMENTS

***NOTE: Patients may be admitted from home, observation or inpatient hospital without a 3-day requirement. If patient is admitted from another facility, the following are required:**

- ☐ Discharge summary
- ☐ Briggs/nursing transfer form (to include last dose of meds given, start and finish dates for Abx and reason for Abx)
- ☐ Discharge medication orders and prior meds
  - 7 day MAR
  - If anticoagulation med is Rx → MD protocol for drug, dose and start/stop
- ☐ PT/OT/ST/Dysphagia discharge summary [if Modified Barium Swallow Study (MBS)/ Swallow Video completed: report]
- ☐ Consult notes
- ☐ EKG; latest labs (CBC, chemistry, PT/INR); all X-rays (CD); CT/MRI scans
- ☐ AHD/living will
- ☐ List of follow-up appointments/dialysis schedule
- ☐ Caregiver contact
- ☐ Discharge disposition
- ☐ Referring facility

  - Contact information: _____

PLUS for REHABILITATION HOSPITAL of the PACIFIC OUTPATIENT REQUIREMENTS (Continued)

- ☐ Prescription
  - ☐ Diagnosis
  - ☐ Contact name and phone number
  - ☐ MD: print name and signature
  - ☐ MD MPI number
  - ☐ Discipline recommended (PT, OT, SP, Dysphagia)
- ☐ Face sheet (including insurance)
- ☐ H & P
  - ☐ If had surgery: surgical report
  - ☐ Name of primary care physician
- ☐ PT/OT/ST/Dysphagia discharge summary or last progress note
  - ☐ If Modified Barium Swallow Study (MBS)/ Swallow Video completed: report
- ☐ Referring facility

  - Contact information: _____

Plus Additional Discharge/Transfer Information Required by Facility Type

Please include the following additional information by facility type

HOME HEALTH/HOME CARE REFERRALS

- Name of community physician (must be enrolled with PECOS for Medicare traditional/Medicare Advantage/ Medicaid/Medicaid Quest plans)
- Face sheet (includes demographics, address of home after discharge, insurance name and number)
- Hospital H & P/ hospital transfer summary/nursing facility H&P/discharge summary/last two physician progress notes
- Immunization records
- Allergies information
- Discharge medications
- Discharge instructions
- Diet instructions
- Other MD/specialists
- Post-discharge MD appointment
- Other information (as applicable)
    - Wound care – wound measurements and onset of pressure ulcer date/any other wound types and stage
    - Antibiotic therapies, TPN, labs
    - PICC Line – PICC line placement date; dressing change date, measurement
    - Foley/indwelling catheter – date last changed; size of catheter
    - Ostomy – size/product #; date last changed
        - Patient/caregiver response to teaching
        - SLP – Modified Barium Swallow (MBS)/Swallow Study Report
        - Activity post discharge/weight bearing status
        - Surgical report
        - PT/OT/SP Summary/Eval
        - DME/Medical supplies company
- Confined to home - homebound status (see Criteria for Homebound Status)
- Justification for Home Health service

HOME HEALTHFACE-TO-FACE REQUIREMENTS FOR MEDICARE

Eligibility Requirements for the Medicare Patient:

- Requires medically reasonable and necessary intermittent skilled services
  (nursing, physical and/or speech therapy; occupational therapy if combined with additional discipline)
- Is confined to home (homebound) - See Criteria for Homebound Status
- Is under the care of a doctor who determines the need for home health care, certified the patient's plan of care and periodically reviews the plan
- Must have face-to-face (F2F) encounter by a doctor or other allowed practitioner who meets Centers for Medicare & Medicaid Services (CMS) criteria (see F2F Encounter Documentation Requirements)

F2F Encounter Documentation Requirements

The following are necessary requirements for home health face-to-face:

- A face-to-face encounter needs to occur no more than 90 days prior to the home health start of care date or within 30 days of the start of home health care, and is related to the primary reason the patient requires home health services
- Encounter was performed by a physician or allowed non-physician practitioner
- Date of encounter is included in the F2F documentation
- F2F document is signed/dated by practitioner who performed F2F encounter, e.g., referring NP/PA, oversight MD signature
- Must include:
    1. Date of encounter
    2. Name of community physician
    3. Patient's name
    4. Skill (for RN, PT or SLP ordered)

(Encounter) Documentation examples:

a. Patient need for observation and assessment of surgical wound and PT to improve limited knee range of motion; improve safety on ambulation and transfers.
b. Wound care completed to right/left (select) great toe. No s/s of infection, but patient remains at risk for infection due to diabetic status. SN visits to perform wound care and assess wound status.

ENCOUNTER EXAMPLES AND CRITERIA

Criteria #1
Describe amount and type of supervision needed, **assistive device or special transportation** needed to leave the home or current condition makes leaving the home medically contraindicated and include environmental conditions that impact home bound status.
Example: Client requires stand by assistance of another person and use of FWW to ambulate in the home due to weakness and impaired balance secondary to CVA.

Criteria #2
Describe exactly what symptoms or impairments are causing the inability to leave the home and cause **considerable and taxing effort** when leaving the home that were not present prior to the acute illness or injury.
Example: Client has orthostatic hypotension when getting up, requiring stand by assistance and verbal cues due to dementia to leave the home safely.

Plus Additional Discharge/Transfer Information Required by Facility Type

Please include the following additional information by facility type

HOME HEALTH/HOME CARE CRITERIA FOR HOMEBOUND STATUS

Patient must either:

- Because of illness, need the aid of supportive devices such as crutches, canes, wheelchairs or walkers; the use of special transportation or the assistance of another person to leave his/her place of residence OR
- Have a condition such that leaving his/her home is medically contraindicated

Then:

- There must exist a normal inability to leave home, and leaving home must require a considerable and taxing effort, whether physical or cognitive
- Infrequent absences or periods of relatively short duration for therapeutic, psychosocial, adult day care or medical treatments, e.g., chemotherapy, radiation or dialysis, or occasional non-medical needs, e.g., family reunion, funeral or church, do qualify for homebound status

HOMEBOUND STATUS DOCUMENTATION EXAMPLES

- Patient is homebound due to inability to ambulate for more than few feet without falling due to poor balance, and extreme fatigue and weakness.
- Beneficiary must use quad cane while ambulating even short distances in the home. Has a very slow, unsteady gait, at times, beneficiary requires assistance of another person to get up and move safely.
- Patient is homebound due to complex surgical wound to left/right (select) foot. The patient is non-weight bearing on left/right (select) foot resulting in balance and transfer limitations that increase patient's fall risk. Leaving the home presents risks of complications such as infection and delayed wound healing for this diabetic patient. It is medically contraindicated for the patient to leave home until wound heals.
- Signature of physician.

Acute/Post-Acute Facilities

- When a patient is referred to home health following discharge from an acute/post-acute facility, the referring facility physician must identify the community physician (must be enrolled in PECOS) who will be following the patient in the community.

Version 4 of The Discharge/Transfer Information List
Updated by the Community Partners June 2019

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

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