

A STUDY TO PROPOSE A MODEL TRANSFER AGREEMENT BETWEEN
COLUMBIA HOSPITAL OF RICHLAND COUNTY, COLUMBIA,
SOUTH CAROLINA AND RIKARD NURSING HOMES,
LEXINGTON, SOUTH CAROLINA

APPROVED BY THE U. S. SCHOOL:

[Signature]
Director of the Program

APPROVED BY THE THESIS COMMITTEE:

A Problem Solving Thesis

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirement for the Degree

of

Master of Hospital Administration

APPROVED BY THE GRADUATE COUNCIL:

By

[Signature]
Lieutenant Colonel Leroy M. Barber, Jr., MSC

DATE: August 17, 1972

Waco, Texas

August 1972



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APPROVED BY THE U. S. ARMY MEDICAL FIELD SERVICE SCHOOL:

Shepard, Director, Long-Term Care, ...
for the assistance and the support ...

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Carolina. Additional recognition is extended to Dr. R. F. Charles, Jr.,
Earl Huddle, ...

APPROVED BY THE THESIS COMMITTEE:

Griffin, James Shown, and Carroll Pickney, who are all members of the
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Special recognition is given
generous time from a very busy schedule ...
duty must greatly assist the patient ...

The owners of the Edward ...
Dean of Columbia Hospital, Glenn B. ...

APPROVED BY THE GRADUATE COUNCIL:

Sincere gratitude is expressed ...
remainder of the family, who ...
during this endeavor.

William G. Island
Dean of the Graduate School

DATE: August 19, 1972

ABSTRACT

A STUDY TO PROPOSE A MODEL TRANSFER AGREEMENT BETWEEN
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University in Partial Fulfillment of the Requirements
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Lieutenant Colonel Leroy M. Barber, Jr., MSC

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University of Michigan, Ann Arbor, Michigan 48108.

This study undertook to provide a model transfer agreement between the Columbia Hospital of Richland County, Columbia, South Carolina and the Rikard Nursing Homes, Lexington, South Carolina.

Data was gathered by means of interviews, personal observation, and a review of pertinent literature.

The study included the mechanics of extended medical care and some of the practical problems in the implementation of this concept. Three approaches to, and the type of, transfer agreement were discussed. It was concluded that the best arrangement between these two institutions would be a new agreement containing detail and specifics.

A recommended agreement was included in the study as an appendix.



TABLE OF CONTENTS
ACKNOWLEDGMENTS

ACKNOWLEDGMENTS 11

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Special recognition is given to Katherine Richardson for her generous time from a very busy schedule. Her initiative and devotion to duty must greatly assist the patient care effort at Columbia Hospital.

The owners of the Rikard Nursing Homes and the acting superintendent of Columbia Hospital, Glenn D. Searcy, cordially opened the doors of their facilities, thereby making this study possible.

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A. PROPOSED TRANSFER AGREEMENT 40
B. PROPOSED TRANSFER AND RETURNAL RECORD 48
BIBLIOGRAPHY 50

CHAPTER I

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	11
Chapter	
I. INTRODUCTION	1
General Information	1
Organization History and Setting	1
Conditions Which Prompted the Problem	2
Statement of the Problem	4
Limitations.	4
Definitions.	4
Methodology	6
Review of the Literature	6
Footnotes.	7
II. DISCUSSION	8
The Need for Extended Care	8
The Mechanics of Extended Care	11
The System at Columbia Hospital	15
Problems in the System	16
A Transfer Agreement	26
The Present Transfer Agreement	30
Available Alternatives within the Framework of the Existing Transfer Agreement between Columbia Hospital and Rikard Nursing Home.	32
Summary.	35
Footnotes	35
III. CONCLUSION	37
Conclusions.	37
Recommendations	38
APPENDIX	
A. PROPOSED TRANSFER AGREEMENT	40
B. PROPOSED TRANSFER AND REFERRAL RECORD	48
BIBLIOGRAPHY	50

CHAPTER I

INTRODUCTION

General Information

The rising cost of providing health care in the United States has become a matter of grave concern, not only to providers but also to government officials, third-party payers, and the general public. Those responsible for health care delivery have realized that imagination and innovation will be required to find solutions to this problem. One such idea is the concept of extended medical care facilities.

Organization History and Setting

Columbia Hospital

In 1892, the Columbia City Union of the International Order of King's Daughters organized the Columbia Hospital. Over the years, the hospital has expanded to its present 500-bed capacity. It is the Richland County hospital and is located in the center of downtown Columbia. The hospital is divided into two main buildings. A new \$24 million facility is approaching its final stages of construction. Upon completion, it will have 600 beds. Since the new hospital is only a few blocks from the present site, the move will have no noticeable effect upon location.

Rikard Nursing Homes

Disenchanted as a social worker, Mrs. L. L. Rikard took over the operation of the former Lexington County Home in 1949. With the motto, on January 1, 1967, with the Title XVII amendment to the Social Security Act. One portion of the amendment required a written transfer agreement

"The Home That Cares", Rikard Nursing Homes of Lexington are today the largest in the Southeast. There are 275 extended-care, 44 intermediate, and 75 custodial beds in the homes. Although Rikard provides all levels of long-term care, only the extended-care portion was considered in this study.

The Rikard Nursing Homes were selected for this study by the South Carolina Hospital Association and the South Carolina Nursing Home Association because of their established reputation of excellence. The nursing home staff prides itself upon the fine physical facilities, the beautifully kept grounds with thousands of blooming flowers, and the cheerful attitude of the employees toward patients.

The home under consideration is located seventeen miles (thirty minutes driving time) from the hospital. It is further than any of the other extended care facilities utilized by Columbia Hospital. In fact, most are located within two or three miles from the hospital. The distance involved is one major reason for selecting the Rikard Homes for the study.

The Hospital Association and the Nursing Home Association felt that if the disadvantage of distance between these two facilities could be overcome, such an agreement could be readily adopted between the hospital and other facilities.

Conditions Which Prompted the Study

The extended-care concept is relatively new. It really began on January 1, 1967, with the Title XVIII Amendment to the Social Security Act. One portion of the amendment required a written transfer agreement

between hospitals and extended-care facilities. As a result, most of these agreements were hastily prepared. The inclusion of many of those detailed objectives and procedures which would have been considered, if experience and time had permitted, was therefore neglected. There have been several changes to the original legislation with respect to eligibility and reimbursement procedures. Those involved in the daily routine administration have made alterations by telephone agreements, but have not revised the original contracts. Discussions with personnel working with patient transfers revealed a lack of information that such a contract even existed. It is felt this shortcoming was due to the changes which have had a tendency to blot out previous agreements and personnel turn-overs through the years. Further interviews with those associated with the programs revealed a general agreement that it was time for a reappraisal based on experiences, and amendments to legislation.

A transfer agreement between the Columbia Hospital and Rikard Nursing Homes was executed on September 16, 1966. The acting superintendent, Mr. Glenn Searcy, of the Hospital and the Nursing Home business manager, Mr. John Cothran, felt that a review and perhaps a revision of the transfer agreement were long overdue. Their contract was one which had been prepared in anticipation of the Title XVIII Amendment to the Social Security Act. Since that time, much had been written on the subject and they themselves had learned a great deal from practical experience. They both agreed their contract was outdated and they were no longer operating on a daily basis under these written agreements.

Statement of the Problem

The problem is to prepare a model transfer agreement for patients from Columbia Hospital, Columbia, South Carolina to Rikard Nursing Home, Lexington, South Carolina.

Limitations

Although there are nearly 400 beds in the three sections of the Rikard Nursing Homes, only the 275 in the extended-care section will be considered in this study.

Definitions

The following is a list of definitions pertinent to further discussion of this study.

Long-term care.--

1. Ambulatory and ancillary care are those elements and degrees of assistance necessary to permit the patient to ambulate to the maximum degree of physical ability and mental motivation.¹

2. Extended Care is that needed for the patient during the immediate post acute phase. Since the services provided are a continuation of the acute phase, medical diagnostic and treatment resources are necessary but at less regular intervals than the acute phase.²

3. Sedentary continued care consists primarily of the provision of bodily care to the patient who to a large extent is bedridden and who for the most part has profited from the acute service in the extended care service.³

Long-term care facilities.--

1. Extended-care facility (ECF) is established with an organized medical staff and a continuous nursing service which provide comprehensive inpatient care (which is usually postacute hospital care), for the most part, of relatively short duration and to serve convalescent patients who are not in an acute episode of illness or who are in a stable stage of illness and who have a variety of medical conditions.⁴

2. Nursing care facility is established with a medical staff or medical staff equivalent and with continuous nursing service under professional nurse direction. These facilities usually provide long-term inpatient care (not necessarily post-hospital) to patients having a variety of conditions requiring service.⁵

3. Resident care facility is established to provide safe hygienic sheltered living for residents not capable of or desiring fully independent living. These furnish regular but not continuous medical and nursing service. Also, they furnish continuous supportive, restorative, and preventive health service.⁶

Reasonable cost.--All necessary and proper costs incurred in rendering the service, subject to principles relating to specific items of revenue and cost. This term is used by the Social Security Administration and the third-party payers to determine payment for hospital and extended-care services. The payer, after an audit of the facility's books, determines the actual cost to that institution to provide patient care on a daily basis. The payer then reimburses the facility that amount of money

plus a percentage (usually around five per cent for depreciation and/or profit). The reimbursement rates are not the same because construction equipment, operating costs, and profits vary.

Retroactive denial.--The procedure whereby a third-party payer refuses to pay for services it feels were unwarranted, such as an excessive number of patient days in a given facility.

Methodology

The research methods used for this study consisted mainly of semistructured and unstructured interviews. In depth discussions were held with many people involved with the problem. In an effort to obtain a full range of ideas, concepts, and suggestions both those groups who were closely associated with the situation, as well as those who were only remotely associated, were brought into the dialogue on an individual basis. Those interviewed included members of the South Carolina Hospital Association and the South Carolina Nursing Home Association, hospital administrators, nursing home administrators, a utilization review committee chairman, nurses, personnel involved in the day-to-day administration of the extended-care concept, and, of course, the patient. Thus, although an extensive research of the literature was made, this paper will rely primarily upon the knowledge and the ideas of the people involved in extended medical care.

Review of the Literature

Because the extended-care concept is still in its infancy, there is very little written on the subject in book form. Most of the books

found provided information on construction, organization, and operation of extended-care facilities but did not go into details on transfer agreements.⁷ The notable exception to this rule was a paperback book published by the American Medical Association. It contained an excellent model for establishing a transfer agreement.⁸ One must consider, however, that an agreement should be written for two particular agencies and that a model, no matter how outstanding it is, should be used as a guide to the specifics.

In contrast to the few books written on extended care, there have been numerous articles written for periodicals on the subject. These articles referred to transfer agreements only in general terms and usually just to the need for one. This is not to say that the periodicals were not pertinent to this study. Quite to the contrary, they will be used extensively in later chapters.

Footnotes

¹Harold N. Willard, "Long Term Care", Hospitals, XLIII (April 1, 1969), 135.

²Ibid.

³Ibid.

⁴"Joint Commission Revised Standards", Hospital Management, CV (March, 1968) p 77.

⁵Ibid.

⁶Ibid.

⁷Dulcey B. Miller, The Extended Care Facility: A guide to Organization and Operation (New York: McGraw-Hill Book Co., Blakiston Division, 1969), p 88.

⁸American Medical Association, The Extended Care Facility: A Handbook for the Medical Society (Chicago: American Medical Association, Department of Hospitals and Medical Facilities, 1967), p 132.

CHAPTER II

DISCUSSION

The Need for Extended Care

Construction costs

The cost of building a new hospital today in the United States is approximately \$60,000 per bed and \$30,000 per bed for hospital additions,¹ as compared to \$17,000 as the cost of construction for a new extended-care bed.² At the present time, there is no hope for any relief in this area. On the contrary, all construction costs are increasing and are expected to continue that trend. Many communities have been shocked that the hospital which they have been planning for the past several years now costs several million dollars more than the original estimate because a year or two had elapsed. In spite of the fact that there is a national shortage of hospital beds, one health care leader has declared that a moratorium on the construction of acute care beds could be made if extended-care facilities could be built and properly utilized where needed.³

Operational costs

Not only have construction costs increased, but employee wages have increased proportionately. In previous years, hospitals were not subject to minimum wage laws, nor were their employees unionized. Now federal legislation requires all hospitals to pay the minimum federal wage, and many are unionized. As an example, a porter who made \$38.50

a week ten years ago, now makes \$143.50.⁴ With today's cost of living, this employee is not likely to be completely satisfied with his salary. Hospital employees still tend to be underpaid when compared to other industries. Hospital wage problems are compounded at the higher skill levels by the shortage of registered nurses. However, it has been found that extended-care patients require 3.3 hours per patient day of nursing care, compared with 4 hours in the hospital. More important however, is that the extended-care facility can effectively operate with a 30 percent/70 percent ratio of professional/nonprofessional care, while the hospital requires a 60 percent/40 percent relationship.⁵

Patient costs

On a national level, hospital costs are approaching \$100 a day and are expected to exceed that figure by 1973.⁶ The average cost for extended care is approximately \$20 per day. The charge for a semiprivate room at the Columbia Hospital ranges between \$41 and \$44.50 per day as compared to a maximum rate of \$13 per day at the Rikard Extended Care facility. Other extended-care rates in the Columbia, South Carolina area go up to \$17.50 per day for a semiprivate room.

It has been estimated that, if hospitalizations in 1969 could have been shortened by only one day, it would have meant a reduction of one billion dollars in health care costs.⁷

Third-party payers

In South Carolina, the Medicare program is administered for the United States Government through a private insurance agency (Blue Cross/Blue Shield) while Medicaid is the responsibility of the State Welfare

Department. Both Medicare and Medicaid presently demand that hospitals discharge their patients as soon as acute skilled nursing care is no longer needed. A close watch is maintained over this requirement by a detailed analysis of the patient's records. A doctor's statement that his patient requires acute care must be substantiated by detailed clinical records. If it is determined that a patient has been retained in a hospital longer than necessary, that hospital is retroactively-denied payment by Medicare or Medicaid.

Blue Cross/Blue Shield directors have advised that they will initiate the same policy for their insurance plan effective April 1, 1971. The Blue Cross subscribers' contract already authorizes two days of extended care for each remaining day of hospital care authorized. An extensive advertisement of this fact on local television and other news media is already in progress.

Summary of extended-care needs

The United States government and medical insurance agencies are among those who have concluded that a progressive patient care system is a means of providing the same level of care at a substantially reduced cost. The government has written extended-care requirements into law, and, as discussed earlier, medical insurance firms are doing the same. In fact, the requirements for South Carolina Blue Cross extended care are patterned after Medicare. The rapidly accelerating costs of constructing and operating hospital beds have forced the adoption of an alternative to unnecessary hospital stays. Hospitals and extended-care facilities

which have experienced retroactive denials have learned the hard way that hospital stays which cannot be fully substantiated do not get reimbursed. Although this lesson is costly, it is not easily forgotten. Hospital administrators are quite sensitive about this problem and they have been quick to spread this lesson learned throughout the health care industry.

It is a logical and a safe conclusion that the extended-care system is here to stay. It is a tried and proven means of reducing medical costs.

The Mechanics of Extended Care

The Social Security Administration has defined eligibility for extended care and an extended-care facility and the conditions of participation for such an institution. Since this defined eligibility and conditions of participation have served as a model which others have followed, they will now be explained.

Extended Care Eligibility. Services in an extended care facility are covered only after an individual has been transferred from a hospital in which he was a patient for not less than three consecutive days before his discharge. An individual is deemed to have been transferred from a hospital to an extended care facility within fourteen days after discharge from such hospital.⁸

An extended-care facility is an institution (or a part of an institution) which has in effect a transfer agreement with one or more hospitals and which:

- (1) is primarily engaged in providing to inpatients
 - (A) skilled nursing care and related services for patients who require medical or nursing care, or
 - (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

- (2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
- (3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;
- (4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;
- (5) maintains clinical records on all patients;
- (6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed in paragraph (2), and has at least one registered professional nurse employed full time;
- (7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- (8) has in effect a utilization review plan which meets the requirements of subsection (k);
- (9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and
- (10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863);

 9

The extended-care facility must be physically separate from the rest of the institution, i.e. it must represent an entire physically identifiable unit consisting of all the beds within that unit such as a separated building, floor, wing, or ward. It is not required that the distinct part be identifiable as a separate unit within the institution, it does not have to be confined to a single location with that institution's physical plant. For example, the ECF may consist of several floors or wards which are scattered throughout several buildings within the institution complex. In each case, however, the patients of the distinct part

must be located in units which are physically separate from those units housing all other patients of the facility.¹⁰

The term "extended-care services" denotes those services and that care provided an inpatient of an extended-care facility, except where otherwise specified, to include:

- (1) nursing care provided by or under the supervision of a registered professional nurse;
- (2) bed and board in connection with the furnishing of such nursing care;
- (3) physical, occupational, or speech therapy furnished by the extended care facility or by others under arrangements with them made by the facility;
- (4) medical social services;
- (5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the extended care facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;
- (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and
- (7) such other services necessary to the health of the patients as are generally provided by extended care facilities; excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.¹¹

A utilization review plan applicable to those services furnished by the extended-care facility must provide:

- (1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;
- (2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the

hospitals and extended care facilities in the locality, or (ii) (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or extended care facility where, because of the small size of the institution, or (in the case of an extended care facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations it is impracticable for the institution to have a properly functioning staff committee for the purpose of this subsection.¹²

A written agreement for the transfer of patients between a hospital and an extended-care facility (or a written undertaking in the case of sole ownership of both institutions) shall be considered effected if there is reasonable assurance that:

- (1) transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician; and
- (2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.¹³

Thus, according to the requirements set forth by the Social Security Administration, a Medicare patient is to be moved to an extended-care facility if he no longer requires acute care but still needs

skilled nursing service. A utilization review committee is to be established in each hospital to insure this procedure takes place. Because of retroactive denial, hospitals have found it necessary to rigidly enforce the utilization plan. In theory, their patient goes from the hospital to the extended-care facility while maintaining continuous, comprehensive medical care.

The System at Columbia Hospital

The focal point for the transfer of a patient from the Columbia Hospital to an extended-care facility is the Medicare office. This office is located in the administrative section of the hospital and is staffed by a very capable hospital employee. The patient's physician makes the decision that his patient no longer requires acute hospital care. At this point, the doctor usually discusses the situation with the patient and the family. They may decide on the institution. They may even make the necessary arrangements, to include transportation. More often, however, they leave the details up to the hospital, including the selection of an appropriate facility. The doctor then personally contacts the Medicare office, or he may request the ward supervisor to do it for him. The Medicare office then ascertains the necessary facts concerning the patient. Sex, illness, medication, and financial status are determined. The Medicare office contacts the nursing homes to determine bed availability and acceptability of the patient. The necessary arrangements for hospital discharge and transportation to the new facility are accomplished.

The Medicare office maintains close contact with the hospital wards and the utilization review committee. Rounds are made each day by a representative of the Medicare office in order to maintain continuous communication with the ward supervisors. In this way, it is possible to get a listing of anticipated discharges along with some informational facts. The same procedure is accomplished with the chairman of the utilization review committee, except that it is sometimes difficult to maintain daily contact because of his busy schedule.

Because the Medicare office is aggressive in its approach to the problems of transferring patients to extended-care facilities, the operation is efficient. The anticipation of difficulties before they occur is a big factor in its success.

Problems in the System

Under-utilization

Plainly stated, extended-care facilities are not being used as intended. Patients who could be discharged or transferred to one of these facilities are remaining in hospitals. It is estimated by some that as many as one-third of those in a hospital could be transferred. Harry K. DeWitt, President and Chief Executive Officer of American Hospital Supply, states that "our hospitals are 40% [sic] filled with half sick—the long term recovery stroke victims, patients with arthritic spines, and accident victims. These are people who need care but not acute care".¹⁴ An examination of the causes of this under-utilization reveals several reasons, which will be explored at this time.

Attitude of the patient and the family.--Many extended-care facilities are located in nursing homes, and those that are not have been mentally placed in that category by the general public. As far as the patient is concerned, it is a nursing home which has not changed since yesteryear, and consequently it is no more than a place where old people go to die. This concept is manifested in the form of pressure which is applied to the physician by the family and the patient to remain in the hospital. These attitudes are further complicated by a genuine lack of understanding as to program benefits and eligibility requirements.

The prevailing health-care-is-a-right attitude enters into the picture, especially if the patient has paid a premium for coverage. Under these conditions, the patient feels he has a right to remain in the hospital. In contrast, there have been occasions when physicians have transferred patients into extended care only to have payment denied on the basis that nursing care was not required. Such a phenomenon is critically referred to as the "ambulance cure" by members of the nursing home industry because the patient is allegedly the recipient of a mystical remedy during the ride to the extended-care facility.¹⁵ The problem is further compounded when the patient or his family receive a bill from the ECF when they had been told by hospital officials that the stay would be covered by an applicable insurance program. These families can easily become embittered and initiate, through gossip, misconceptions concerning extended care.

In the past, many nursing homes were poorly managed and dirty and not very pretty places to live. Additionally, many were fire traps

which resulted in the deaths of thousands of nursing home inhabitants. Most people are unaware of the strict laws and social pressures which have reversed this deplorable situation over the years.

Attitude of the physician.--The emergence of the extended-care concept has brought about a change in the pattern of practice of medicine. This system is one which the doctor himself did not propose, and this is one of the reasons he is against it. Interviews with several physicians revealed that the majority of those who enter the field of medicine do so because of its freedom and independence, and this concept of extended care is an encroachment upon this freedom. There is a great deal of paperwork associated with the treatment of patients where there is a third-party payer. The justification for treatment, hospitalization, and extended care is required in detailed, written specifics. The fact that the doctor says, "I think the patient should remain in the hospital for another few days", is not sufficient according to the third-party payees who examine the medical records of each patient in detail. He then feels as if his word as a doctor is not good enough, and he does not like it. Additionally, there are many physicians who either lack the courage to confront, or do not want to offend, the patient and/or his family and therefore knuckle under to an insistent desire to remain in the hospital.

When Medicare and extended care first began, the hospitals left it up to the doctor to get his patient transferred to a nursing home. At that time, there was a shortage of extended-care beds, so the physician or his nurse had to make several calls. If his patient was on welfare, matters

were even more complicated because the approval of that agency was required before the patient would be accepted in an extended-care facility. This was a time-consuming and lengthy process. There were many cases in which, in order to accomplish the transfer in less than six weeks, the doctor had to contact personally some influential person in the agency. As can be expected, the physicians, since they were not really in favor of the program, found it easier and less traumatic simply to keep the patient in the hospital. The physician was rarely hurt by this procedure because for some unknown reason he has been paid for all his services by Medicare. Payment was denied for that period of hospitalization which could not be justified. As a result, it was the hospital which usually absorbed the cost unless collection could be made from the patient.

The regulations and the administrative requirements for Medicare, Medicaid, and medical insurance, with respect to hospitalization or extended care, are detailed, lengthy, varied, complicated, and, in some instances, contradictory. Physicians, therefore, occasionally make honest mistakes in handling their patients. They are chagrined and angry when payment for their service is later refused. General practitioners, especially, and other physicians now require their nurse assistants to be well versed in the ramifications of the programs. Others anticipate the future need for an administrative assistant, as well as a nurse in their offices, as an expert in this field.

It is estimated that approximately 14.5 per cent of the general hospitals in the country has a hospital-based, extended-care facility in

operation.¹⁶ Accordingly, for the majority of cases, the physician must go to another facility to see his patient. Many doctors consider this a significant imposition upon their already cramped schedules. Materially, this problem increases with the distance between institutions. In the case of Columbia Hospital and Rikard Nursing Home, most physicians transfer their responsibility to the nursing home with the patient.

A study conducted by the Medical Care Research Center of Washington University, St. Louis, Missouri, claims that physically separated, long-term care facilities that do not provide easy access to other hospital areas are not conducive to high-quality patient care. Another study by the University of Wisconsin concluded that the physical relationship of the hospital to the long-term care facility influenced transfer of patients, administrative organization, staffing, and physician services.¹⁷ Although there is no factual evidence to validate this type of conclusion to the extended-care facility, health care planners, who advocate hospital-based extended care are using such assumptions for their arguments.

Should a doctor retain responsibility to the extended-care facility for the patient, he is authorized reimbursement for only one visit per week. A majority of doctors interviewed feel they must visit their patients more often, especially with the number of liability cases in the courts today.

The view from the hospital

Hospital administrators are becoming extremely cost conscious for several reasons. Endowments as a source of income have steadily

decreased over the years. As previously discussed, labor costs have increased tremendously within the past decade. In an effort to counteract these forces the administrators are attempting to operate their facilities in the most efficient way possible and to reduce the number of payments due the hospital. They are thus caught in the squeeze when a third-party payer refuses to pay the hospital because a patient was kept there too long by his physician. Some administrators recommend that third-party payers likewise deny payment to the doctor in these cases as a drastic cure to the problem. These administrators feel that the patient's physician and his peers on the utilization review board are either lax in their duties or are deliberately defying the system. In either case, it is the hospital that loses money. They furthermore charge doctors with retaining in the hospital those patients classified as "interesting or educational" rather than transferring them.

Nursing homes sometimes refuse to accept certain categories of patients. One nursing home, for example, will not admit the patients of a certain doctor because past experience dictates that the doctor "unloads" patients not authorized extended care. Hospital administrative personnel, therefore, have to shop or hunt for a facility which has a vacancy and which will accept the patient. One community in northeast Ohio has overcome this problem by the establishment of an agency to monitor extended-care beds. An existing operating unit, in this case, the county chronic illness center, was used to keep costs down. Extended-care facilities report beds available by various types (male, female,

or either) to the illness center. This information is then made available to the hospitals.¹⁸

Hospitals have had to hire additional help to manage the extended-care system. As discussed earlier, a specialist in this area, although a luxury in the doctor's office, is an absolute necessity in the hospital. Thus, another personnel cost is added to the hospital budget.

In spite of the national shortage of hospital beds, it was claimed by an interviewee that some hospitals operate far below their bed capacity. In such cases the administrator encourages the physicians to keep their patients in the hospital rather than transferring them. It has already been noted that the physicians are not eager to move the patients. The administrator and the physician team up to provide revenue for the hospital. Of course, the physicians must ensure the patient records are maintained in such a manner that the hospital will in fact be reimbursed.

The view from the extended-care facility

Both hospitals and long-term care facilities are deeply concerned with the procedures for reimbursement. As explained earlier, payers pay on an operational cost basis. Those administrators who operate their facilities in an efficient manner are extremely bitter about this system. They charge the operational cost system encourages waste and inefficiency. In some locations, neighboring facilities vary in reimbursements received by more than \$20 per day because of the cost differences in hospital

operation. Such inequities tend to cause hard feelings and resentment toward the system. Additionally, the institutions do not know the exact amount they will be paid because it all depends upon the yearly audit. During a given year, they receive compensation based upon the previous year's accounts. If, at the end of the current operating year, it is found that costs were lower than those for the previous year, then the facility is required to return money in the form of credit to the payer. Conversely, if there is a substantial increase in costs, it means the institution has had to bear this burden for an entire year without remuneration. Administrators claim extreme hardship in operating with a system of such financial uncertainty. As a result, some nursing homes refuse to accept those patients under a plan with which they have had collection problems. Discussions with long-term care facilities revealed that at one time they considered a boycott of all Medicaid patients. A physician stated that even now some facilities claim to be full when a hospital attempts to transfer a specific type of patient.

The administrative overhead has similarly been increased in the nursing homes. Additional personnel have been hired to handle the paperwork. The facilities used to keep their own books but now must hire accountants to do this for them. The Rikard Nursing Homes business manager stated this one requirement added an additional cost of approximately \$5,000 per year.

When the Medicare legislation was passed, most of the nursing homes enlarged their extended-care units in anticipation of an increased

workload. In addition, there were many new facilities constructed. Big name corporations invested large sums of money in chain-type building. Their planning was predicted upon the assumption that doctors, patients, and hospitals would use the system as intended. When this failed to materialize, many extended-care beds were left empty. Even today, there are long-term institutions with entire floors or wings which have never been opened. One doctor charged in an interview that this situation exists in a known community where there is a hospital operating at well over 100 per cent of its bed capacity, and has patients who should be transferred to an ECF.

Prior to admitting a patient, extended-care facilities closely examine his financial situation and his medical condition. The so-called "ambulance cures" mentioned earlier have made them overly cautious because the extended care facility ends up absorbing the bill. Moreover, because of a lack in communication, the nursing homes think retroactive denials are enforced only on their facilities and not on hospitals. Additionally, these nursing home administrators charge that such denials are made by lay personnel (clerks) who overrule the valid findings of a utilization review committee composed of professionals.

There are very few long-term care facilities which are publicly financed. Therefore, they cannot afford to lose money. They closely examine the capability of a patient to defray costs himself in the event he is ineligible for extended care.

Nursing home administrators have voiced the complaint that the records which follow a patient from the hospital are deficient in one or more respects. They claim that the summaries are incomplete, pertinent data are ignored, and special instructions pertaining to the patient's care are often left out.¹⁹ If the extended-care facility accepts patients under these conditions, there is a probability of legal responsibility for improper detrimental treatment or lack of proper treatment. Presently, there are no known records which include the patient's previous ward and the name of his nurse and her telephone number, which, if included, would facilitate direct communication between nursing personnel.

The view from the
third-party payer

Those required to make payments for hospital or long-term care services see a definite increase in hospital costs and the number of people using these services. In order to compensate for these changes, third-party payers must either substantially increase their rates or tighten up on payments. The agencies are met with a great deal of political and social pressure against the former.

There are documented cases in which beneficiaries were illegally admitted to hospitals for a 3-day period in order to qualify for transfer to an extended-care facility when, really, they only needed resident care.²⁰ Administrative records reveal the patient is allowed to leave

the hospital for short periods of time to visit, shop, or make a hair appointment. By regulation, this patient requires acute 24-hour nursing care as stated by a physician and substantiated by a utilization review committee. Such facts are difficult to reconcile.

A staff member in a payer organization claims that based on his review of hospital records, only 20 per cent of the utilization review committees are effective. If this accusation is true, it is indicative of the type of problem which exists. These general attitudes, accusations, and counter-accusations have contributed to the development of more comprehensive guidelines by the payers followed by careful scrutiny and strict enforcement.

A Transfer Agreement

General

"Signing a transfer agreement between a hospital and a nursing home can form the beginning of a dialog [sic] that will produce mutual understanding and respect."²¹ In addition to being a requirement in the conditions of participation, a contract which is carefully considered and mutually enacted can serve not only as a legal document but also as a guide for agreements, requirements, and procedures. Thus, it can become a useful tool for daily use in closing any existing communication gaps which might exist. It should be the beginning of an era of cooperation and understanding between the hospital and the nursing home.

Nursing Home Accreditation

The hospital should not consider the enactment of a transfer agreement unless the nursing home has been accredited by the Joint Commission on Accreditation of Hospitals. Evidence of such accreditation should be presented to the hospital. Formerly the Joint Commission recognized nursing homes accredited by the American Hospital Association or the National Council for the Accreditation of Nursing Homes.

The hospital should not enter into a joint transfer agreement if the nursing home has not been certified as a provider of services by the Social Security Administration. Violations of this rule would present insurmountable financial problems for both institutions.

Transfer Records

When patients leave one facility to go to another, sufficient information should be transferred with them to assure that continuity of care is provided. In the past, nursing home administrators have charged hospitals with failure to send adequate records with the patient. These administrators claim summaries have been incomplete, pertinent data ignored, and special instructions for patient care have been omitted, and this situation can cause unnecessary harm to the patient.

As discussed earlier, once the patient is accepted by the nursing home they assume responsibility for that patient. If the patient should receive improper treatment because of faulty records, or a lack of records, the nursing home could be held liable.

Nursing homes are required by the Joint Commission on Accreditation, the Social Security Administration, and State Laws to maintain proper medical records on each patient. Failure to do so could, therefore, lead to loss of accreditation or revocation of a state license. In *Yanke v. State Department of Public Health*, 328 p. 2d 556 (California District Court of Appeals, 1958) a nursing home had its license revoked for violation of state regulations concerning proper medical records.²² It would appear, then, that a nursing home might be subject to abrogation of license or accreditation if a transfer agreement did not require adequate records or if adequate records were not obtained as a routine practice. Since improper records can be the cause of injury to a patient, there is the possibility of litigation which would result in a decision of negligence. Liability might be placed on the hospital which failed to transfer the information or the nursing home which did not demand information. To date, this problem has not been specifically discussed by the courts.²³ It is entirely possible and reasonable, however, to assume that either institution could be held liable. It should be a valid assumption that the transfer agreement might be the deciding factor in determining where to fix liability. Because of the increasing number of court cases involving medical injuries and the increase in the amount of judgments, the legal aspects of patient transfer must be seriously considered. Simply stated, institutions cannot afford to overlook giving this subject its due emphasis.

Although only the transfer from hospitals to nursing homes has been discussed there are instances (such as a serious worsening of condition) causing a patient to be returned to the hospital. In this case, the hospital must demand a reversal of proper medical information.

Specific Considerations

As a result of this study, there are several specific considerations which should be examined prior to drafting a transfer contract. Those that follow might serve as a checklist.

1. The extent of detail placed in the document must be determined. Is it to be specific and detailed or general and broad in nature?
2. The type of patient to be transferred must be defined.
3. The amount of information to be transferred with patient to assure continuity of health care must be specified. Diagnosis, current medical findings, rehabilitation potential, a brief summary of the course of treatment followed, nursing information, dietary requirements, ambulation status, administrative information, or social problems are subjects which must be considered for inclusion as a part of the transfer agreement.
4. The procedures for selection of an extended-care facility by the patient must be outlined.
5. The roles and extent of participation of the institutions must be determined. Will the agreement between the two facilities be exclusive?

6. The actual moment of transfer must be delineated. When will responsibility for the patient be transferred from one facility to the other?
7. The physicians' participation must be specified. Who can practice in the respective facilities?
8. The administrative procedures to be followed to effect the transfer must be clearly delineated.
9. The possibilities for readmission to the hospital must be defined.
10. The consideration for the transfer of the patient's personal belongings must be specified.
11. The qualifications of the extended-care facility and its capabilities must be discussed and affirmed.
12. The procedures for diagnostic tests subsequent to the transfer for which the nursing home has no capability must be outlined and approved.
13. A simplified procedure should be established to enable quick access to information, if a nurse at the institution to which the patient is transferred has a specific question concerning a patient.

The Present Transfer Agreement

General Comment

The present transfer agreement between the Columbia Hospital and Rikard Nursing Homes was signed by responsible representatives from both institutions on September 16, 1966. This contract has neither been revised since that date nor has it been reviewed in detail.

Specific Shortcomings

A partial listing of specific areas which deserve consideration in the original contract will follow. This is done in an effort to dramatically display the reasons for this study. It is not an attempt to criticize, for it must be recognized that literally hundreds of changes have evolved since the initiation of extended care.

1. The terminology is outdated. In order not to confuse the different types of long term patients, specific nomenclatures have been assigned. No where, for example, does the original contract make reference to the phrase extended care. Yet this term constitutes the basics for the agreement.

2. The contract as written does not provide for a specific periodic review.

3. Although a liaison committee was formed, it did not provide for specific meeting times nor was their authority defined.

4. A definitive statement concerning the transfer of medical records was not included.

5. The type of patients to be transferred was not a subject for the original contract.

6. Responsibilities for the transfer of patients were not included in sufficient detail to allow for the orderly reassignment from the hospital to the ECF. This procedure is a prime example of one of those things which have been worked out to mutual satisfaction but has not been placed in the agreement.

Available Alternatives within the Framework
of the Existing Transfer Agreement
between Columbia Hospital and
Rikard Nursing Home

Since there is, at the present time, a transfer agreement in effect between Columbia Hospital of Richland County and Rikard Nursing Home, the available alternatives for the preparation of a model transfer agreement are as follows:

1. Make no examination of the agreement because it is the written contract backing up a system which is now working to mutual satisfaction.
2. Rewrite the agreement, making it general in nature.
3. Rewrite the agreement, making it detailed and specific.

The discussion of those alternatives which follows is a reflection of those specific considerations mentioned in the checklist earlier in this chapter. It does not include an item by item comparison but rather is a compilation of those subjects considered most pertinent to that alternative.

First alternative

The most obvious advantage in making no changes to the existing agreement is that there is no reason to "upset the applecart". Those personnel involved in the mechanics of patient transfer have a good telephone relationship. For the most part, these transfers are a smooth and orderly process. Additionally, this alternative would conserve resources at a time when both facilities are short personnel.

In contrast to the advantages, however, there exists the fact that the present agreement is over five years old. During that period of time, there have been many policy, personnel, and procedural changes which have not been incorporated or added to the old contract. Moreover, the agreement was written before the concept of extended-care transfers had been tested because it was written in order to comply with the conditions of participation. As a result, there have been lessons learned as the concept was applied to the working, practical world.

In the original agreement, for example, the nursing home was to bill the patient for all services received during his stay at that institution. Since the, changes to Medicare regulations have prohibited extended care facilities from assessing patients for services received during outpatient visits to the hospital. Clearly, then, it is a disadvantage to allow this clause to remain in the contract.

Second alternative

A completely new agreement would have the advantage of a complete and comprehensive review. It would be able to incorporate or examine all of the lessons learned in the past five years. Since this alternative was to be general in nature, it would allow the operating technicians individual freedom in the daily routine of transferring patients and administering the program. Regulations could be interpreted by the workers to meet the ever-changing situations as required.

The major disadvantage of general policies is that it is possible for the means to justify the end. Since there are no firm rules for accomplishing a goal, any method may be acceptable, especially to the one attempting to attain the goal. The health care industry has a high personnel turnover rate, and broad rules do not provide the necessary guidance to operate in an efficient manner.

Third alternative

Detailed contractual agreements in writing, if properly executed, provide a standardized formula for getting things accomplished. In those situations in which there is a disagreement, there is a previously agreed upon solution. These agreements have been made by top-level management from both the hospital and the extended-care facility based upon the recommendations of their respective staffs. Replacement personnel filling in during emergencies or absences are provided with a ready reference to assist them in their tasks.

A detailed contract may fix responsibilities which at a later date might cause either disagreement or legal complications. The existing contract does not delineate exactly when the medical responsibility for the patient passes from the hospital to the nursing home.

A problem associated with detailed contracts is the lack of flexibility afforded to the participants. This situation may stifle imagination and innovation which could result in boredom and job dissatisfaction. Since there are many more written considerations, it generally takes longer to obtain agreements and approvals.

Summary

Although the concept of extended care is relatively new, it has undergone a great amount of transition. Definitions, transfer procedures, the financial reimbursement system and the types of patients eligible are but a few examples. These changes have been so rapid, of such number, and of such magnitude it is easily understood why the affected facilities have not had time to incorporate them in their written agreements.

Footnotes

¹John P. Solomon, "The Physician and Health Care Costs", Recorder, XXXIV (December, 1970), 5.

²"American Hospital Supply Forms New Company to Build Modular ECF's", Modern Hospital, CXIII (November 10, 1969), 24.

³Ibid.

⁴"U. S. Facing a Crisis in Health As Medical Care Costs Soar", Newsday (Long Island), XXX (November 10, 1969), 4R.

⁵Stephen M. Morris, "120 Bed ECF Includes Rehabilitation, Mental Health Services", Hospital Topics, XLVI (August, 1968), 23.

⁶"U. S. Facing a Crisis in Health As Medical Care Costs Soar", p. 2R.

⁷"The Physician and Health Care Costs", p. 5.

⁸Medicare and Social Security Explained (Chicago: Commerce Clearing House, Inc., 1965), n. p.

⁹Medical and Social Security Law as of July 30, 1965 (Chicago: Commerce Clearing House, Inc., 1965), n. p.

¹⁰Harold J. Mast, "A Descriptive Study of the Relation Between Ownership of Extended Care Facilities and Manner of Complying with the Conditions of Participation for Medicare", (unpublished Master's dissertation University of Iowa, 1968), p. 22.

- ¹¹Medical and Social Security Law as of July 30, 1965 n. p.
- ¹²Ibid.
- ¹³Ibid.
- ¹⁴"American Hospital Supply Forms New Company to Build Modular ECG's", p. 24.
- ¹⁵South Carolina Nursing Home Association, Hearing on Medicare (Columbia, S. C., July 15, 1969), n. p.
- ¹⁶Morris, "120 Bed ECF Includes Rehabilitation, Mental Health Services," p. 23.
- ¹⁷Harold J. Mast, "ECF's and Long-Term Care", Hospitals, XLIV (July 16, 1970), 64.
- ¹⁸Richard S. Lamden, "Cooperation between Hospitals and ECF's Solves Bed Location Problem", Hospitals, XLIII (January 16, 1969), 78.
- ¹⁹Eric W. Springer, "Hospital Negligence Case May Have Impact on Nursing Homes", Modern Nursing Home, XXIV (January, 1970), 24.
- ²⁰Robert L. Archer, "Medicare and Extended Care Facilities", Hospitals, XLIV (November 16, 1970), 48.
- ²¹Robert Bainum, "Preliminary Steps to a Hospital-Nursing Home Patient Transfer Agreement", Hospitals, XLII (June 16, 1968), 78.
- ²²Springer, "Hospital Negligence Case May Have Impact on Nursing Homes", p. 24.
- ²³Ibid.

CHAPTER III

CONCLUSION

Conclusions

Physicians and their patients will be slow in their acceptance of the extended care concept.

There are serious problems in the manner in which hospitals and extended-care facilities are reimbursed by third-party payers. A breakdown in communication is a major contributing cause of this difficulty.

The cost of health services will continue to play a primary role in the concept of extended care. As the prices of hospital beds continue to increase, combined with a greater demand for services, it will be realized that the proper use of extended care will assist in alleviating expenses.

The national shortage of skilled nurses is still another factor which will influence the requirement to expand the use of extended care.

A city, a county, or a regional agency designated as the operator to locate extended-care beds would be of great assistance to hospitals.

Prior to hospital admission, or as soon as practical, the patient and his family should be provided with information concerning extended

care. If the physician thinks his patient will progress to a point of transferral, an approximation of this time should be given. The physical, monetary, emotional advantages should be included in this briefing.

The importance of providing health care with continuity dictates that the transfer agreement be detailed and comprehensive. The unforeseen problems of dealing with people will preclude the inclusion of all details and each patient will have individual problems, because of the uniqueness in dealing with people rather than machines or procedures. Boredom on the part of program administrators will not be a problem.

The transfer and referral record which is presently in use between Columbia Hospital and Rikard Nursing Homes could be rewritten to include information which will allow nurses to exchange needed information.

The South Carolina Hospital Association and the South Carolina Nursing Home Association have excellent rapport. Their continued cooperation helps to close the gaps which exist between the hospitals and the extended-care facilities in that state.

Recommendations

It is recommended that:

1. The Columbia Hospital of Richland County and the Rikard Nursing Home enact the transfer agreement contained as Appendix A.

2. The Columbia Hospital of Richland County and the Rikard Nursing Home replace the present transfer and referral record with the one proposed in Appendix B.

3. That subsequent to the adoption of the previous primary recommendations, the following secondary recommendations be enacted:

A. The South Carolina Hospital Association and the South Carolina Nursing Home Association enlist the aid of the news media to explain the reasons for extended care, the process of eligibility for the program, and the basic mechanics of administration.

B. An agency be designated to act as a coordinating center for extended-care beds in the vicinity of the Columbia City area.

C. The professional staff of the Columbia Hospital prepare a formal briefing for all staff members and prospective members to explain extended care.

D. Prior to admission to the Columbia Hospital medical staff, the physician be required to visit with the administrator of at least one extended-care facility.

E. The South Carolina Blue Cross-Blue Shield Association conduct workshop clinics to explain reimbursement procedures, to include eligibility requirements. This should be accomplished on a regular, recurring basis.

F. The Columbia Hospital establish a system of orientation for all patients and their families upon admission to the hospital. Extended care would be a topic of discussion. If possible, an anticipated date of transfer should be provided at this time.

State of South Carolina
County of Richland
and Lexington

THIS AGREEMENT is made as of the _____ day of _____, 19__ by and between the Columbia Hospital of Richland County, Columbia, South Carolina, and Richard Nursing Home, Lexington, South Carolina.

WHEREAS, Columbia Hospital is a facility, equipped and staffed to provide acute and intensive medical care; and

WHEREAS, Richard Nursing Home owns and operated a skilled nursing facility for the treatment of extended care, intermediate care, and custodial care; and

APPENDIX A

PROPOSED TRANSFER AGREEMENT

WHEREAS, both parties to this Agreement want to insure continuity of care and treatment of each patient in the Hospital and in the extended-care, skilled-nursing facility, using the skills, the resources, and the physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and the postacute stages of illness, and

WHEREAS, both the Hospital and the Nursing Home desire, by means of this Agreement, to assist physicians and the parties hereto in the treatment of patients, (a) by facilitating the timely transfer of patients and medical and other information necessary or useful in the care and treatment of patients transferred, (b) in determining whether such patients can be adequately cared for otherwise than by either of the parties hereto.

State of South Carolina
 County of Richland
 and Lexington

THIS AGREEMENT is made as of the _____ day of _____, 19___, by and between the Columbia Hospital of Richland County, Columbia, South Carolina, and Rikard Nursing Homes, Lexington, South Carolina.

WHEREAS, Columbia Hospital is a facility, equipped and staffed to provide acute and intensive medical care; and

WHEREAS, Rikard Nursing Homes owns and operates a skilled nursing facility for the treatment of extended care, intermediate care, and custodial care; and

WHEREAS, both parties to this Agreement want to insure continuity of care and treatment appropriate to the needs of each patient in the Hospital and in the extended-care, skilled-nursing facility, using the skills, the resources, and the physical plant of both parties in a coordinated and cooperative fashion to improve patient care at both the acute and the postacute stages of illness, and

WHEREAS, both the Hospital and the Nursing Home desire, by means of this Agreement, to assist physicians and the parties hereto in the treatment of patients, (a) by facilitating the timely transfer of patients and medical and other information necessary or useful in the care and treatment of patients transferred, (b) in determining whether such patients can be adequately cared for otherwise than by either of the parties hereto.

NOW, THEREFORE, THIS AGREEMENT WITNESSETH:

That in consideration of the potential advantages accruing to the (a) patient of each of the parties, (b) their physicians, and (c) the mutual advantages accruing to the parties hereto, Columbia Hospital and Rikard Nursing Homes hereby covenant and agree with each other as follows:

1. The Board of Trustees of the Columbia Hospital of Richland County and the Board of Directors of Rikard Nursing Homes shall have exclusive control of the management, assets, and affairs of their respective institutions; neither party by virtue of this Agreement assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other party to this Agreement.

2. Each institution will appoint a liaison committee of at least one person to assist in an orderly process of the general administration of this Agreement with respect to policies and procedures.

3. The Columbia Hospital Superintendent and the Rikard Nursing Business Manager agree to meet a minimum of once each quarter at one of the institutions to deal with problems arising from the Agreement. The first meeting will be at the Columbia Hospital at a mutually agreed upon time and date. Thereafter, they will be held at alternating facilities.

4. It is agreed that patients of the Hospital may be transferred to the Nursing Home on the basis of medical need as determined by the patients' physicians subject to the following conditions:

(a) The physician directing the transfer must be a member of

the Columbia Hospital Medical Staff. If the doctor is not a member of that staff, the attending physician must refer said patient to a member of the Columbia Hospital Staff in order to effect a transfer.

(b) The transferring institution shall make available to the admitting institution all credit and financial records in its possession.

(c) Prior to transfer the hospital will state whether or not the patient medically requires the services of skilled nursing care twenty-four hours a day in an extended-care facility. For those patients who do require these services, such will be thoroughly substantiated.

(d) The admitting institution reserves the right to refuse to accept any patient for any reason.

(e) The transferring institution will explain to the patient and his family the reasons for the transfer, the financial requirements, and the administrative procedures. This will be accomplished by the transferring institution upon admission of the patient or as soon thereafter as practical. The patient's family will be encouraged to visit Rikard Nursing Homes prior to transfer to that institution.

(f) The transferring institution will prepare the patient for transfer. Medications to be administered and enroute requirements will be planned for and satisfied. Unless medically contra-indicated, the patient will be bathed.

(g) The transferring institution will make all necessary arrangements for the transfer. Except where medically contra-indicated, the patient's family will be given the option to provide transportation.

5. Medical and legal responsibility remains with the transfer-

ring institution until such time as the patient is accepted by the admitting facility. The admitting facility will examine the patient and medical records. It is the responsibility of the admitting facility to annotate time and date of acceptance in the remarks section of the transfer and referral record. A copy of the transfer and referral record will be returned to the transferring institution by that agency which transported the patient.

6. The Hospital and the Nursing Home agree to transmit with each patient at the time of transfer, or, in the case of an emergency, as promptly as possible thereafter, a duplicate abstract of pertinent medical and other records necessary to provide continuous and comprehensive medical care. Such information must include, but is not confined to, (a) current medical findings, (b) diagnosis, (c) rehabilitation potentials, (d) a brief summary of the course of treatment followed in the hospital or nursing home, (e) nursing and dietary information useful in the care of the patient, and (f) administrative and pertinent family information.

7. Personal effects of patients transferred will accompany patients transferred, particularly money, valuables, and/or information for items related to these items. If given to an ambulance driver or an orderly, the transferring institution will obtain a receipt for those items.

8. Direct contact and coordination are encouraged between the nursing staffs of the respective institutions.

9. Columbia Hospital agrees to readmit the transferred patient if his medical condition deteriorates to a point where Rikard Nursing Homes can no longer effectively provide necessary medical attention. Rikard Nursing Homes agrees to give priority to that patient when his condition improves and transfer to extended care is again warranted.

10. Services unavailable at Rikard Nursing Homes such as physiotherapy and radiology will be provided to the transferred patient by Columbia Hospital on an outpatient basis.

11. All charges for inpatient care will be billed by the facility directly to the patient, the third-party payers, or other coverage.

12. Services performed on an outpatient basis by the Hospital subsequent to transfer to the Nursing Home will be billed by the Hospital to the patient, the third-party insurance, or other coverage. This direct billing by the Hospital includes costs incurred for travel by an ambulance service.

13. Any dispute which may arise under this Agreement shall first be discussed directly by the Departments of the parties involved. If the dispute cannot be resolved at this level, it shall be referred to the Hospital Superintendent and the Nursing Home Business Manager.

14. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other hospital on either a limited or a general basis while this Agreement is in effect.

15. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall first be obtained from the party whose name is to be used.

16. Every effort will be made to improve the transfer of nursing information and techniques between institutions.

17. This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of this Agreement.

18. A confirmed copy of this Agreement with all amendments, if any, together with a copy of the current policies and procedures, referral forms, and other such documents designed to implement this Agreement shall be kept in the administrative files of each of the parties for ready reference.

19. This Agreement shall be reviewed as a minimum annually by the management of the respective institutions.

20. This Agreement shall be effective from the date of execution and shall continue in effect indefinitely, except that either party may withdraw by giving sixty (60) days notice in writing to the other party of its intention to withdraw from this Agreement. Withdrawal shall be effective at the expiration of the sixty (60) day period. However, if either party shall have its license to operate revoked by the State of South Carolina or becomes ineligible as a provider of service

under Title I, Part 1, of Public Law 89-97, this Agreement shall terminate on the date such revocation or ineligibility becomes effective.

IN WITNESS WHEREOF, the parties hereto have hereto executed their Hands and Seals this _____ day of _____ 19__.

SIGNED SEALED AND DELIVERED
IN THE PRESENCE OF:

BY _____

TITLE _____

AS TO _____

BY _____

TITLE _____

AS TO _____

APPENDIX A

PROPOSED TALKS AND REFERRAL RECORD

TRANSFER AND REFERRAL RECORD

Patient's Name _____ Date _____ 19__
 Address _____
 Attending Physician _____ Phone _____
 Birth Date _____ Sex _____
 Religion _____ Soc. Sec. No. _____
 Sponsor or nearest Relative _____
 Name-Relationship _____
 Address-Phone _____

TRANSFERRED FROM Name of Facility _____
 Address _____ Phone _____
 Ward _____ Ward Sup. _____ Phone _____ Room # _____
 TRANSFERRED TO Name of Facility _____
 Address _____ Phone _____

Diagnosis _____

Medication at Time of Transfer Treatment at Time of Transfer

APPENDIX B

PROPOSED TRANSFER AND REFERRAL RECORD

Rehabilitation Potential: _____
 Signature of Physician _____
 Signature of Physician _____

Ambulatory: Yes ___ No ___ With Aids: Yes ___ No ___ Side Ballist: Yes ___ No ___
 Diet _____

Incontinent: Bowel Control _____ Bladder Control _____

Remarks and pertinent information (Describe fully patient's condition, special needs and provide nurse's suggestions):

Does patient know his diagnosis? _____
 Signed _____
 Title _____

TRANSFER AND REFERRAL RECORD

Patient's Name _____ Date _____ 19____
 Address _____
 Attending Physician _____ Phone _____
 Birth Date _____ Sex _____ SMWD
 Religion _____ Soc. Sec. No. _____
 Sponsor or nearest Relative _____
 Name-Relationship _____
 Address-Phone _____

TRANSFERRED Name of Facility _____
 FROM Address _____ Phone _____
 Ward _____ Ward Sup _____ Phone _____ Room # _____
 TRANSFERRED Name of Facility _____
 TO Address _____ Phone _____

Diagnosis _____

Medication at Time of Transfer Treatment at Time of Transfer

Rehabilitation Potential _____
 Signature of Physician _____
 Signature of Physician _____

Ambulatory: Yes ___ No ___ With Asst: Yes ___ No ___ Side Rails: Yes ___ No ___
 Diet _____

Incontinent: Bowel Control _____ Bladder Control _____

Remarks and pertinent information (Describe fully patient's condition, special needs and provide nurse's suggestions):

Does patient know his diagnosis? _____

Signed _____
 Title _____

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