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Practice Resource

Difficult Discharges: Sending Patients Out Without Getting Into Trouble

Brad Nokes, Kim C. Stanger, and Lisa Carlson

ABSTRACT: Providers across the health care spectrum often struggle with difficult discharge decisions, including the disposition of patients who should be discharged but who either refuse to leave the facility or have no place to go for needed post-discharge care. Retaining such patients diverts limited resources from others who need them, places a heavy financial and emotional burden on providers, and exposes some providers to increased regulatory scrutiny. On the other hand, improper or impolitic discharges may expose the provider to, at best, bad publicity and, at worst, liability to the patient, family, or government regulators. In this Practice Resource, we hope to outline the primary legal issues and provide some practical suggestions for dealing with these cases.

Disclaimer: Although we have tried to summarize key federal and common state statutes, state laws vary widely and cases or standards in a particular jurisdiction may affect the analysis. Providers should review their own particular state and local laws, standards, and relevant contracts to determine or confirm their obligations.

Brad Nokes et al., *Difficult Discharges: Sending Patients Out Without Getting Into Trouble*, J. Health and Life Sci. L., Oct. 2020 at 60.

Difficult Discharges

ARTICLE CONTENTS

THE LEGAL LANDSCAPE FOR PRACTITIONERS AND PROVIDERS IN GENERAL

Malpractice/Patient Abandonment

Once a practitioner assumes the care of a patient, the practitioner or other provider may be liable for malpractice if they fail to render care consistent with the applicable standard of care, including discharging or transferring patients inappropriately. In addition, state licensing statutes often prohibit physicians and other providers from "abandonment of a patient"; violations may result in administrative penalties.[1] Patients may also sue the provider under the common law theory of patient abandonment.[2] As one court explained:

> it "is well settled that a physician or surgeon, upon undertaking an operation or other case, *is under the duty,* in the absence of an agreement limiting the service, of continuing his [or her] attention, *after the first . . . treatment,* so long as the case requires attention." *Ricks v. Budge,* 91 Utah 307, 64 P.2d 208, 211 (1937) (emphasis added). "A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires." *Id.* at 212. Accordingly, a medical provider "'is bound to exercise reasonable and ordinary care and skill in determining when he [or she] should discontinue his [or her] treatment and services.'" *Id.* (quoting *Mucci v. Houghton*, 89 Iowa 608, 57 N.W. 305, 306 (Iowa 1894)).[3]

To avoid liability for patient abandonment, the provider generally must: (1) notify the patient of the provider's intent to withdraw from care; (2) give the patient sufficient time to transfer their care to another appropriate provider; and (3) provide necessary care in the meantime. Thirty days' prior notice is common, and the required notice period likely depends on the circumstances of the particular case, including the nature of ongoing care and the ability of the patient to obtain appropriate care elsewhere.

Discrimination Statutes

Although providers may be entitled to withdraw care after giving sufficient notice, they generally cannot discriminate against persons in violation of federal and state anti-discrimination statutes, including discrimination based on disability, race, color, national origin, religion, sex, or sexual orientation.[4] The Centers for Medicare and Medicaid Services (CMS) cautions hospitals:

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1 *See, e.g.,* Idaho Code § 54-1814(15) (2020).
2 *See, e.g.,* 1 Am. Law Med. Malpractice § 3:15 (2017).
3 Newman v. Sonnenberg, 81 P.3d 808, 811 (Utah Ct. App. 2003).
4 *See, e.g.,* Section 504 of the Rehabilitation Act; Americans with Disabilities Act; 45 C.F.R. pt. 92 (2020).

> These statutes and their implementing regulations require that covered entities administer their services, programs and activities in the most integrated setting appropriate to individuals with disabilities and prohibit covered entities from utilizing criteria or methods of administration that lead to discrimination .... [H]ospitals should ensure that their discharge practices comply with applicable Federal civil rights laws and do not lead to needless segregation.[5]

Other Considerations

Patient abandonment and the Emergency Medical Treatment and Active Labor Act aside (discussed in greater detail below), the law generally does not preclude a provider from "firing" or discharging a patient from the practice; however, a provider may limit his/her right to withdraw from caring for the patient by assuming contractual or other voluntary obligations. For example, a provider may enter managed care or other agreement, accept grants, or otherwise undertake obligations that require the provider to treat certain patient populations, restrict his/her ability to refuse care, or impose restrictions or processes relating to the involuntary termination of care. Providers should carefully consider the strings attached to such arrangements.

THE LEGAL LANDSCAPE FOR HOSPITALS

The Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act (EMTALA) generally prohibits hospitals from transferring or discharging patients with an emergency medical condition that has not been stabilized unless either (1) the patient or their authorized surrogate has requested the transfer, or (2) a physician certifies that the benefits of the transfer or discharge outweigh the risks.[6] In either case, the transfer or discharge must be appropriate, *i.e.*, the hospital must provide treatment within its capacity which minimizes the risks to the patient's health; the hospital effects the transfer through qualified personnel and equipment; and, in the case of a transfer to another facility, the hospital contacts the receiving facility and the receiving facility agrees to accept the transfer; and the hospital sends medical records to the receiving facility.[7]

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5 State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, at A-0799 (Rev'd 12/29/17) [hereinafter Hospital Interpretive Guidelines].

6 42 U.S.C. § 1395dd(c) (2020); 42 C.F.R. § 489.24(e).

7 42 U.S.C. § 1395dd(c)(2); 42 C.F.R. § 489.24(e)(2).

Under EMTALA, competent individuals and/or their legally authorized personal representatives generally have the right to refuse continuing care or a proposed transfer. In such cases,

> [a] hospital is deemed to [satisfy EMTALA] if the hospital offers the individual the further medical examination and treatment [required by EMTALA] and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.[8]

The hospital's EMTALA obligations end once the individual's emergency medical condition has been stabilized; accordingly, a hospital may transfer or discharge a stabilized individual without having to comply with EMTALA transfer requirements.[9] Under the statute and regulations, an individual is "stabilized" if:

> no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, [in the case of a pregnant woman who is in labor], that the woman has delivered (including the placenta).[10]

The relevant Interpretive Guidelines define "stabilized" slightly differently. Under the Guidelines,

> [a]n individual will be deemed stabilized if the treating physician or [qualified medical person] attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.[11]

For discharge home,

> An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably

8 42 U.S.C. § 1395dd(b)(2); *see also* 42 C.F.R. § 489.24(d)(3), (5).

9 42 C.F.R. § 489.24(e)(1).

10 42 U.S.C. § 1395dd(e)(3)(B); 42 C.F.R. § 489.24(b).

11 CMS, State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, at Tag A-2407/C-2407 (Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf [hereinafter EMTALA Interpretive Guidelines].

> performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The [emergency medical condition] that caused the individual to present to the dedicated ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.[12]

Of course, the hospital must also comply with the standard of care and discharge requirements, as described below.

The hospital's EMTALA obligations also end once the patient is admitted in good faith as an inpatient.[13]

> An individual is considered to be "admitted" when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight.[14]

Admitting the patient also ends the EMTALA obligation of another hospital with specialized capabilities to accept a transfer.[15] Accordingly, hospitals that plan to transfer an emergency patient to another facility may want to carefully consider whether they should admit the patient, thereby terminating the receiving facility's obligation to accept the patient.

Medicare Conditions of Participation (CoPs)

On September 26, 2019, CMS issued a final rule revising discharge planning requirements applicable to hospitals, including critical access hospitals. The revised regulations became effective on November 29, 2019.

Hospitals

The Hospital CoPs affirm the patient's or personal representative's right to be informed and involved in treatment decisions, including those relating to discharge:

> (1) The patient has the right to participate in the development and implementation of his or her plan of care.

12 *Id.*
13 42 C.F.R. § 489.24(d)(2)(i).
14 EMTALA Interpretive Guidelines, at Tag A-2407/C-2407.
15 42 C.F.R. § 489.24(f).

> (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.[16]

The CoPs affirm, however, that the right to make informed decisions "must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate."[17]

The Hospital CoPs contain fairly detailed rules governing discharge planning and discharges of hospital inpatients. Among other things:

The hospital must screen patients to identify at an early stage of hospitalization those who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.[18] This screening should ideally occur upon admission as an inpatient or shortly thereafter.[19]

If a patient is determined to need discharge planning evaluation, or if requested by the patient, the hospital must timely create and provide to the patient a discharge planning evaluation which addresses the likelihood of the patient's capacity for self-care or the need for alternative care, thereby facilitating appropriate arrangements for needed care post-discharge.[20] If the patient or their family/care giver cannot address the post-discharge needs, the hospital must determine whether there are other services available to meet the needs, *e.g., home health; hospice or palliative care; respiratory, physical, or speech therapy; pharmaceuticals and supplies; medical equipment and supplies; residential care; skilled nursing; etc.*[21]

If indicated by the evaluation, the hospital—through qualified personnel and discussion with the patient or their personal representative—must develop an appropriate discharge plan, and counsel the patient, family or other interested persons to prepare for post-hospital care.[22]

> [H]ospitals are expected to engage the patient, or the patient's representative, actively in the development of the discharge plan, not only to provide them the necessary education and training to provide self-care/care, but also to incorporate the patient's goals and preferences as much as possible into the plan. A patient will be more likely

16 *Id.* § 482.13(b)(1)–(2).
17 *Id.* § 482.13(b)(2).
18 *Id. § 482.43(a).*
19 Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 84 Fed. Reg. 51836, 51850 (Sept. 30, 2019) (to be codified at 42 C.F.R. pts. 482, 484, & 485).
20 42 C.F.R. § 482.43(a).
21 Hospital Interpretive Guidelines, at A-0806.
22 42 C.F.R. § 482.43(a).

> to cooperate in the implementation of a discharge plan that reflects his/her preferences, increasing the likelihood of a successful care transition and better health outcomes.[23]

The hospital must engage in on-going evaluation of the patient's condition to identify any changes that would require modification to the patient's discharge plan and make such necessary changes.[24]

If post-discharge care is necessary, the hospital must provide a list of participating home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF) and long-term care hospitals (LTCH) available to provide post-hospital care, disclose any financial interest in the HHA or SNF on the list, and allow the patient and/or family to choose among participating providers.[25] The hospital must also assist patients in selecting a post-hospital care provider by using and sharing relevant quality data about available providers.[26]

Upon request by the patient's physician, the hospital must arrange for the initial implementation of the patient's discharge plan.[27] In addition to providing in-hospital education/training to the patient or others who will be providing care in the patient's home, it includes:

- Transfers to rehabilitation hospitals, long term care hospitals, or long-term care facilities;
- Referrals to home health or hospice agencies;
- Referral for follow-up with physicians/practitioners, occupational or physical therapists, etc.;
- Referral to medical equipment suppliers; and
- Referrals to pertinent community resources that may be able to assist with financial, transportation, meal preparation, or other post-discharge needs.

> The discharge planning process is a collaborative one that must include the participation of the patient and the patient's informal caregiver or representative, when applicable. In addition, other family or support persons who will be providing care to the patient after discharge need to be engaged in the process. Keeping the patient, and, when applicable, the patient's representative and other support persons informed throughout the development of the plan is essential for its success. Providing them with information on post-discharge options, what to expect after discharge and, as applicable, instruction

23 Hospital Interpretive Guidelines, at A-0818.
24 42 C.F.R. § 482.43(a)(6).
25 *Id.* § 482.43(c).
26 *Id.* § 482.43(a)(8).
27 *Id. § 482.43(a)(4).*

and training in how to provide care is essential. The patient needs clear instructions regarding what to do when concerns, issues, or problems arise, including who to call and when they should seek emergency assistance. Although it may be an important component of the discharge instructions, it is not acceptable to only advise a patient to "return to the ED" whenever problems arise.

There are a variety of tools and techniques that have focused on improving the support provided to patients who are discharged back to their homes. A comprehensive approach employing combinations of these techniques has been found to improve patient outcomes and reduce hospital readmission rates, including, but not limited to:

- Improved education to patients and support persons regarding disease processes, medications, treatments, diet and nutrition, expected symptoms, and when and how to seek additional help []
- Written discharge instructions, in the form of checklists when possible, that are legible, in plain language, culturally sensitive and age appropriate;
- Providing supplies, such as materials for changing dressings on wounds, needed immediately post-discharge; and
- A list of all medications the patient should be taking after discharge, with clear indication of changes from the patient's pre-admission medications;

The education and training provided to the patient or the patient's caregiver(s) by the hospital must be tailored to the patient's identified needs related to medications, treatment modalities, physical and occupational therapies, psychosocial needs, appointments, and other follow-up activities, etc. Repeated review of instructions with return demonstrations and/or repeat-backs by the patient, and their support persons will improve their ability to deliver care properly. This includes providing instructions in writing as well as verbally reinforcing the education and training.

It is also necessary to provide information to patients and their support persons when the patient is being transferred to a rehabilitation or a long term care hospital, or to a long term care setting, such as a skilled nursing facility or nursing facility. The information should address questions such as: the goal of treatment in the next setting and prospects for the patient's eventual discharge home.[28]

28 Hospital Interpretive Guidelines, at A-0820.

The hospital must discharge, transfer, or refer patients, where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to appropriate post-hospital care service providers, suppliers, facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.[29]

> "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.[30]

The Interpretive Guidelines recognize that hospitals may have constraints on their ability to transfer or refer the patient, *e.g.,*

- 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.[31]

29 42 C.F.R. § 482.43(b).
30 Hospital Interpretive Guidelines, at A-0837.
31 *Id.*

The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include the periodic review of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that they are responsive to patient post-discharge needs.[32]

Discharge planning is not required for outpatients, including those who present to an acute care hospital emergency department and who are not admitted as hospital inpatients.[33]

Critical Access Hospitals

As of November 29, 2019, critical access hospitals (CAHs) are expected to adhere to discharge planning requirements that are nearly identical to those applicable to hospitals.[34] There are necessary differences between the regulations as a result of the challenges that are unique to CAHs, including their rural location, small size, and limited resources.[35] One such difference is that CAHs are not expected to include in a patient's discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.[36]

Medicare Discharge Appeal Rights

Medicare inpatients in a hospital (including CAHs) have the right to appeal a discharge decision to the relevant Quality Improvement Organization (QIO).[37]

No later than two days following admission, the hospital must give the beneficiary or their personal representative a copy of CMS's written notice, "An Important Message from Medicare" (CMS-R-193), advising the beneficiary of their right to an expedited appeal of the discharge decision.[38] Delivery of the notice is valid when the beneficiary or their representative signs and dates the notice acknowledging receipt. If the beneficiary or representative refuses to sign the notice, the hospital may annotate the notice to indicate the refusal.[39]

No more than two calendar days before discharge, the hospital must present a copy of the signed notice to the beneficiary or their representative prior to discharge.[40]

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32 42 C.F.R. § 482.43(a)(7).
33 CMS, ICN 908184, Discharge Planning, at 4 (2014).
34 *Compare* 42 C.F.R. § 482.43, *with id.* § 485.642.
35 Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 84 Fed. Reg. 51836, 51870 (Sept. 30, 2019) (to be codified at 42 C.F.R. pts. 482, 484, & 485.
36 *Cf.* 42 C.F.R. § 482.43(c).
37 *Id.* §§ 405.1205, .1206.
38 *Id.* § 405.1205. The "IM" form is available at *Hospital Discharge Appeal Notices,* CMS, https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html (last modified Apr. 20, 2020).
39 42 C.F.R. § 405.1205(b).
40 *Id.* § 405.1205(c).

The beneficiary may request an expedited review of the discharge decision from the QIO. If the beneficiary requests the review no later than the day of discharge, the QIO must review the discharge decision within one day after receiving pertinent information. If the beneficiary fails to timely request the review but remains in the hospital, the QIO must review the discharge decision within two days. If the beneficiary fails to timely request the review but does not remain in the hospital, the QIO must review the discharge within 30 days.[41] Additional requirements for the review are set forth in 42 C.F.R. § 405.1206.

If the hospital believes that discharge is appropriate but it cannot obtain the concurrence of the physician, the hospital may request expedited review.[42] The process for such reviews is set forth in 42 C.F.R. § 405.1208.

If the beneficiary is dissatisfied with the QIO decision but remains in the hospital, he/she may request reconsideration according to the procedures in 42 C.F.R. § 405.1204. If the beneficiary is no longer in the hospital, he/she may invoke the general claims appeal process.[43]

Joint Commission

The Joint Commission has several standards affecting discharges and discharge planning. For example:

> The hospital must respect the patient's right to participate in decisions about his/her care; however, the Joint Commission affirms that "*[t]his right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.*"[44]

Consistent with the hospital CoPs, the hospital must begin the discharge planning process early; identify post-discharge needs; and work with the patient and care team to plan the discharge and assist in arranging post-discharge services.[45] Before the hospital discharges or transfers the patient, the hospital must inform and educate the patient about his or her follow-up care, treatment and services.[46] Upon discharge or transfer, the hospital must give relevant care information to other providers who will provide post-discharge or post-transfer care.[47] The hospital must document the patient's discharge information.[48]

41 *Id.* § 405.1206.
42 *Id.* § 405.1208.
43 *Id.* § 405.1208(e).
44 RI.01.0.01 (emphasis in original).
45 PC.04.01.03.
46 PC.04.01.05.
47 PC.04.02.01.
48 RC.02.04.01.

State Law Requirements

State statutes and regulations may impose additional requirements concerning transfers, discharges, discharge planning, and documentation. Such requirements typically appear in licensing statutes and regulations, or Medicaid regulations, provider manuals, or other guidance documents. Laws concerning trespass or eviction may also become relevant when taking action against patients who refuse to leave. In North Carolina, for example, a patient who refuses to leave the hospital after two physicians certify that that the patient should be discharged commits a trespass and is guilty of a misdemeanor.[49] Hospitals should be familiar with applicable state law requirements.

Private Payers

Private payer contracts may also contain provisions relevant to transfers and discharges, including but not limited to coverage limitations; pre-authorizations; utilization review; patient appeals of coverage determination; *etc.* Providers should not only know the conditions and limits on coverage, but also resources provided by the payers to assist in explaining those limits to the insured patient and/or identifying other treatment alternatives.

THE LEGAL LANDSCAPE FOR LONG TERM CARE FACILITIES

Medicare Long Term Care Patient Rights

Skilled nursing facilities participating in Medicare and nursing facilities (NFs) participating in Medicaid must generally satisfy a number of Medicare regulations relating to discharge. For example:

To the extent practicable, competent residents must be provided with opportunities to participate in the care planning process.[50] To that end, the resident has the right to be informed of, and participate in, his or her treatment, including his/her plan of care; however, the patient does not have the right "to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate."[51]

As with hospitals, nursing facilities must develop and implement an effective discharge planning process that focuses on the resident's goals, prepares the residents to be active partners, and prepares them for effective transition to post-discharge care.[52] The process should generally begin on admission, involve ongoing evaluation and communication with the

49 N.C. Gen. Stat. § 131E-90 (2020).
50 42 C.F.R. § 483.10(b) (2020).
51 *Id.* § 483.10(c)(8).
52 *Id.* § 483.21(c).

resident and/or the resident's representatives, and consider the patients goals in transitioning to care in community settings.[53] The facility must prepare a discharge summary that includes required elements.[54]

Medicare conditions the circumstances and processes under which nursing facilities may discharge or transfer residents:

> The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
>
> (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
>
> (D) The health of individuals in the facility would otherwise be endangered;
>
> (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (F) The facility ceases to operate.[55]

The facility must properly document the bases for the transfer or discharge and forward information to the receiving provider.[56]

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53 State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, at F660 (Rev. 173, 11-22-17), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf [hereinafter LTC Interpretive Guidelines].

54 42 C.F.R. § 483.21(c)(2).

55 *Id.* § 483.15(c)(1)(i).

56 *Id.*

Before the transfer or discharge, the facility must notify the resident, the resident's representative, and state long-term care ombudsman of the transfer or discharge in writing.[57] The notice must contain certain information and be made at least 30 days before the transfer or discharge unless the health or safety of individuals would be endangered, the resident's health warrants an immediate transfer or discharge, or the resident has not resided in the facility for 30 days.[58]

If a facility transfers the resident to a hospital or the resident goes on therapeutic leave, the facility must generally allow the resident to return consistent with the Medicare rules and state bed-hold policies.[59] If the facility determines that the resident cannot return to the facility, it must comply with the rules concerning discharges.[60] As explained in the Interpretive Guidelines:

> A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on his or condition when originally transferred to the hospital. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:

- Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.
- Ascertain an accurate status of the resident's condition—this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.
- Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.
- Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:

57 *Id.* § 483.15(c)(3); *see also id.* § 483.10(g)(14).
58 42 C.F.R. § 483.15(c)(4).
59 *Id.* § 483.15(d).
60 *Id.* § 483.15(e).

- Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;
- Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

If the facility determines the resident will not be returning to the facility, the facility must notify the resident, his or her representative, and the LTC ombudsman in writing of the discharge, including notification of appeal rights. If the resident chooses to appeal the discharge, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.[61]

Medicare Discharge Appeal Rights

As with hospital inpatients, Medicare nursing facility residents must be given CMS's standard written notice of their discharge rights, prior to the discharge, including the right to appeal discharge decisions.[62] The notice must be given at least two days before the discharge. If the SNF's services are expected to last fewer than two days, the notice must be given at the time of admission.[63] The delivery of the notice is valid when the resident or their representative signs the notice. If the resident refuses to sign the notice, the provider should document same. The facility may not transfer or discharge a resident while an appeal of the discharge is pending unless the failure to discharge or transfer the resident would endanger the health or safety of the resident or other individuals in the facility.[64]

State Law Requirements

As with hospitals, many if not all states impose similar and/or additional requirements on nursing facilities through licensing acts and Medicaid regulations. The federal requirements are usually more stringent than state law provisions, but providers should review their own state laws and regulations to confirm and comply. Additional state laws may be relevant, including eviction and anti-discrimination statutes.

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61 LTC Interpretive Guidelines, at F626.
62 42 C.F.R. § 405.1200(b).
63 *Id.* § 405.1200(b)(1).
64 *Id.* § 483.15(c)(1)(i)(f).

THE LEGAL LANDSCAPE FOR RESIDENTIAL CARE/ASSISTED LIVING FACILITIES

Assisted living facilities are generally regulated by state law instead of federal law. The scope of services that the facilities may provide and the characteristics of residents who may be admitted vary by state, and are generally outlined in some form of admission agreement. Many if not most states impose requirements similar to Medicare requirements for hospitals and nursing homes, including admission and discharge criteria; pre-admission screening and periodic post-admission assessments; resident rights; notice and appeal procedures relating to involuntary discharges or termination of admission agreements; responsibilities for assisting with discharges; *etc.*[65] A few states specify the conditions for emergency placements, such as individuals being discharged from the hospital.[66] Medicaid conditions or regulations may impose requirements on participating facilities. In addition, anti-discrimination and landlord/tenant laws may apply in these settings, and may require facilities to follow formal eviction processes. Providers should be aware of the requirements in their states. The National Center of Assisted Living provides a helpful survey of state regulations.[67]

In addition to statutes and regulations, the facility's admission agreement likely includes terms relevant to admission and discharges. Although many of the terms are mandated by statute, facilities may impose additional conditions or terms that are not inconsistent with regulatory requirements. Interested entities should review and, to the extent permitted, modify the admission agreement to address anticipated concerns.

THE LEGAL LANDSCAPE FOR OTHER PROVIDERS

Other providers or community resources do or may have similar regulatory or contractual limitations affecting placement or discharges, including home health agencies, hospice, behavioral health facilities, *etc.* Providers should be familiar with these laws and standards as appropriate.

SOME PRACTICAL SUGGESTIONS

The following presents some practical suggestions for discharging patients under difficult circumstances, including discharging from physician practices. The sections covered include:

1. The patient who will not leave;
2. The patient who refuses readily available resources;

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65 *See* HHS, Office of the Assistant Sec'y for Planning & Evaluation, *Compendium of Residential Care and Assisted Living Regulations and Policy: 2015 Edition* (2015), https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition.

66 *Id.*

67 *Policy,* AHCA/NCAL, https://www.ahcancal.org/ncal/advocacy/regs/Documents/2017_reg_review.pdf (last visited Aug. 29, 2020).

3. The patient who is willing but has nowhere to go;
4. The disruptive, threatening, or noncompliant patient; and
5. Best Medicine: Prevention.

The Patient Who Will Not Leave

Discharging patients who simply will not leave when they reach objective discharge criteria can be manageable situations with thoughtful anticipation and preparation. Providers and staff should ensure all hospital Conditions of Participation and accreditation requirements regarding discharge planning and patient choice are followed. Additionally, staff should also ensure they comply with all applicable notice and appeal rights (e.g. Important Message from Medicare notices, etc.). Following those often will help patients move forward with a successful discharge. Additionally, following the requirements will ensure that the appropriate staff are involved with the discharge by identifying special needs the patient, such as a psychiatry consult. Following those processes should solve most problems. However, some patients still refuse discharge for various reasons.

Core of the Problem

The first step providers should take to move a patient towards discharge is to get at the core of the problem by determining the reason for the patient's refusal. Often the patient's basic reason for refusing to be discharged can be readily managed. Some common reasons patients refuse to leave are:

1. Patient has nowhere to go;
2. Patient feels s/he will not get adequate care at home;
3. Patient feels that s/he is not medically ready to be discharged, or there is disagreement among health care team;
4. Patient is scared or does not understand options or manner in which s/he will be cared for in an alternative setting; or
5. The surrogate decision maker does not consent to discharge because, for example, they cannot care for patient, do not like the nursing home or transitional care, the available nursing home is too far away, or prefer to have the hospital bear costs of care.

Discharge Planning

Of the proceeding list, the first and last items can prove the most challenging to overcome. The other three can be overcome through a robust discharge planning process following the

guidance from the State Operations Manual for the Conditions of Participation for hospitals[68] using competent discharge planners including social workers and nurse care managers. Providers should discuss and address discharge early on during an inpatient admission with the patient and any involved family or other caregivers for all patients in order to accustom the patient and the caregivers to the needs of the patient post-discharge and allow for them to determine where the patient will go. This also will help providers form a united front on when discharge is appropriate for the patient, which should help the patient develop confidence in the discharge plan. Providers should also involve family or others who will provide care to the patient at home after discharge early in the discharge planning process, because doing so can increase the comfort level of both the patient and the caregiver in the caregiver's ability to provide adequate care at home.

Additionally, a robust discharge planning process should include arranging for alternative care, such as long-term care, transitional care, home health services, or community resources. Part of arranging for those services includes providing the patient with information regarding the available providers for the contemplated services and sharing key performance data about those providers, including the star-rating of the facility. If star-ratings are provided to the patient, discharge planners should take the time to explain what those mean including the limitations of the rating system so that patients are not disregarding good services simply because a rating is lower.[69] Patients should understand that facilities may have a lower rating for a variety of reasons. Additionally, patients should know that going to a facility that they do not prefer does not mean they will need to stay at that facility but can go there as an interim measure while they are on a preferred facility's waiting list. Although patients may find anticipating another transfer later unappealing, a transfer likely will be more appealing than the costs of unnecessary inpatient care.

Strong Encouragement and Formal Proceedings

For those patients or family who are simply not cooperative, various actions may improve their willingness to move towards discharge. If those actions are not successful, formal proceedings to evict a patient or seek other injunctive relief can be pursued. The first step for dealing with patients of this type should be to ensure all necessary notices are given to the patient, including a notice that inpatient services are no long needed, denials of continued coverage by the patient's payer, and notices of appeal rights. Patients should then be made aware that payers almost always will stop paying once care is no longer necessary and the provider has the right to bill the patient directly for costs after notice and appeal rights. Part of this should include informing the patient or his/her personal representative of the ongoing costs s/he may incur

68 *42 C.F.R. § 482.43 Condition of Participation: Discharge Planning*, *in* State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 200, 02-21-20), at A-0799, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

69 *Five-Star Quality Rating System, CMS,* https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html (last modified Aug. 26, 2020).

for an unnecessary inpatient admission. Both steps are helpful for both encouraging patients to accept discharge and convincing a court to grant injunctive relief if necessary. Additional steps that could be taken to encourage patients is to turn off amenities as appropriate (e.g. TV, phone, etc., if allowed by rules and regulations) and stop providing services.

Surrogate disqualification and guardianship.

If the family is uncooperative with the discharge plan when the patient does not have decision-making capacity, a hospital can petition a court to disqualify the surrogate decision-maker allowing for the next in line to make decisions or seek a court-appointed guardian. A guardian might also be appointed in situations where the patient has decision-making capacity but is unable to care for themselves independently and needs ongoing post-acute care but is unwilling to consent to such care (see below on patients who refuse services). The purpose of the guardian is to help make decisions for the patient that are in the patient's best interest. If a guardianship is pursued, the duties of the guardian should be limited, such as only for discharge. Doing so may encourage potential guardians to serve in that capacity. The guardian can be involved in the discharge and transition to another facility, and then petition to be relieved. Additionally, nursing homes may want a guardian or someone who can make decisions before they will accept the patient. Hospital legal counsel should check state probate law for processes or options.

Trespass and eviction.

Some states have statutes proscribing refusal to leave a hospital that do not require following a formal process, such as North Carolina's statute on patients refusing to leave after discharge. That statute allows for the hospital to trespass a patient if two physicians review the case and are of the opinion that the patient is cured or no longer needs inpatient treatment.[70] Other state laws (or lack thereof) may allow for trespassing a patient without any formal process because, as a discharged patient, the now hospital visitor can be asked to leave as any other visitor. If the patient is trespassed, the patient should be escorted out of the hospital by well-trained security or law enforcement officers. Non-ambulatory patients or other patients who are unable to care for themselves should not be trespassed without arranging for post-discharge care because doing so is not in the best interest of the patient, is likely inconsistent with the mission of the hospital or health care system, and doing so will help the hospital avoid making local headlines for dumping patients who cannot take care of themselves on the streets[71] (see below for assisting non-ambulatory patients).

70 N.C. Gen. Stat. § 131E-90 (2020).

71 Jessica A. York, *Late-Night Santa Cruz Hospital Discharge of Nearly-Naked Homeless Man Riles Community*, Mercury News, Jan. 15, 2018, https://www.mercurynews.com/2018/01/15/late-night-santa-cruz-hospital-discharge-of-nearly-naked-homeless-man-riles-community/; Melinda Carstensen, *Patient Dumping in America: Hospitals Discharging Sick Homeless Back onto the Street,* Fox News, May 14, 2015, https://www.foxnews.com/health/patient-dumping-in-america-hospitals-discharging-sick-homeless-back-onto-the-street.

Some states may require the facility to go through an eviction proceeding prior to trespassing a patient. Legal counsel should check their state's requirements statutes or case law for removing patients by eviction, trespass, or another petition for injunctive relief.

Documentation

Documentation of all relevant facts and actions is necessary to protect the facility and providers. Documentation should include all competency evaluations and discussions relating to discharge. The medical record should include the patient's accurate medical stability at all stages to help refute claims of violating EMTALA. Any disruptive conduct should be documented either in the medical record or in some other event tracking system in order to establish that the patient exhibits a pattern of disruptive behavior. Additionally, all efforts to resolve problems should be well documented, such as prior warnings, attempts at less aggressive measures, and the patient's response to those measures.

The Patient Who Refuses Readily Available Resources

Similar to patients who simply will not leave, some patients refuse readily available resources. Those resources may either be post-acute care services or inpatient services necessary to improve the health of a patient sufficient to allow for a safe discharge. Patients with decision-making capacity can always refuse to accept care. Autonomy and self-determination have long been pillars of informed consent. However, refusal of such care can become problematic if the refusal decreases providers' ability to improve patients' health sufficient for discharge or disrupts the discharge process by preventing transitioning to a lower level of care. Managing patients who are refusing care generally follows one of two paths, the choice of which depends on the patient's ability to care for themselves.

Non–ambulatory Patients

Patients who are unable to care for themselves, either because they are not fully ambulatory or otherwise have impairments and are refusing services can be some of the most difficult to safely discharge and will likely require additional resources. These patients may be homeless or may have severe comorbidities that need ongoing management. These patients should not simply be removed from the hospital and left to manage themselves.

However, hospitals do have options with patients of this type. First, a hospital should have a mental health provider conduct a mental health evaluation to determine both the patient's decision-making capacity and whether the patient is in need of inpatient psychiatric services (i.e. the patient is suicidal and attempting suicide through refusing medical care). If the patient does not have decision-making capacity, then a surrogate decision-maker should be involved. If the patient needs psychiatric services, then an involuntary-commitment process should be started for the patient. However, both courses have drawbacks. Surrogate-decision makers can be as problematic as the patient. If so, providers should follow the guidelines above

regarding guardians or disqualifying the highest-level surrogate decision-maker. The drawback to involuntary commitment is that some states' involuntary commitment statutes do not allow for also providing medical treatment against the patient's will. However, a patient who receives mental health treatment may improve enough mentally to where they will consent to the previously refused medical care.

If the patient has capacity and does not meet criteria for involuntary commitment, Hospitals might still follow the guardianship process for their state. In Utah, the definition of "incapacitated" in the probate code includes adults who are "impaired to the extent that the individual lacks the ability, even with appropriate technological assistance, to meet the essential requirements...[to] provide for necessities such as food, shelter, clothing, health care, or safety."[72] Statutes such as this can be used to petition a probate court to appoint a guardian even for patients who have capacity. The threat of seeking a court-appointed guardian may be enough to encourage the competent patient to follow providers' recommendations.

Ambulatory Patients

Patients who are ambulatory and able to care for themselves should be managed similarly to a patient who is leaving against medical advice. If the patient is refusing any treatment that requires inpatient admission, the patient should be informed that unless s/he consents to the treatment, the hospital will no longer be able to treat the patient and the patient no longer requires inpatient admission and, consequently, will be discharged. The discussion and refusal should be carefully documented. If the hospital utilizes a form for refusing treatment that describes the treatment and the risks of not receiving the treatment, the form should be presented to the patient and included with the discharge paperwork. If the patient refuses to leave after discharge, then the patient should then be handled as a patient who simply refuses to leave.

In these situations, however, providers should be willing to discuss with patients all options for ongoing rehabilitative treatment and not remain focused on the best treatment option that the patient is refusing. There may be treatment options to which the patient may be willing to agree that will improve the patient's health sufficient for transferring or discharging the patient.

The Patient Who Is Willing but Has Nowhere to Go

Some patients are willing to comply with discharge but for various reasons there is not a safe discharge option. Those reasons can include caregivers refusing to take the patient back, patient has no home or their home is unsafe, the patient requires services that are not available in the community, the patient requires help at home but no one is available to provide needed care, or the patient just is unable to get to the next care setting if not transferring by ambulance.

72 Utah Code Ann. § 75-1-201(22) (2020).

Involving Family/Guardians

If patients in these circumstances have family members, guardians, or others with responsibility for the patient's care, those legally responsible persons should be included in the post-acute care planning. If the legally responsible persons refuse to accept the patient or cooperate in an appropriate plan of care, hospital and providers may seek relief through their state's abuse or neglect statutes and contacting the appropriate state office.[73] Additionally, hospitals and providers may seek court action to compel the responsible person to act. However, there may be situations in which the family or caregiver is unable to provide required care, requiring the hospital to look to other options.

Long-Term Care Bed Hold

If the patient came to the hospital from a long term care facility, the care facility may be obligated to take the patient back under applicable bed-hold policies.[74] However, those facilities may have chosen to not hold beds, which will require the hospital to find another facility to which the patient can go for ongoing care.

Transportation and Hotel

Hospitals may consider arranging for transport of the patient for care in another setting. After ensuring the hospital is complying with patient inducement requirements,[75] it may provide funds for a taxi, bus pass, or other travel to the next care setting or to a homeless shelter. Additionally, the hospital might consider paying for a hotel room for a limited period while the patient makes further arrangements if it can do so within a patient inducement safe harbor.

Community Programs

Many cities have successfully established transitional care facilities, respite care programs, and recuperative care programs.[76] They provide various support services, including meals, clothing and hygiene, education, transportation, case management, counseling, housing referrals, job training, and other services. Hospital case management staff should be well acquainted with the various community resources available to patients who do not have a place to go but need ongoing care.

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73 Utah's definition of "Neglect" in its Adult Protective Services Program includes "failure of a caretaker to provide necessary care, including...medical, or other health care for a vulnerable adult" and "knowing or intentional failure by a caretaker to carry out a prescribed treatment plan that causes or is likely to cause harm to the vulnerable adult." *Id.* § 62A-3-301(21).

74 *See* 42 C.F.R. § 483.15(d) (2020).

75 OIG finalized a safe harbor for local transportation. Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Safe Harbors Under the Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 81 Fed. Reg. 88368, 88379 (Dec. 7, 2016) (to be codified at 42 C.F.R. pts 1001, 1003), https://www.federalregister.gov/d/2016-28297/p-139.

76 Jennifer Joynt, Cal. HealthCare Found., No Place to Go: Addressing the Challenge of Homeless Patients in Sacramento (2006), https://www.issuelab.org/resources/10434/10434.pdf.

Subsequent Care

If the patient has a place to go but lacks resources for follow-up care, case management should be aware of any free or sliding scale clinics in the area that can provide the needed care and arrange for the patient to be seen at the clinic. Case management can also help determine if the patient qualifies for home health services and arrange that care. If the patient does not qualify for home health, other arrangements can be made to bring patients back for follow-up care in an outpatient setting or explore telehealth options. The hospital may consider paying for or subsidizing care in another setting subject to a fraud and abuse analysis and review of anti-supplementation rules concerning nursing facilities.[77] Additionally, case managers can work with the patient's health plan to develop a creative solution. The health plan may be willing to pay for uncovered services if doing so keeps the patient out of the hospital.

Sue the State

Finally, the hospital may consider a lawsuit to require the state to provide care in the community.[78]

The Disruptive, Threatening, or Noncompliant Patient

Often disruptive, threating, or noncompliant patients are not ready for discharge; however, their actions create an environment where a therapeutic relationship can no longer be maintained requiring the patient's discharge. These situations are encountered beyond just inpatients. Physician practices may also find it necessary to discharge disruptive, threatening, or noncompliant patients. In any case, these situations require providers, case managers, or practice managers to have some difficult conversations with the patient and then discharge them with clear reasons for the discharge. It is in the provider's best interest, whether hospital or physician practice, to have a solid process for managing these patients in order to protect providers and staff, limit liability, and curtail ongoing problems.

Behavior/Treatment Agreements

In the hospital setting, when patients are exhibiting behaviors that disrupt the therapeutic relationship or interfere with their care, providers, whether themselves or through risk management or social work, should discuss with the patient the ramifications of the continued behavior. One option that can be used to facilitate this discussion is a behavior or treatment agreement. Such an agreement can serve multiple purposes. First, it puts in writing the unacceptable behaviors the patient is exhibiting. Sometimes patients do not realize that their behavior is not acceptable and seeing it in writing can help them recognize the inappro-

77 OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832, 56846 (Sept. 30, 2008); 42 U.S.C. § 1395cc(a) (2020); 42 C.F.R. § 489.20.

78 *See* Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (ADA Title II requires states to provide care for persons with mental disabilities in the community wherever possible rather than in an institutional setting).

priateness of it. Second, having the parameters necessary for ongoing treatment in agreement form sets boundaries and encourages the patient to follow it. Although s/he may choose to not abide by it, the patient is clearly informed of the ramifications of not complying. Finally, it serves as documentation of the discussion and the patient's awareness of the steps taken prior to discharge.

Physician practices or other outpatient settings can also benefit from behavior agreements. Those agreements can be tailored to the outpatient setting, placing limits on inappropriate conduct, limiting how patients interact with the clinic (e.g. limiting the number of calls made in a day, proscribing emailing to personal email addresses, contacting staff via social media, etc.), requiring certain follow-up with other providers, and other necessary actions the patient needs to do or not do in order to maintain a productive therapeutic relationship. When the agreement is presented, the discussion should have more than one representative from the clinic with the patient for safety and corroboration purposes. Additionally, those situations should also be carefully documented for the same reasons stated above in the hospital setting.

Medication Management Agreements

When patients begin requesting more refills of medications subject to abuse, providers sometimes begin to fear that their patient is becoming medication-dependent and want to just discharge the patient in order to avoid dealing with a medication-dependent patient. Providers who prescribe medications subject to abuse can use a medication management agreement that outlines acceptable behaviors the patient must follow in order for the provider to continue prescribing medications subject to abuse and the ramifications for not complying. Providers should define the clinical reasons when such agreements are presented, such as when the patient requests a refill. Consistently following the defined clinical reasons can help providers avoid profiling patients, which can lead to further problems. Additionally, providers must also do what they say they will do in the agreement in order to avoid liability in using medication management agreements. A court might find the provider liable for medical malpractice or a jury may find that the provider violated his/her own standard of care for not following his/her own prescribing policies when prescribing medications subject to abuse and something happens to the patient related to the medications.

Discharge

If discharge is necessary because the patient continues to be disruptive, threatening, or noncompliant, then providers must follow the requirements for appropriately withdrawing from the care of the patient to avoid claims of patient abandonment. Each state may have differing requirements or penalties, so counsel should become familiar with their state's requirements. The discharge discussion should be clear, and, if in an outpatient setting, followed by a letter that outlines a specific period during which the provider will continue to provide care including refilling prescriptions, advise the patient to find another provider with

information on who to contact to find a provider, and inform the patient how to obtain his or her medical record.

Noncompliance after Discharge

Some discharges from an inpatient setting may occur at the appropriate time, but the patient is unlikely to be compliant with follow-up care. For example, typically patients who have been treated inpatient for IV antibiotic therapy can be discharged with a PICC line in place to facilitate continued IV antibiotic treatment either through outpatient care or home care. However, known IV drug users may use the port to inject narcotics once outside the hospital, potentially creating liability for the hospital and providers. Or an indigent or undocumented patient who receives dialysis inpatient likely will not seek follow up outpatient dialysis but will rather wait until s/he is at the point that they need to return to the emergency department for dialysis.

In these situations, hospitals should become creative and involve community resources to help patients in these difficult circumstances. For example, arrangements can be made for IV drug users to be discharged to a rehab center or other place designed for addiction recovery where the patient can be monitored for appropriate use of the PICC line. Or the line can be pulled with specific requirements for returning for treatment. Otherwise, the patient may need to remain in the hospital until the course of IV antibiotics is complete. Options should be explored for unfunded patients needing expensive outpatient follow-up care, such as dialysis or infusion therapy, because those treatments will likely cause the patient to come back to the emergency department if the patient does not follow through. Those options could include setting up a payment plan for outpatient dialysis or help arranging for funding.

Best Medicine: Prevention

Community Partnerships

Hospitals, long term care facilities, and outpatient clinics can help themselves avoid many of these difficult discharges through some preventative work. Depending on available resources, providers can work with the community to develop transitional care facilities or resources. Providers and community leaders may identify and grow community resources, such as long-term care, assisted living, or community health centers to help with patients who are not ready to go home or their home is not suitable for discharge. To address the needs of the homeless population, community leaders can develop recuperative care, respite care[79], shelters, clinics, and mental health clinics. In the wake of a few embarrassing discharges of homeless people from area hospitals, communities in California have implemented collabora-

79 *See* Steven Ross Johnson, *Shelter for Convalescence: Hospitals Link with Respite Programs to Aid Homeless Patients Through Recovery,* Mod. Healthcare, Mar. 22, 2014, http://www.modernhealthcare.com/article/20140322/MAGAZINE/303229937.

tive programs with health systems that can serve as a model for other communities. Additionally, California has enacted legislation that requires hospitals to have "a written homeless patient discharge planning policy and process" that places certain requirements on the hospital for preparing for discharge, ensuring the patient has safe place to where s/he can be discharged, and coordinating with area services for homeless.[80]

Develop an Effective Discharge Program

Providers can also develop an effective discharge program involving social work, discharge planners, providers, and nursing that can decrease the burden of difficult discharges. Providers should expend the resources to train or hire discharge planners that can better facilitate care transitions. Involving social workers early when patient concerns arise can help providers understand and address patient concerns. Discharge planners can also help plan for discharge from the beginning by confirming the patient's situation, such as competency, payer source, homelessness, and post-discharge resources. Discharge planners can consider the transition plan early so that the hospital can begin making arrangements and plans before time of discharge. Social work and nursing can educate and prepare patients or surrogates for discharge from the beginning to help them better prepare. They can also answer questions patients have so patients can better understand their medical condition, which may reduce fear. Social work, nursing, and discharge planners can establish patient responsibilities up front and delineate acceptable conduct. They can also involve supporting services as early as appropriate, such as community programs that may assist during admission or post-discharge, social service programs, substance abuse programs, or housing programs.

Assist in Obtaining Financial Assistance or Insurance

Providers should obtain patient's source of payment or subsistence early. Providers can facilitate signing patients up for Medicaid, VA benefits, SSI, SSDI, or other payer programs that may enable the patient to cover necessary ongoing care after discharge. Similarly, providers should be knowledgeable about how to obtain food stamps, cash assistance, and other social program assistance. Additionally, providers can assist in obtaining insurance while being mindful of the limits on paying insurance premiums. While considering these options for financial assistance available to patients, providers should also account for managing undocumented patients who may not be eligible for some programs.

Inpatient Admission

Subject to EMTALA, providers should be aware of admitting potential problem patients as inpatient. Admitting a patient as an inpatient may limit a hospital's ability to transfer a patient

80 Cal. Health & Safety Code § 1262.5 (2020). *See also* Lois Richardson & Peggy Broussard Wheeler, Cal. Hospital Ass'n, Discharge Planning for Homeless Patients (2018).

under EMTALA. Additionally, admission triggers discharge rights. Providers can prepare processes to assist admitting physicians in determining if inpatient care is the best option for some patients. Alerts can be created in the electronic health record and attached to patients as appropriate that notify providers of violent or abusive patients and the patient's prior acts that can help inform providers on how to interact with these patients. The alerts should be designed in a manner that informs but does not stigmatize. Having this information can help providers determine if care in some other setting is more appropriate or allow hospitals to begin preventative measures, such as beginning with a behavior agreement up front.

Preventing Readmissions

Hospitals should look at the long term and consider that patients who are not properly cared for are likely to return to the facility. Hospitals should coordinate with the emergency department and primary care physicians to avoid the revolving door.

Ethics Committees

Bioethics (depending on the facility may be a committee or a single ethicist) can assist patients, families, and providers in negotiating some of the difficult ethical, interpersonal, and communication dilemmas involved with difficult patients and difficult discharges, and help determine ethically permissible outcomes. Bioethics can analyze the situation from an ethical perspective and provide recommendations or confirmation and support for difficult choices. Bioethics can also help with communication issues and dispute resolution. If facilities end up developing a policy to try to address some of the issues involved with difficult patients, it can be helpful to have bioethics weigh in to address potential ethical issues up front. Finally, if a care provider does end up in litigation with one of these situations, a bioethics consult can help both as evidence of the process that was followed in arriving at the conclusion providers did, and to validate the ultimate decision.

CONCLUSION

The difficult discharge situations discussed above often leave hospitals and other health care providers struggling to find a solution that satisfies their legal, moral, and business obligations. Too often, providers are left on their own to do the best they can without an adequate legal framework or community resources to help. Until the law changes, providers should work proactively with the patient, the patient's caregivers, and community partners to address potential problems in advance, including defining and documenting expectations and identifying or developing potential resources to assist patients post-discharge. Sadly, in the case of patients who are incompetent or otherwise unable to care for themselves, the problems will continue until communities come up with a more wholistic plan for caring for the mental and physical needs of the patients beyond simply sending them to the local hospital.

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