Hackensack Meridian *Health* at Home
Transfer and Discharge Policy

Transfer: 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 resulting in a transfer or referral, the patient, his/her representative, as well as his/her primary physician, will be notified and involved in planning decisions.

Transfer/Referral Criteria
Home health services for a patient will not be arbitrarily terminated. The patient may be transferred/referred only for the following reasons:

- A change in condition requiring emergent care, hospitalization, or placement in an alternate care setting.
- A change in condition requiring services outside the scope provided by the organization.
- The patient moves from the geographic area served by the organization.
- The organization is closing or eliminating a particular service.
- The patient and/or caregiver requests transfer to another home health provider.

Discharge: When the patient's plan of care changes and this change results in discharge from or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in planning decisions.

Definitions
Termination/Discharge: Discontinuance of all services by the organization.
Reduction of Services: A change in the patient's service plan in which one (1) or more existing services are discontinued.

Discharge/Reduction of Services Criteria: Services will be terminated when the patient meets one (1) or more of the following discharge criteria:

- There is a change in the patient's medical or treatment program in which the patient's needs are greater than the agency's capability.
- A change in the patient's condition requires care or services other than that provided by the organization.
- If appropriate, the goals of home health have been attained or are no longer attainable.
- There is no longer anyone to provide supportive/custodial care.
- The patient or family/caregiver refuses or discontinues care.
- The patient or family/caregiver refuses to cooperate in attaining the objectives of home health.
- Conditions in the home are no longer safe for the patient or organization personnel.
- Family/caregiver has been prepared and is capable of assuming responsibility for care.
- The patient moves from the geographic area served by the organization or becomes a resident of an inpatient facility with no foreseeable return to the home setting.
- The patient's physician (or other authorized licensed independent practitioner) has failed to renew orders, or the patient has changed physicians and orders cannot be obtained from the new physician (or other authorized licensed independent practitioner) to support patient's needs.
- The physician (or other authorized licensed independent practitioner) gives orders that are not consistent with the stated diagnoses, as required by law, and fails to give the needed orders when requested by the organization.
- If the physician face-to-face encounter was not completed prior to the initial certification, the patient or family/caregiver refuses to obtain a physician face-to-face visit within 30 days of start of care.
- The organization is eliminating a particular service or all of its services or is unable to provide sufficient staff with requisite skills to meet the patient's need(s).
- The patient expires.
- The patient is unwilling or unable to pay for services directly or through a third party.
- The patient no longer meets coverage criteria for the payer source and elects not to pay privately for services.
- The patient refuses assignment of an employee on a discriminatory basis.
- The patient or a person in the household subjects the clinician to prohibited harassment.
- The agency ceases to operate