G454

(Rev. 219; Issued: 04-12-24; Effective: 04-12-24; Implementation: 04-12-24)

§484.50(d) ***Standard: Transfer and discharge.***

[…The HHA may only transfer or discharge the patient from the HHA if:]

(1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician *or allowed practitioner* who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities;

Interpretive Guidelines §484.50(d)(1)

When a patient's care needs change to require more than intermittent services or require specialized services not provided by the agency, the HHA must inform the patient,

patient representative (if any), and the physician *or allowed practitioner* who is responsible for the patient's home health plan of care that the HHA cannot meet the patient's needs without potentially adverse outcomes. *(As noted in §484.2, "allowed practitioner" means a physician assistant, nurse practitioner, or clinical nurse specialist as defined at this part.)* The HHA should assist the patient and his or her representative (if any) in choosing an alternative entity by identifying those entities in the patient's geographic area that may be able to meet the patient's needs based on the patient's acuity. Once the patient chooses an alternate entity, the HHA must contact that entity to facilitate a safe transfer. The HHA must ensure timely transfer of patient information to the alternate entity to facilitate continuity of care, i.e., the HHA must ensure that patient information is provided to the alternate entity prior to or simultaneously with the initiation of patient services at the new entity.

Also see *the discharge planning requirements at §484.58 and the requirements at* §484.110(a)(6)(ii) regarding time frame for the transfer summary.