Freudenthal HOME HEALTH

Transfer/Referral Criteria & Process

Policy No. 4-043.1

PURPOSE

To outline the process for transferring or referring a patient to another service provider.

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 will be made.

When the patient's plan of care changes and this change results in a transfer or referral, the patient, his/her representative, as well as his/her primary physician (or other authorized licensed independent practitioner), will be notified and involved in planning decisions.

Definitions:

Service Provider: Another home health, hospice or health care facility.

Transfer/Referral Criteria:

Home health care services for a patient will not be arbitrarily terminated. They may be transferred/referred only for the following reasons, which will be documented in the clinical record:

1. Medical reasons
    A. A determination of the inappropriateness of continuing the services
    B. A change in the patient's medical or treatment program resulting in services or care that cannot be provided
2. Other reasons
    A. Moved out of service area
    B. No longer a preferred provider

PROCEDURE

1. The organization will assist the patient and/or caregiver in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.
2. The organization will ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
3. When a patient is referred to another organization, service, or individual, the patient will be informed of any financial benefit to Organization's Name.

4. The physician (or other authorized independent practitioner) will be notified and an order will be obtained to transfer the patient.

5. The physician (or other authorized independent practitioner) who writes the patient transfer order will verbally confirm the transfer arrangements and give the appropriate information to the receiving health care provider.

6. The clinician or designee will:

    a. Inform the patient and family/caregiver of the physician (or other authorized independent practitioner) transfer order.

    b. Involve the patient and family/caregiver in the transfer.

    c. Serve as a liaison between the patient, the family/caregiver, and the physician relative to the transfer arrangements.

    d. Notify all internal or external providers of care for the patient.

7. All necessary medical information pertaining to the patient's current condition and treatment, post-discharge goals of care and treatment preferences will be sent to the receiving facility or health care practitioner.

8. The organization will comply with requests for additional clinical information necessary for the treatment of the patient.

9. All communication with the receiving provider, physician (or other authorized licensed independent practitioner), and patient will be documented in the clinical record.

10. Within 48 hours of transfer, the clinician will complete a transfer summary.
    (See "Transfer Summary" Policy No. 4-044.)

11. Within 48 hours of transfer, the clinical records clerk will send a copy of the transfer summary or clinical record to the receiving provider.

12. A copy of the transfer summary will also be sent to the physician (or other authorized licensed independent practitioner).

13. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.