Sullivan County Department of Public Health

Title: Transfer Process **Number**: AG- 65 **Page Number:** 1 of 2	Original Approval: 7/01 Reviewed/ revised: 8/04, 11/05, 6/18, 2/22, 4/24

Statement/ Purpose:
To provide guidelines for the transfer of home health care patients to another health care organization.

Authority:
CMS CoP 484.50 (d)

Application:
All SCDPH staff

Terminology:

Responsible Party:
Director of Patient Services

Cross-Reference:
Discharge Process, The Outcome and Assessment Information Set (OASIS)

Procedure:
1. When the needs of the patient can no longer be met through Agency services or the patient moves out of the agency's service area, the case manager (or designee) contacts the receiving agency with pertinent information regarding the patient's health status.
2. When the patient requires hospital emergency or inpatient services:
    a. And the clinician is in the home:
        i. The clinician assesses the patient's condition thoroughly.
        ii. The clinician reports significant findings to the physician, unless the situation requires immediate emergency intervention.
        iii. The clinician delegates tasks to the support system, if present (i.e., calling 911 if appropriate).
        iv. If the patient requires emergency care, the clinician provides ongoing assessments and/or care until emergency personnel arrive. Emergency personnel are provided with a report regarding the patient's medical history. The clinician calls the emergency department with a report of the patient's current status and any other pertinent information.
        v. If the patient requires non-emergency hospital services, the receiving department is contacted with a report of the patient's current medical condition and any additional pertinent information.
        vi. The case manager is notified of the patient's hospitalization.
3. If the patient is admitted to another facility:
    a. The Clinician who makes the last home visit is responsible to complete a Transfer to Inpatient OASIS (See OASIS policy) and Transfer to Inpatient Facility Summary which must be sent to the facility which

received the patient within 2 business days of the agency becoming aware of the transfer.

b. Documentation of the transfer must include:
    i. Admission date
    ii. Name of physician responsible for the home health plan of care
    iii. Reason for admission to home health
    iv. Type of services and frequency
    v. Medications patient is on at the time of transfer

4. For patients who require placement in a Skilled Nursing Facility:
    a. A PRI & Screen shall be completed by qualified personnel.
    b. The agency shall have sufficient number of trained, qualified and approved assessors and screeners to meet H/C PRI & Screen requirements and to attest to accuracy of patient review forms.
    c. Any CHHA patient who receives a PRI& Screen assessment shall be provided with quality data for preferred facilities.