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§482.43(d) Standard: Transfer or Referral

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Interpretive Guidelines §482.43(d)

The hospital must take steps to ensure that patients receive appropriate post-hospital care by arranging, as applicable, transfer to appropriate facilities or referrals to follow-up ambulatory care services.

"Appropriate facilities, agencies, or outpatient services" refers to entities such as skilled nursing facilities, nursing facilities, home health agencies, hospice agencies, mental health agencies, dialysis centers, suppliers of durable medical equipment, suppliers of physical and occupational therapy, physician offices, etc. which offer post-acute care services that address the patient's post-hospital needs identified in the patient's discharge planning evaluation. The term does not refer to non-healthcare entities, but hospitals also are encouraged to make appropriate referrals to community-based resources that offer transportation, meal preparation, and other services that can play an essential role in the patient's successful recovery.

"Appropriate facilities" may also include other hospitals to which a patient is transferred for follow-up care, such as rehabilitation hospitals, long term care hospitals, or even other short-term acute care hospitals.

Necessary medical information must be provided not only for patients being transferred, but also for those being discharged home, to make the patient's physician aware of the outcome of hospital treatment or follow-up care needs. This is particularly important since the increasing use of hospitalists in the inpatient hospital setting means the patient's physician may have had no interaction with the patient throughout the hospital stay. When the hospital provides the patient's physician with necessary medical information promptly, among other things, this provides an opportunity for the patient's physician to discuss with the hospital care team changes to the patient's preadmission medication regimen or other elements of the post-discharge care plan about which the physician may have questions. Facilitating opportunities for such communication and dialogue enhances the likelihood of better patient outcomes after discharge.

The "medical information" that is necessary for the transfer or referral includes, but is not limited to:

- Brief reason for hospitalization (or, if hospital policy requires a discharge summary for certain types of outpatient services, the reason for the encounter) and principal diagnosis;
- Brief description of hospital course of treatment;
- Patient's condition at discharge, including cognitive and functional status and social supports needed;
- Medication list (reconciled to identify changes made during the patient's hospitalization) including prescription and over-the-counter medications and herbal. (Note, an actual list of medications needs to be included in the discharge information, not just a referral to an electronic list available somewhere else in the medical record.);
- List of allergies (including food as well as drug allergies) and drug interactions;
- Pending laboratory work and test results, if applicable, including information on how the results will be furnished;
- For transfer to other facilities, a copy of the patient's advance directive, if the patient has one; and
- For patients discharged home:
    - Brief description of care instructions reflecting training provided to patient and/or family or other informal caregiver(s);
    - If applicable, list of all follow-up appointments with practitioners with which the patient has an established relationship and which were scheduled prior to discharge, including who the appointment is with, date and time.
    - If applicable, referrals to potential primary care providers, such as health clinics, if available, for patients with no established relationship with a practitioner.

The regulation requires transfer or referral "along" with necessary medical information. In the case of a patient being transferred to another inpatient or residential health care facility, the necessary information must accompany the patient to the facility. However, in the case of a patient discharged home who is being referred for follow-up ambulatory care, the transmittal of the information to the patient's physician may take place up to 7 days after discharge or prior to the first appointment for ambulatory care services that may have been scheduled, whichever comes first. If the patient's physician is not yet able to accept the information electronically from the hospital, the hospital may provide the information to the patient with instructions to give this information to the physician at their next appointment.

For Information – Not Required/Not to be Cited

Scheduling of follow-up appointments for ambulatory care services by the hospital prior to discharge has been found to be an effective tool to ensure prompt follow-up and reduce the likelihood of a preventable readmission. This follow-up visit shortly after discharge provides an opportunity for the patient to address any issues or concerns experienced

after the inpatient stay. It also provides an opportunity for the primary care physician or practitioner to review and reinforce the post-hospital plan of care with the patient, for rehabilitation therapy to begin in a timely manner, to clarify any concerns related to medication reconciliation or other adjustments to the patient's pre-hospital regimen, etc.

It is recognized that hospitals have certain constraints on their ability to accomplish patient transfers and referrals:

- They must operate within the constraints of their authority under State law;
- A patient may refuse transfer or referral; or
- There may be financial barriers limiting a facility's, agency's, or ambulatory care service provider's willingness to accept the patient. In such cases the hospital does not have financial responsibility for the post-acute care services. However, hospitals are expected to be knowledgeable about resources available in their community to address such financial barriers, such as Medicaid services, availability of Federally Quality Health Centers, Area Agencies on Aging, etc., and to take steps to make those resources available to the patient. For example, in most states hospitals work closely with the Medicaid program to expedite enrollment of patients eligible for Medicaid.

Survey Procedures §482.43(d)

- Review a sample of records for discharged patients who had a discharge plan to determine if:
  - For patients discharged home:
    - Necessary medical information was sent to a practitioner with which the patient has an established relationship prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first;
    - For patients without an established relationship with a practitioner, information was provided on potential primary care providers, such as health clinics, if available.
  - For patients transferred to another inpatient facility, was necessary medical information ready at time of transfer and sent to the receiving facility with the patient?
  - When applicable, there is documentation in the medical record of providing the results of tests, pending at time of discharge, to the patient and/or post-hospital provider of care?