Prosser
Memorial Health

SUBJECT:	Hospital Admission Policy	NO:	

☒ Policy ☐ Procedure ☐ Protocol/Pre-Printed Order ☐ Other:

☒ New ☐ Supersedes # ;		Effective Date	5/21/2021
Author	M. Fuller, CNO/COO	Date of Electronic Distribution	5/21/2021
Dept. Manager	Acute Care and FBP	Medical Director/ CAH Oversight	
Administrative	K. Mellema, CQO	Policy Committee	
Committee		Other	

Audit Review:	Initials:						
	Date:						

PURPOSE: The mission of Prosser Memorial Health (PMH) is to improve the health of our community. To this end, hospital admission is based on medical necessity. No patient will be denied admission or care based on race, color, national origin, creed, religion, age disability, sex (birth or re-assignment), sexual orientation, or gender identity. Every patient seeking care will be treated with dignity and respect, and afforded all other patient rights detailed by the Washington State Department of Health (WADOH) and the Centers for Medicare and Medicaid Services (CMS).

POLICY:

A. **Admission –** All patients may only be admitted by a physician or Advanced Level Partitioner (ALP) who has been granted admitting privileges by the PMH Medical Staff and Board of Commissioners, and only to the extent privileges have been granted.
B. **Responsibility –** The admitting provider has the responsibility to oversee care of the patient until an appropriate provider to provider hand off has occurred. The hospital has the responsibility to provide care and services under the providers direction.
C. **General Consent** – A general consent will be obtained prior to admission. The general consent allows the patient to consent to low-risk treatment and procedures during admission (i.e. physical assessment, diagnostic testing, Intravenous fluids, etc.).
D. **Informed Consent** – Informed consent will be required and obtained before any invasive or high-risk procedures. The patient must be provided an explanation of the procedure, risks and benefits, and any alternative treatment options.
E. **Inability to Obtain Consent –** In the event the patient is unable to provide consent and a surrogate decision maker is not available, consent for emergency treatment will be implied.
F. **Advanced Directive** – The patient will be asked if they have an advanced directive at the time of admission or offered assistance in developing one if not already completed. The patients advanced directive will be entered into the Electronic Medical Record to ensure is readily available to all providers of care.
G. **Financial information** – The patient will be provided all financial notifications required by CMS. Assistance in understanding, applying for, and obtaining a financial assistance will be provided upon request (including charity care). When ever possible patients will be provided cost estimates prior to admission and upon request.
H. **Care partners** – The patient and family/support people (designated by the patient) will be considered members of the care team. Information and explanations will be provided as needed, and participation in joint decision making and care planning will be facilitated.

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I. **Education and Information -** All information needed by the patient and patient designated support system to understand and participate in care will be provided. To include but not limited to the following:
    1. Patient Rights
    2. Patient Handbook
    3. Visitor policy
    4. Orientation to the room, call light, whiteboard, fall prevention, Rapid Response Team Activation, and all other appropriate safety measures.
    5. Food service and any dietary restrictions.
    6. The name and role of all care providers.
    7. Departmental staff in accordance with WADOH regulations.
    8. How to access interpreter services.
    9. Access and utilization of ambulatory aids as indicated.
    10. Care plan customized to the patients needs.
    11. New medications and potential side effects.

J. **Bed placement –** Bed placement will be determined by the patients care needs. Single occupancy rooms are not always available. The decision to cohort patients will take into consideration the patients' gender, care needs, risk of infection, and orientation. To the extent possible, patients without infection will not be roomed with patients with a known contagious infection (i.e. MRSA, COVID-19, etc.).

K. **Admission Status –** The patients admission status (Inpatient, Observation, Outpatient, or Swing Bed) will be determined by CMS criteria as outlined by InterQual. This criterion takes into consideration the patient's intensity of service and severity of illness.

L. **Discharge Planning –** Discharge planning begins on admission as the patient's history, physical assessment, social support, home environment, and activities-of-daily living are evaluated to anticipate any discharge support needs. An interdisciplinary team (provider, nurses, pharmacist, respiratory therapists, social services, case management, dieticians, and rehab therapists) will collaborate with the patient and family to establish as successful discharge plan. The patients history & physical, discharge summary, and medication list will be provided to the patient and the next provider of care at discharge.

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SUBJECT:	Outpatient Orders: Privileged and Non-privileged Providers	NO:	345-0017

☒ Policy ☒ Procedure ☐ Protocol/Pre-Printed Order ☐ Other:

☒ New ☐ Supersedes # ;	Effective Date	08/14/2019

Author	M. Fuller, CNO/COO	Date of Electronic Distribution	08/14/2019
Dept. Manager	Marla Davis, Director	Medical Director/ CAH Oversight	MEC Approval 8/7/2019
Administrative	M. Fuller, CNO/COO	Policy Committee	
Committee		Other	

Audit Review:							
	Initials:	mf					
	Date:	5/2021					

PURPOSE:

To ensure compliance with the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) in regard to who may order outpatient services at Prosser Memorial Health.

POLICY:

A. Outpatient Services at Prosser Memorial Health may be ordered (and patient may be referred for hospital outpatient services) by a practitioner who is:
   1. Responsible for the care of the patient;
   2. Licensed in, or holds a license recognized in the jurisdiction where the practitioner sees the patient:
   3. Acting within the practitioner's scope of practice;
   4. Has not been excluded from participation in any federal or state health care program;
   5. This includes both practitioners who are privileged by the Prosser Memorial Health Medical Staff and non-privileged providers who satisfy the hospital's polices for ordering applicable outpatient services and for referring patient for hospital outpatient services.

B. Orders for the following types of Outpatient Services will **not** be accepted from non-privileged practitioners:
   1. Orders from practitioners not licensed in the United States (such as Canada or Mexico).
   2. Invasive procedures requiring moderate sedation or above.
   3. Orders regarding immediate family members.
   4. Inpatient or Observation patient orders.
   5. Opioid administration of any kind, without review and approval by a privileged member of the Medical Staff.
   6. Administration of chemotherapy and blood transfusions without review and approval by a privileged member of the Medical Staff.

7. Orders related to obstetrical complications identified during routine outpatient diagnostic procedures; such as ultrasound, biophysical profiles, or non-stress testing.

C. Orders for non-formulary/non-stock supplies or costly medications/supplies may require pharmacy &/or administrative review to ensure the service can be provided to the patient prior to the order being accepted.

D. Pre-authorization may be required for outpatient procedures and will be the responsibility of the ordering provider to obtain.

E. Patient self-referrals for outpatient diagnostic testing is allowed where applicable under federal or state law:
   1. Medicare allows for the self-referred screening mammograms based on age and frequently requirements. Patients presenting for self-referred screening mammograms will be requested to provide a personal provider name for results but no order is required.
   2. Speech Therapy, Massage Therapy and Physical Therapy may be self-referred under Washington State Law.

DEFINITIONS:

A. **"Outpatient Services"** shall mean those therapeutic services (e.g. physical therapy or wound care) or diagnostic services (e.g. laboratory or imaging services) provided by Prosser Memorial Health, either at the hospital or a clinic site.

B. **"Order"** for the purpose of this policy, shall mean an order for Outpatient Services that satisfies regulatory compliance and organizational policy. At a minimum orders must include:
   1. Date of order;
   2. Patient name;
   3. Test or service being ordered;
   4. Serial orders must include a start and stop date, but may not exceed 12 months;
   5. Diagnosis or reason for service;
   6. Licensed practitioner signature;
   7. Verbal orders be given orally by a licensed practitioner to an RN or LPN. Verbal order should be used infrequently and must be authenticated by the ordering provider within 30 days.

C. **"Practitioner"** shall mean a doctor of medicine (MD), doctor of osteopathy (DO), doctor of dental surgery (DDS), doctor of podiatric medicine (DPM), doctor of optometry (OD), chiropractor (DC), physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), or certified nurse midwife (CNM), provide that such person holes a license to practice recognized by the jurisdiction where he or she saw the patient.

D. **"Non-privileged Practitioner"** shall mean a practitioner who has not been privileged or credentialed by the Prosser Memorial Health Medical Staff.

E. **"Critical Value"** shall mean values determined by the Prosser Memorial Health Medical Staff to require results to be immediately reported to the ordering provider so as to ensure timely and appropriate follow up with the patient.

PROCEDURE:

A. Orders for outpatient services may be submitted electronically via EPIC, by fax, or in writing. (Orders not originated in the EPIC EMR will be scanned into the media tab of the patients EMR record).
B. Orders requiring pre-authorization should have authorization submitted with the outpatient order.
C. Non-privileged providers will have their licensure confirmed and be checked against the Office of Inspector General (OIG) exclusion listed in accordance with hospital policy and procedure.
D. Laboratory procedures, plain film x-rays, and ECG's will be accommodated on a walk in basis with presentation to the hospital or clinic admission areas.
E. Diagnostic Imaging and Cardiopulmonary procedures will be scheduled via the Prosser Memorial Health Call Center or department scheduler(s).
F. Procedures to be completed in the Outpatient Special Procedures Department (OSP) (i.e. IV therapy, wound care, pre-surgical hospitalist consults, blood products, and medication injections) may be scheduled by calling (509-303-0818) and faxing (509-786-7228) the Outpatient Special Procedures (OSP) unit.
G. Medication orders will be reviewed by a pharmacist prior to administration via the EPIC EMR.
H. Incomplete or unclear orders will be clarified with the ordering practitioner prior to the procedure being completed.
I. Patients experiencing an adverse reaction or complication during an outpatient procedure will be evaluated and treated in the Emergency Room. The ordering provider must be notified of the patient complication and a new order obtained prior to a subsequent procedure being completed.
J. Critical values will be called to the ordering provider in the timeframe determined by the Medical Staff. If unable to reach the ordering provider or designated back up provider, the patient will be contacted and referred to the Prosser Memorial Health Emergency Department for evaluation.

REFERENCES:

Center for Medicare and Medicaid Services (CMS), (February 2018). *Provider compliance tips for ordering hospital outpatient services.* Retrieved May 21, 2019, from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforOrderingHospitalOutpatientServices-ICN909405.pdf

Center for Medicare and Medicaid Services (CMS), Office of Clinical Standards and Quality/Survey & Certification Group. (February 17, 2012). *Referring Practitioners Ordering Outpatient Services in Hospitals.* Retrieved May 21, 2019, from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter12_17.pdf

SUBJECT:	Swing Bed Admission Criteria	NO:	607-0006
☒ Policy ☐ Procedure ☐ Protocol/Pre-Printed Order ☐ Other:			
☐ New ☐ Supersedes #607-0006; 09/05/2005		Effective Date	11/09/2010
Author	Karen Livezey	Date of Electronic Distribution	11/09/2010
Dept. Manager	Mary Ella Clark, RN	Medical Director/ CAH Oversight	
Administrative	Merry Fuller RN	Policy Committee	
Committee		Other	

Audit Review:		sc	S. CARR	mec	TG	shm	tlt
	Initials:	sc	S. CARR	mec	TG	shm	tlt
	Date:	01/2012	04/25/12	03/19/14	3/04/15	08/19/16	03/09/18
Audit Review:	Initials:	CRH	JP				
	Date:	3/22/19	11/17/20				

PURPOSE: To define parameters to place a person into a swing bed designation.
Swing bed designation is used for short-term skilled nursing care or skilled rehabilitation services. The expected length of stay shall be less than 100 days.
Swing bed designation shall not be used for non-skilled or custodial care services.

ELIGIBILITY CRITERIA:

Financial requirements: Needs to meet one of the following:

Medicare
- Enrolled in Medicare Part A
- Has benefit days available to use
- Three day qualifying acute inpatient admission
- Within 30 days of discharge from an acute care facility
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

Medicaid (co-pay)
- Enrolled in Washington State Medicaid program
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.
- If admitted from home, pre-authorization needs to be obtained from DSHS Home and Community Services Caseworker

Private pay with or without secondary insurance
- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

Private (commercial) Insurance
- Pre authorization

- Qualifying medical condition
- Requires daily skilled nursing services or skilled rehabilitation which can only be provided in a skilled nursing facility or swing bed.

DEFINITIONS:

Qualifying condition
Requires and receives daily Skilled Nursing Services &/or Skilled Rehabilitation Therapies

- Daily in terms of skilled nursing requires skilled nursing care 7 days/week
- Daily in terms of skilled rehab therapies may be translated to 5 days/week if the services are not available 7 days per week and skilled rehab is the only reason for admission.

Skilled nursing and/or skilled rehabilitation services are services that:

- Are ordered by a physician
- Require the skills of a qualified technical or health professional
- Must be provided directly by or under the general supervision of skilled personnel to ensure patient safety and achieve desired results
- May require skilled personnel to perform or supervise because of special medical conditions

Practical Matter
As a "practical matter" the services can only be provided on an inpatient basis in a Swing Bed or Skilled Nursing Facility. The following may be used as requirements for designation for practical matter:

- Individual's condition
- Availability of other types of services
- Feasibility of using other types of services
- Excessive physical hardship
- Less economical
- Less efficient or effective
- Limited support system