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| Transfers | **Last Revision:** | March 2018 |
| **Last Reviewed** | March 2018 |
| **Applies to the following THA Group Companies:** | * Island Health Care * Island Hospice * RightHealth® |
| **Included in the following THA Manual:** | Administrative Policy & Procedure Manual  Provision of Care, Treatment & Service |

#### POLICY

When a patient’s needs change significantly and he/she requires care that cannot be provided by the organization, a transfer/referral to another service provider is made. A transfer may be either planned or unplanned based on the circumstances and events leading to the transfer. A transfer summary is completed for all transfers and sent to the receiving organization in a timely manner. The patient and representative (if any) have a right to be informed of the organization’s policy for transfer.

**PURPOSE**

To outline the process for transferring or referring a patient to another service provider and define the requirements for documentation of the transfer.

###### Transfer/Referral Criteria

The organization’s services are not arbitrarily terminated. The patient may be transferred/referred only for the following reasons, which are documented in the clinical record:

1. The transfer is necessary for the patient’s welfare because THA Group and the physician who is responsible for the home health plan of care agree that the organization can no longer meet the patient’s needs, based on the patient’s acuity. The organization must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the organization’s capabilities;
2. The patient or payer will no longer pay for the services provided by the organization;
3. The patient moves from the geographic area served by the organization.
4. The patient refuses services, or elects to be transferred or discharged;
5. The transfer is appropriate because the physician who is responsible for the home health plan of care and the organization agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the organization and the physician who is responsible for the home health plan of care agree that the patient no longer needs the organization’s services.
6. The patient, family/caregiver, and/or physician request a transfer to another healthcare provider

# PROCEDURE – ISLAND HEALTH CARE

1. The Director of Patient Centered Care (DPCC) is responsible for ensuring that all transfer documentation is complete, including documentation that the transfer summary has been forwarded to the receiving facility.
2. The DPCC ensures our Hospital Clinical Liaison is notified of the transfer either by email, telephone call or text message “ALERT - Patient Transferred to “*facility*” where *facility* is the name of the facility/hospital. PHI should not be included in text message.

The Territory Rep will follow the patient while in the facility and inform case managers that the patient is current under THA Group’s IHC home care services.

1. The DPCC is also responsible for ensuring that the physician is notified of the transfer and physician notification is documented.
2. The contact in the clinical record will be entered as a “Transfer”.
3. For a planned transfer, the DPCC will ensure:
   1. A physician’s order for transfer is obtained
   2. The patient and family/caregiver is informed of the transfer arrangements.
   3. The patient and family/caregiver is involved in the transfer.
   4. Serves as a liaison between the patient, the family/caregiver, the receiving organization and the physician relative to the transfer arrangements.
   5. All disciplines involved in the patient’s care are notified of the transfer.
4. For an unplanned transfer, the director of patient care will ensure:
   1. The physician is notified of the transfer.
   2. The receiving organization is contacted to determine the reason for transfer if necessary.
   3. All disciplines involved in the patient’s care are notified of the transfer.
5. The Transfer Summary and Transfer fax cover sheet are faxed to the receiving facility within 48 hours of the transfer.
6. The Transfer OASIS is completed by the first primary clinician notified of transfer.
7. The Transfer information includes:
   1. The reason for transfer.
   2. The physical and psychosocial status at the time of transfer, including specific medical, psychosocial, or other problems requiring interventions or follow-up.
   3. Continuing symptom management needs.
   4. Medication profile with all current medication.
   5. A summary of the care provided.
   6. Any instructions and/or referrals provided to the patient.
   7. The existence of any Advance Directives known to the organization.
   8. The date of transfer.
8. All communication with the receiving provider, physician, and patient is documented in the patient’s clinical record.

**PROCEDURE – RIGHTHEALTH**

1. The Telehealth/Telehealth RN is responsible for ensuring that all transfer documentation is complete, including documentation that the transfer summary has been forwarded to the receiving facility.
2. The Telehealth/Telehealth RN ensures our Hospital Clinical Liaison is notified of the transfer either by telephone call or text message “ALERT - Patient Transferred to “facility” where facility is the name of the facility/hospital. PHI should not be included in text message.  
   The Telehealth/Telehealth RN also documents in the Communication note the name of the Territory Rep notified.
3. The Territory Rep will follow the patient while in the facility and inform case managers that the patient is current under THA Group’s RightHealth services.
4. The Telehealth/Telehealth RN is also responsible for ensuring that the physician is notified of the transfer and physician notification is documented. Telehealth trends will be sent to the Physician.
5. The Telehealth/Telehealth RN serves as a liaison between the Territory rep, patient, the family/caregiver, the receiving organization and the physician relative to the transfer arrangements.

6. All disciplines involved in the patient’s care are notified of the transfer.

7. For an unplanned transfer, the Telehealth/Telehealth RN will ensure:

* 1. The physician is notified of the transfer.
  2. The receiving organization is contacted to determine the reason for transfer if necessary.
  3. All disciplines involved in the patient’s care are notified of the transfer.
  4. All communication with the receiving provider, physician, and patient is documented in the patient’s clinical record.

# PROCEDURE – ISLAND HOSPICE

1. The RN Care Manager confirms that all members of IDT are aware of the transfer plan.
2. The RN Care Manager completes and sends the Island Hospice Transfer Form to the receiving agency with a face sheet and hospice discharge summary.
3. The discharge summary includes, but is not limited to, treatments, symptom and pain management, current plan of care, most recent physician orders and, if patient is in 3rd election period or later, F2F documentation
4. The RN Care Manager provides verbal report to the receiving facility.
5. With transfer to another hospice, the patient is discharged from Island Hospice.

Transfer Fax Cover Sheets can be found at [G:\Approved Forms 2015\Fax Cover Sheets](file:///G:\Approved%20Forms%202015\Fax%20Cover%20Sheets).