Mental Health Emergency Center		
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Scope: ☒ Mental Health Emergency Center (MHEC)		

ADMISSION, TRANSFER AND DISCHARGE

POLICY STATEMENT

It is the policy of the Medical Staff to ensure the following guidelines for admission, transfer and discharge of patients are consistently observed. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. ADMISSION

1.1 Generally

A patient may be admitted to the Medical Center only by a Practitioner who possesses admitting privileges. A patient seeking admission to the Medical Center who does not or cannot designate his or her choice of an admitting Practitioner shall be referred to the Medical Staff Member on call who shall then arrange for appropriate care.

1.2 Determination of Admission Status.

Prior to admitting a patient to the Medical Center, the admitting Practitioner must conclude that the admission is medically necessary and determine whether the patient should be admitted as an inpatient or an outpatient. Medicare does not recognize a separate patient status called "observation;" therefore, all Medical Center patients admitted for "observation" services must be admitted as outpatients.

1.3 Admission Order.

All Medical Center inpatients must be admitted upon the recommendation of a Physician.[1] The admitting Practitioner must enter an admission order that includes the following:

(a) admission diagnosis(es) and reason(s) for admission;

(b) admission status (inpatient or outpatient)

[1] Wis. Admin. Code DHS § 124.05(2)(g)1 (2016).

(c) name of the admitting Practitioner; and

(d) name of the attending Physician (as applicable).

1.4 Admission Note.

For each Medical Center inpatient, within twenty-four (24) hours of admission, the admitting or attending Practitioner shall complete an admission note which includes:

(a) a concise statement of the patient's complaints, including the chief complaint, and the date of onset and duration of each;[2]

(b) the reason(s) for admission for care, treatment, and services, including the patient's initial diagnosis(es), diagnostic impression(s), or condition(s);[3]

(c) treatment goals and the plan of care (plans of care and discharge plans should be initiated immediately upon admission and be modified in the progress notes as patient care needs change); and

(d) any information related to the patient's condition, including but not limited to alcohol or drug use or mental illness, as may be necessary to assure the protection of other patients, Medical Center personnel and Medical Staff Members from patients who maybe a source of danger to themselves or others.

If an admission note is entered by an Advanced Practice Clinician, refer to The Advocate Aurora Health ("AAH") Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

1.5 Responsibility of the Admitting Practitioner.

Until care is transferred to another Practitioner, the admitting Practitioner shall remain responsible for: (1) the care and treatment of the patient at the Medical Center; (2) the prompt completion and accuracy of those portions of the medical record for which he or she is responsible; (3) the provision of necessary special instructions; (4) and the transmission of reports regarding the patient's condition to the patient, the referring practitioner (if any), and the patient's representatives (if any).

1.6 Transfer of Care.

Transfer of care shall not be effective until the transferring Practitioner has communicated with, and documented in the patient's medical record the acceptance of, the Practitioner assuming responsibility for the patient's care.

1.7 Frequency of Patient Attendance.

In order to ensure timely care and treatment of all Medical Center inpatients, the attending Practitioner must come to the Medical Center and evaluate his/her patients as soon as reasonably possible after admission. As a general guideline, for patients admitted from the Emergency Department to an inpatient unit, the attending Practitioner should evaluate the patient within twelve (12) hours of admission. After the initial visit, all Medical Center inpatients should be seen on at least a daily basis by the admitting or

[2] Wis. Admin. Code DHS § 124.14(3)(a)2 (2016).
[3] Wis. Admin. Code DHS § 124.14(3)(a)5 (2009).

attending Practitioner, or his or her designee. These timeframes are guidelines, and certain circumstances will require greater urgency.

1.8 Order of Priorities for Admissions

The following order of priority will be used for the admission of patients:

(a) Emergency Admission**.** Admission of a patient whose condition is such that probable serious harm will occur to the patient if intervention is not initiated and the patient is not admitted within twenty-four (24) hours or less.

(b) Urgent Admission**.** Admission of a patient with an acute, but not life or limb threatening condition, evaluated as stable but requiring therapeutic intervention within forty-eight (48) hours or less.

(c) Routine Admission**.** Elective admission involving all services.

(d) Observational Care Admission**.** An admission initiated when the attending Practitioner needs an extended time to evaluate an outpatient's medical condition in order to determine the need for inpatient admission. An observational care admission permits high intensity service for a short duration of time, generally less than forty-eight (48) hours. Observation status is based on specific criteria.

1.9 Continued Stay.

The admitting or attending Practitioner must ensure that the medical record contains documentation explaining the need for ongoing hospitalization in accordance with the MHEC Utilization Review Plan and the AAH Medical Records Policy.

2. TRANSFER[4]

2.1 Transfer of Care to an Alternate Provider within the Medical Center.

Refer to Section 1.6 above.

2.2 Transfer to Another Medical Facility.

Refer to Section 3.6 below.

3. DISCHARGE[5]

3.1 Discharge Planning.

The admitting or attending Practitioner's decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer of his/her patients must be based on the assessed needs of the patient, regardless of the recommendations of any Medical Center internal or external review process.[6] The admitting or attending Practitioner may

[4] JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3) (Jul. 2015).
[5] JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3) (Jul. 2015).
[6] JCS LD.04.02.05, EP 1 (Jul. 2015).

request a discharge planning evaluation, and the Medical Center will perform the evaluation upon request. In addition, the admitting or attending Practitioner shall cooperate with the Medical Center's discharge planning staff to:

(a) Identify any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer;

(b) Include the patient, the patient's family, Practitioners, clinical psychologists, and other staff involved in the patient's care, treatment, and services in planning for the patient's discharge or transfer;

(c) Assist in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services; and

(d) Provide the patient and the patient representative information regarding:

i. why he or she is being discharged or transferred;

ii. any alternatives to transfer or discharge;

iii. the types of continuing care, treatment, and services the patient will need after discharge; and

iv. how to obtain any continuing care, treatment, and services that the patient will need.

3.2 Discharge Order.

A Medical Center patient may be discharged only after a discharge order from the patient's attending Practitioner is entered into the medical record.

3.3 Discharge Instructions.

The admitting or attending Practitioner must ensure that the patient or his/her patient representative receives appropriate written discharge instructions.

3.4 Discharge Summary.

(a) Generally. The admitting or attending Practitioner is responsible for ensuring that a Discharge Summary is entered or dictated within fourteen (14) days after discharge. If a Discharge Summary is dictated more than twenty-four (24) hours prior to the patient's actual discharge, the admitting or attending Practitioner must ensure the Discharge Summary is updated as necessary. The admitting or attending Practitioner may delegate the completion of the Discharge Summary to another qualified Practitioner or an Advanced Practice Clinician, if such other Practitioner or Advanced Practice Clinician is knowledgeable about the patient's condition, the patient's care during hospitalization, and the patient's discharge plans. If the admitting or attending Practitioner delegates the completion of the Discharge Summary to another qualified Practitioner or Advanced Practice Clinician, the admitting or attending Practitioner must verify the content of the Discharge Summary and co-sign and date the Discharge Summary.[7]

[7] CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).

(b) Inpatients (more than 48 hours inpatient stay). The medical record of each Medical Center inpatient who is discharged after an inpatient stay of forty-eight (48) hours or more must contain a Discharge Summary, which includes:

i. date of discharge;

ii. definitive final diagnosis(es) expressed in the terminology of a recognized system of disease nomenclature;[8]

iii. reason(s) for the patient's admission/registration and transfer or discharge;

iv. significant findings and complications (if any);

v. summary of the care, treatment and services provided (including the procedures performed, treatments rendered, the outcome(s) of such procedures and treatments and progress towards goals);

vi. condition of the patient upon discharge (including the patient's physician and psychosocial status) stated in a manner that allows specific comparison to the patient's condition upon admission/registration;[9]

vii. the method of transport (if any);

viii. provisions for follow-up care (including any post-hospital appointments, how post-hospital patient care needs are to be met, plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living facilities, and community resources or referrals made or provided to the patient); and

ix. any other specific instructions given to the patient and/or the patient's representatives upon discharge (e.g., activity, diet, medications, follow-up care, etc.).[10] If no discharge instructions were required, the discharge summary shall indicate as such.

(c) Inpatients (less than 48 hours stay). The medical record of each Medical Center inpatient who is discharged after an inpatient stay of less than forty-eight (48) hours and each Medical Center outpatient who underwent a procedure requiring anesthesia services must include a Discharge Summary. Such Discharge Summary may be abbreviated, but at a minimum must include: (i) the outcome of the treatment(s) or procedure(s) provided; (ii) the disposition of the case, including the patient's condition; and (iii) any recommended follow-up care or instructions.[11] The final progress note may serve as the Discharge Summary if it contains the elements described in this Section.

[8] 42 CFR § 482.24(c)(2)(viii) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)13 (2016).
[9] 42 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).
[10] Wis. Admin. Code DHS §§ 124.14(3)(a)14 (2016).
[11] 42 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).

(d) Patient Who Leave Against Medical Advice. If a patient leaves the Medical Center against medical advice, document the circumstances in the patient's medical record and refer to the AAH policy on informed refusal.

(e) Death. In the event of a patient's death, please refer to the AAH Autopsy Policy.

3.5 Discharge/Transport from the Emergency Department.
For standards and documentation requirements related to Emergency Department patients discharged to home or transported to a non-Medical Center facility, refer to Medical Center's EMTALA Policy.

3.6 Discharge/Transport from Medical Center.
Medical Center patients may be discharged and transported to another non-Medical Center facility if the Practitioner ensures that:

(a) the receiving facility has the capability to manage the patient's condition;

(b) the receiving facility has consented to the admission and appropriate transfer arrangements have been made;

(c) the patient is considered sufficiently stabilized for transport; and

(d) All pertinent medical information necessary to ensure continuity of care accompanies the patient to the receiving facility (including a Discharge Summary that includes the elements set forth in Section 3.4).

3.7 Objections to Discharge.
Medicare patients have the right to appeal a discharge that the patient considers premature.[12] Should a competent patient leave the Medical Center against the advice of the attending Practitioner or without proper discharge, a notation of the occurrence shall be made in the patient's medical record. The patient must be asked to sign a form acknowledging departure against medical advice and releasing the attending Practitioner and the Medical Center and its employees and officers from all liability that may arise as a consequence. If it is clear that the patient refusing treatment lacks decision-making capacity, it may be necessary to obtain guidance from a court before discontinuing treatment or allowing the patient to refuse treatment or to self-discharge against medical advice. Therefore, in such event, consultation with Medical Center counsel should be obtained.

REFERENCES:

Federal Regulations

- 42 CFR § 482.13 (a) (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.24(c)(2)(vii-viii) (Interpretive Guidelines, effective October 17, 2008).

Wisconsin Statutes

- Wis. Stat § 146.37 (2016).

[12] 42 CFR § 482.13 (a) (Interpretive Guidelines, effective October 17, 2008).

Wisconsin Administrative Code

- Wis. Admin. Code DHS § 124.05 (2016).
- Wis. Admin. Code DHS § 124.14 (2016).
- Wis. Admin. Code DHS § 124.20 (2016).
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FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL:

BOARD OF DIRECTORS APPROVAL: