

ALLIANT QUALITY KIDNEY COLLABORATIVE



GUIDE TO COMPLETING THE INVOLUNTARY DISCHARGE (IVD) PROCESS

This document contains vital information pertaining to the Involuntary Discharge (IVD) process as outlined in the Centers for Medicare & Medicaid Services End Stage Renal Disease (ESRD) Facilities Conditions for Coverage. Please read carefully and refer to the document *General Guidelines for the Involuntary Discharge Process* before completing this document.

A dialysis facility MUST:

- Notify the ESRD Network at least 30 days **prior to** the discharge.
- Complete this entire packet on all involuntary discharges **prior to** the discharge and submit to the appropriate ESRD Network:
 - In cases of immediate **and severe threat**, submit the completed packet **within 48 hours** of the incident/discharge.
 - In cases of non-payment of fees, ongoing and disruptive behavior, facility ceases to operate, and/or facility can no longer meet patient's medical need, submit the completed packet **within the first two (2) business days** after you have given (or mailed) a patient your facility's 30-day-notice of discharge letter. Example: If the patient's discharge letter has the date of May 15, you should submit the completed packet to the Network within two (2) business days of May 15.
- Retain a copy of this completed packet in the patient's medical record.

§ 494.180 Condition: Governance

(f) Standard: Involuntary Discharge and Transfer Policies and Procedures

The governing body must ensure that all staff follows the facility’s patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred unless:

- (1) The patient or payer no longer reimburses the facility for the ordered services;
- (2) The facility ceases to operate;
- (3) The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs.
- (4) The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the facility medical director ensures that the patient’s interdisciplinary team:
 - (i) Documents the reassessments, ongoing problem(s), and efforts to resolve the problem(s), and enters this documentation into the patient’s medical record;**
 - (ii) Provides the patient and the local ESRD Network with a 30-day notice of the planned discharge;**
 - (iii) Obtains a written physician’s order that must be signed by both the medical director and the patient’s attending physician concurring with the patient’s discharge from the facility;**
 - (iv) Contacts another facility, attempts to place the patient there, and documents that effort; and**
 - (v) Notifies the State Survey Agency of the involuntary discharge or transfer.**
- (5) In the case of an immediate and severe threat to the health and safety of others, the facility may utilize an abbreviated involuntary discharge.

Network 8	Network 14
Alabama, Mississippi, Tennessee	Texas
(601) 936-9260	(972) 503-3219

TO AVOID A SECURITY INCIDENT, DO NOT EMAIL THIS INFORMATION TO THE ESRD NETWORK. MAIL or FAX ONLY.

Involuntary Discharge Checklist for Dialysis Facilities

If you have made the decision to involuntarily discharge a patient complete the attached information to ensure compliance with the Conditions for Coverage. **Remember:** The ESRD Network requires this documentation for all involuntary discharges. Be aware that your submitted documentation is the only paper evidence of the situation. **This information is to be completed and faxed to the Network PRIOR to discharge or within 48 hours of an immediate discharge.**

Demographic Information

Patient Name _____ Date of Birth _____

First Date of Dialysis _____ Gender _____ Race _____

Insurance Provider _____

Facility Provider Number: _____

Name and title of person completing this form **(please print):** _____

Facility telephone number _____ Facility Fax Number _____

Name of Facility Medical Director _____

Name of Patient's Attending Physician _____

Name of Facility Administrator _____

Involuntary Discharge Information

Date of Last Treatment _____ Date Facility Notified Network _____

Date Facility Notified the State Survey Agency _____ **(Attach copy of incident form.)**

Date patient was notified of Discharge _____ Date of Anticipated Discharge _____

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Part II: MENTAL HEALTH ASSESSMENT

Mental Health Problem/Diagnosis Reported: Yes No

If yes, provide explanation and/or diagnosis (attach physician documentation)

Chemical Dependency/Abuse Reported: Yes No

If yes, provide explanation and/or diagnosis (attach documentation)

Cognitive Deficit Reported: Yes No

If yes, provide explanation and/or diagnosis (attach physician documentation)

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Part III: PATIENT'S DISPOSITION

(Where will the patient dialyze immediately after discharge?)

- Admitted to another Outpatient Facility
- Patient in Correctional Facility
- Patient Died
- Patient Transplanted
- Not Admitted to another Outpatient Facility – Other – Comment _____
- No Outpatient Facility Accepts – Hospital Acute
- No Outpatient Facility Accepts – Other – Comment _____
- Unknown

Part IV: REQUIRED DOCUMENTATION

	Date Sent to Network office:
<input type="checkbox"/> Patient discharge letter or transfer notice	/ /
<input type="checkbox"/> Police Report <i>(if applicable)</i>	/ /
<input type="checkbox"/> Facility's discharge and transfer policy/procedure	/ /
<input type="checkbox"/> Facility's patient rights and responsibilities document	/ /
<input type="checkbox"/> Documentation of Medical Director approval	/ /
<input type="checkbox"/> Documentation of facility's inability to meet patient's medical need <i>(if applicable)</i>	/ /
<input type="checkbox"/> Copies of patient's interdisciplinary reassessments <i>(if applicable)</i>	/ /
<input type="checkbox"/> Documentation of ongoing problem and efforts to resolve	/ /
<input type="checkbox"/> Medical Director and Attending Physician's signed order	/ /
<input type="checkbox"/> Documentation of efforts to relocate patient	/ /
<input type="checkbox"/> Documentation of facility notifying State Survey Agency of discharge	/ /
<input type="checkbox"/> Other: _____	/ /

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Part V: CROWNWEB ENTRY

When reporting an involuntary discharge in CROWNWeb, please remember to report the “discharge reason” as “Involuntary.” Do not list the reason as “Discontinue”, “Other” or “Transfer.” If you have submitted an involuntary discharge packet to the Network, you should still report the discharge reason as “Involuntary” even if you know that a patient was accepted at another dialysis facility.

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Part V: STATE SURVEY AGENCY CONTACT INFORMATION

Alabama	Division of Health Care Facilities Al. Dept. of Public Health 201 Monroe St., Ste. 600 Montgomery, AL 36104	334-206-5075 Fax: 334-206-5088
Mississippi	Health Facilities Licensure MS State Dept. of Health P.O. Box 1700 Jackson, MS 39215	800-227-7308 Fax: 601-364-5050
Tennessee	Division of Health Care Facilities	East TN: 865-594-9396 Fax: 865-594-5739 West TN: 731-984-9684 Fax: 731-512-0063
Texas	TX Department of State Health Services Regulatory Licensing Unit Facility Licensing Group Delivery Code 2835 PO Box 149347 Austin, TX 78714-9347	888-973-0022 Fax: 512-834-4514

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