VOLUME 4: MEDICAL SERVICES	Effective Date: 01/2010
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4.3.2 HEALTH CARE TRANSFER PROCEDURE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

This procedure provides standarized processes for ensuring continuity of health care services during patient movement and includes, but is not limited to, intrafacility transfers, interfacility transfers, transfers to outside entities, Medical/Psychiatric and Return, hospital discharges, and other patient transportation.

II. DEFINITIONS

Bus List: A list of inmates who have a bus seat or have an alternate means of transport scheduled.

Endorsed List: A list of inmates endorsed for transfer, but not yet assigned transportation arrangements.

Home Institution: Institution where a patient is endorsed and to which he or she will return after completing the medically necessary health care services at the treating institution.

Interfacility Transfers: Transfers occurring from one California Department of Corrections and Rehabilitation (CDCR) institution to a separate CDCR institution (e.g., from Richard J. Donovan Correctional Facility to California State Prison-Sacramento).

Intrafacility Transfers: Transfers occurring within the same institution (e.g., from A yard to B yard), causing a patient's medications to be distributed from a different medication administration location.

Medical/Psychiatric and Return: The process used when a patient requires medically necessary health care services which are only accessible at or via a CDCR institution other than where the patient is housed. Medical/Psychiatric and Return requires an overnight stay at the treating institution prior to the return to the home institution.

Outside Facility Transfers: Transfers to facilities not under CDCR control and/or oversight (e.g., Modified Community Correctional Facility and Community Correctional Facility, California Out-of-State Correctional Facility, local jails, court, hospitals, Department of State Hospitals [DSH] Facilities).

Patient Services Plan: A systematic process by which a nurse assesses the need of each patient and plans for and coordinates services, referrals, and patient education.

Primary Care Team: An interdisciplinary team that organizes and coordinates services, resources, and programs to ensure consistent delivery of appropriate, timely, and patient-centered, evidence-based care to a designated patient panel.

Transport: Movement of a patient from his or her endorsed institution for the purposes of accessing health care or other services that are not available at the endorsed institution.

Treating Institution: The institution where a patient is sent to receive medically necessary health care services that cannot be provided at the home institution.

III. PROCEDURE

A. General Requirements

1. Health care staff shall ensure all patients are screened for appropriateness for transfer, health care information is packaged, and coordination of services are managed to ensure continuity.
2. The transfer packet shall include, but is not limited to, the following items:
   - Health Care Transfer Information form.
   - Patient Summary Sheet.
   - Patient Services Plan (PSP).
   - Medications.
   - Medication Administration Record (MAR).
   - Medication Reconciliation.
   - Active Physician's Orders.
   - Transfer Checklist.
3. Health care staff at the receiving institution shall notify their Supervising Registered Nurse (SRN) if any documentation, Durable Medical Equipment (DME), or medications are missing for newly arrived patients. Missing items shall be recorded on the Transfer Checklist and the Health Care Transfer Information form. The SRN shall facilitate attainment of the missing items in accordance with applicable DME or Medication Management policies and ensure the actions are documented.
4. Active Physician's Orders and the MAR shall be honored at the receiving institution to ensure continuity of administration of medication transferred with the patient until the patient is evaluated by a provider and/or psychiatrist at the receiving institution.

B. Custody Initiated Transfer

1. Intrafacility Transfers
   a. Custody staff shall notify nursing staff via the Pending Bed Assignments (IPTR149) report of movement when a patient is to be moved to a new location that changes where he or she receives health care services.
   b. The Sending Yard Registered Nurse (RN) shall prepare for the transfer through the following:
      1) Printing and reviewing the Patient Summary Sheet.
      2) Communicating as needed with the receiving nursing staff to discuss alerts and other pertinent health care information.
   c. Intrafacility Transfer of Medication
      Upon the determination that a patient's new housing assignment change will cause the patient to receive medications from a different medication administration location, the following procedure shall be followed:
      1) Custody staff shall:
         a) Print out the Pending Bed Assignments (IPTR149) report from the Strategic Offender Management System prior to moving any patient whose bed change will result in a change of medication administration location. The report is sorted by the "To" (receiving) facility.
         b) Provide a copy of the report by area for each medication administration location change to the medication administration staff (RN/Licensed Vocational Nurse [LVN]/Psychiatric Technician) in the sending facility clinic.

2) Licensed nursing staff shall:
   a) Check the patient on the report against the current MAR to determine the need to have medications relocated with the patient to include Nurse Administered (NA)/Direct Observation Therapy (DOT) and Keep-on-Person (KOP) medications.
   b) Note the number of KOP medications the patient should carry to the new housing assignment, sign off on the front of the report to indicate it has been reviewed, and make a copy of the report for tracking purposes.
   c) Release the Patient Summary Sheet, medications, and MARs in a correctly labeled, sealed envelope/container, along with the signed report, to the custody officer to deliver to licensed nursing staff at the new/receiving medication administration location.
3) The custody officer shall:
   a) Ensure the patient has his or her KOP medications in possession for the new housing assignment.
   b) Transport the signed report, along with any medications and MARs provided by licensed nursing staff, to the medication administration location serving the patient's new housing unit. All medications and MARs shall be moved with the patient.
   c) Notify a nursing supervisor and custody sergeant in the event of difficulties in following this procedure to ensure medications are moved with the patient at all times.

d. The Receiving Nurse shall complete the patient transfer process through the following:
   1) Review the Patient Summary Sheet.
   2) Obtain any missing medications.
   3) Work with scheduling staff to ensure all pending appointments are continued.
   4) Ensure all pending MAR/medications are taken to the medication line.

2. Interfacility Transfers

The Classification and Parole Representative (C&PR) or designee shall provide a Bus List to health care staff as identified in the local operating procedure (LOP) one week prior to the transfer.

a. Sending
   1) The Receiving and Release (R&R) RN shall access the Quality Management Portal and review the Patient Summary Sheet for each patient on the Transfer List to ensure the following:
      a) The patient has not developed any new conditions that require medically necessary health care services.
      b) All medications, DME, and appointments are addressed and listed.
      c) Any special transportation requirements have been identified.
   2) If the patient has no new conditions that require medically necessary health care services, the R&R RN shall notify the C&PR the patient has no contraindications to transfer.
   3) If the patient has a clinical condition that requires medically necessary health care services, the R&R RN shall review the patient's health record.

a) The R&R RN shall consult with the appropriate Primary Care Team (PCT)/Mental Health Primary Clinician (PC)/Primary Dentist (as indicated) regarding the patient's case and the appropriateness of a transfer, as necessary.
b) If the R&R RN and PCT/PC/Primary Dentist (as indicated) determine the patient does not meet the medical hold criteria (refer to Section III,D), the patient is cleared for transfer. The R&R RN shall notify the C&PR the patient has no contraindications to transfer.
c) If the R&R RN and PCT/PC/Primary Dentist (as indicated) determine that the patient meets the medical hold criteria (refer to Section III,D), a medical hold shall be placed on the patient's transfer.
   i. The R&R RN shall mark the patient as NOT approved for transfer on the Transfer Checklist and communicate the hold to the C&PR.
   ii. If there is disagreement regarding the appropriateness of the patient transfer, the R&R RN shall initiate a temporary medical hold and elevate the case to the SRN II.
   iii. The SRN II shall follow the problem resolution process as defined in the LOP.

4) If the patient is approved for transfer, the R&R RN shall:
   a) Notify the C&PR that the patient has no contraindications to transfer.
   b) Complete the Health Care Transfer Information form.
   c) Notify clinic staff to flag all MARs.
   d) Notify clinic staff to prepare NA/DOT medications (excluding narcotics) for transfer.
5) Upon final review prior to transfer, the R&R RN shall gather required transfer documents and supplies and place them in the White Transfer Envelope. At a minimum, the White Transfer Envelope shall include the following:
   - Health Care Transfer Information form.
   - Disability Placement Program Verification form.
   - Comprehensive Accommodation Chrono form.
   - Patient Summary Sheet.
   - PSP.
   - Medications.
   - MAR.
   - Medication Reconciliation.
   - Active Physician's Orders.
   - Transfer Checklist.
6) The night before the transfer, following the last medication pass, the clinic staff, R&R RN, or Transfer Nurse shall collect the MARs and NA/DOT medications from the appropriate yards, and place them in the appropriate White Transfer Envelope.
7) At the time of boarding, the R&R RN shall complete the following:
   a) Perform pre-boarding transfer check, reviewing the content of the White Transfer Envelope for completeness.

b) Conduct a face-to-face evaluation of the patient for urgent/emergent needs.
c) Obtain KOP medications from the patient (except inhalers/nitro/glucose tabs or gel) and place the medications in the White Transfer Envelope.
d) Ensure applicable DME transfers with the patient.

8) If the patient is cleared for transfer, the R&R RN shall sign off the Transfer Checklist and insert the signed checklist in the White Transfer Envelope.
9) If the patient is NOT cleared for transfer:
   a) The R&R RN shall document on the Transfer Checklist the decision to place a medical hold on the patient and notify the SRN II.
   b) The SRN II shall monitor all transfer medical holds, and discuss the case with the appropriate PCTs for continuous improvement purposes.

b. Receiving

1) Licensed health care staff shall review pertinent health care information (e.g., Comprehensive Accommodation Chrono form, Disability Placement Program Verification form, Health Care Transfer Information form, PSP, Patient Summary Sheet, Mental Health Level of Care (LOC) Chrono, Dental Classification, Medication Reconciliation, and MARs) to make appropriate follow-up appointments/notifications for continuity of care.
2) Licensed health care staff shall notify custody staff regarding necessary accommodations. The accommodations listed on the Comprehensive Accommodation Chrono form shall remain in force at the receiving institution unless a physician at the receiving institution re-evaluates the patient and determines that the accommodation is no longer required.
3) While completing the Initial Health Screening form(s) or appropriate corresponding electronic form, and documenting in the patient's health record, licensed health care staff shall conduct an interview with the patient to confirm relevant data contained on the Transfer Checklist, Health Care Transfer Information form, the Patient Summary Sheet, or the appropriate corresponding electronic forms, and PSP.
4) For patients on prescribed medication, the licensed health care staff shall document on the Initial Health Screening form(s) or appropriate corresponding electronic form, and Transfer Checklist, if the medication was received with the patient.
   a) All prescription medications properly labeled and currently prescribed shall be used by the receiving institution. NA/DOT medications and MAR's will be forwarded to the appropriate medication administration location.
   b) All correctly labeled KOP and any over-the-counter (OTC) medication in manufacturer OTC packaging shall be returned to the patient.
   c) Missing medications shall be obtained from the pharmacy or after-hours medication supply per pharmacy policy and LOPs.
5) Licensed health care staff shall obtain vital signs and weight for all patients upon arrival. In addition, fingerstick blood glucose shall be obtained for patients with a history of diabetes. The licensed health care staff shall document the vital signs on the Initial Health Screening form(s) or the appropriate corresponding electronic form.

6) If the LVN or Psychiatric Technician completes the Initial Health Screening form(s) or appropriate corresponding electronic form, they shall contact an RN for assessment and disposition of those patients who answered "yes" to any questions on those forms. The contact with the RN shall be documented in the patient's health record, Initial Health Screening form(s) or the appropriate corresponding electronic form.
7) All patients shall be screened for Tuberculosis (TB) and Coccidioidomycosis, as indicated.
8) Based on RN review of all relevant data, a disposition, including timeframe and referral to an appropriate clinician and PCT, shall be recorded on the Initial Health Screening form(s) or appropriate corresponding electronic form. All patients shall be assigned to a specific PCT panel and scheduled for an initial evaluation by the appropriate care team member within designated policy timeframes that are clinically appropriate. Dispositions which warrant a referral include, but are not limited to, the following procedural requirements:
    a) Patients with acute symptoms or who appear to be in need of urgent treatment shall be escorted to the Triage and Treatment Area (TTA) for further evaluation.
    b) Patients who are clinically high risk or otherwise require complex care management shall be evaluated by the designated Primary Care Provider (PCP) within seven calendar days of arrival to the receiving institution.
    c) Patients who have one or more chronic conditions but are not considered high risk or require complex care management (i.e., clinically medium risk) shall be evaluated by the designated PCP or primary care RN within 30 calendar days of arrival to the receiving institution.
    d) Patients who have no known chronic conditions and are considered clinically low risk shall be evaluated by the designated PCT member within 180 calendar days of arrival to the receiving institution.
    e) Patients shall be referred immediately to the Mental Health Program for evaluation if they exhibit any characteristics indicative of an acute exacerbation of mental illness, inability to care for themselves, or concerns of danger to themselves or others (e.g., abnormal behavior, evidence of hallucinations, suicidal ideations, or evidence of self-harm).
    f) Patients shall be referred routinely to the Mental Health Program for evaluation if they are enrolled in the Mental Health Services Delivery System (Correctional Clinical Case Management System or Enhanced Outpatient Program) and do not require an urgent or emergency referral.
    g) Information concerning upcoming specialty appointments shall be provided to the institution Utilization Management (UM) Nurse.

3. Parole/Discharge
    a. The Chief Medical Executive (CME) or the Chief of Mental Health (CMH) in collaboration with the Regional UM Nurse Consultant Program Review (NCPR) shall ensure that institutional health care staff coordinates patient pre-release health care arrangements including benefits application, medical record transfers

to the identified post-parole placement location, and transfer of care calls as needed.

b. The institutional UM nurse shall collaborate with the institutional Transitional Case Management Parole coordinator, PCT, custody team, and regional UM team to facilitate transition planning and transfer of the patient to the identified post-parole community placement. Pre-release transition planning shall include:
   - Reviewing discharge instructions.
   - Medication Reconciliation.
   - Reviewing DME and ensuring the patient has his/her DME upon parole.
   - Identifying and addressing transportation needs.
   - Transmitting of pertinent medical information to the receiving provider prior to transfer.
   - Facilitating a care coordination transfer of care call with sending and receiving facilities.

c. For patients paroling from within the CDCR institution:
   1) The PCP and/or Primary Psychiatrist shall write an order to discharge the patient with a 30-day supply of necessary medications, DME, and follow-up appointments.
   2) Upon discharge, health care staff shall provide the patient with the following:
      a) A 30-day supply of medications ordered by the PCP and/or Primary Psychiatrist.
      b) DME ordered by the PCP.
      c) Information related to follow-up appointments.
      d) A copy of the most current Patient Summary Sheet.

d. For patients paroling directly from a Community Hospital or DSH bed, the UM RN in collaboration with the Regional UM NCPR coordinates transition planning. Discharge medications and follow-up appointments depend on where the patient is being sent (e.g., county hospital, remaining in the same hospital, or discharged into the community).

C. Health Care Initiated Transfers

1. Health care initiated transfers within the institution
   a. Licensed nursing staff from the sending medication administration location shall collect the patient's MAR and NA/DOT medications in a sealed envelope/container for delivery to the licensed nursing staff in the receiving medication administration location.
   b. Custody staff shall retrieve KOP medications from a patient's assigned housing unit when it becomes apparent that the patient will not be returning to his or her housing unit and ensure delivery to the licensed nursing staff in the receiving facility.
   c. Under no circumstances shall KOP medications be packed with a patient's property.
2. Health care initiated transfers between institutions
   a. If the CME/CMH/Supervising Dentist (SD) or designee at the sending institution determines that a patient requires a permanent transfer, the CME/CMH/SD or designee shall follow the procedures outlined in Inmate Medical Services Policies

and Procedures (IMSP&P), Volume 4, Chapters 29.1 and 29.2, Medical Classification System Policy and Procedure.

b. Once a bed has been designated by the Health Care Placement Oversight Program (HCPOP), the CME/CMH/SD or designee shall contact the CME/CMH/SD at the receiving institution to provide necessary clinical transfer information.
c. If there is not an agreement regarding the transfer, the CME/CMH/SD or designee at the sending institution shall contact the Regional Deputy Medical Executive/ Regional Mental Health Administrator (RMHA)/Regional Dental Director (RDD) or designee. The impacted Regional Deputy Medical Executives/RMHAs/RDDs shall make the final clinical determination regarding the placement of the patient. The Regional Deputy Medical Executives/RMHAs/RDDs or designees shall notify the sending and receiving institution's CME/CMH/SD or designee regarding their decision.
d. The CME/CMH/SD or designee at the sending institution shall contact the CME/CMH/SD or designee at the receiving institution to initiate the transport of the patient.
e. The sending institution's CME/CMH/SD or designee shall complete a Medical Classification Chrono (MCC) and/or a Mental Health LOC Chrono.
f. The R&R RN shall complete the Health Care Transfer Information form and include the date, time, and location of any appointments if known. The R&R RN shall place a copy of the Health Care Transfer Information form in the White Transfer Envelope. Transfer packets shall be completed in accordance with the interfacility transfer process described above in Section III,B,2.

3. Medical/Psychiatric and Return
   a. Home Institution to Treating Institution
      1) If the CME/CMH/SD or designee at the home institution determines that a patient requires a Medical/Psychiatric and Return transfer, the CME/CMH/SD or designee shall follow the procedures outlined in IMSP&P, Volume 4, Chapters 29.1 and 29.2, Medical Classification System Policy and Procedure.
      2) Once a bed has been designated by HCPOP, the CME/CMH/SD or designee shall contact the CME/CMH/SD at the treating institution to provide necessary clinical transfer information.
      3) The CME/CMH/SD or designee at the home institution shall contact the Regional Deputy Medical Executive/RMHA/RDD or designee if there is not an agreement for the Medical/Psychiatric and Return transfer. The impacted Regional Deputy Medical Executives/RMHAs/RDDs shall make the final clinical determination regarding the placement of the patient. The Regional Deputy Medical Executives/RMHAs/RDDs or designees shall notify the home and treating institution's CME/CMH/SD or designee regarding their decision.
      4) The CME/CMH/SD or designee at the home institution shall contact the CME/CMH/SD or designee at the treating institution to initiate the transport of the patient.
      5) The home institution's CME/CMH/SD or designee shall complete a MCC and/or a Mental Health LOC Chrono.
      6) The R&R RN shall complete the Health Care Transfer Information form and include the date, time, and location of the appointment if known. The R&R

RN shall place a copy of the Health Care Transfer Information form in the White Transfer Envelope. Transfer packets shall be completed in accordance with the interfacility transfer process described above in Section III,B,2.

7) The UM staff at each institution shall maintain a Medical/Psychiatric and Return tracking system.

b. Arrival at Treating Institution
   1) The treating institution shall accept all patients coordinated through HCPOP or as determined by the impacted Regional Deputy Medical Executive/ RMHA/RDD.
   2) Upon arrival of the patient at the treating institution, the designated health care staff shall review the Health Care Transfer Information form in the R&R area and identify Medical/Psychiatric and Return patients.
   3) The R&R RN shall notify the UM Nurse, the Specialty Clinic Nurse, and the CME/CMH/SD of the Medical/Psychiatric and Return patient's arrival and appointment date and time.
   4) The CME/CMH/SD is responsible for ensuring necessary follow-up is completed prior to the return of the patient to the home institution. Upon completion of necessary follow-up, the patient shall be returned to the home institution as soon as possible.

c. Treating Institution to Home Institution
   1) The treating institution's CME/CMH/SD or designee shall notify the home institution's CME/CMH/SD or designee of any additional follow-up and shall discuss the patient's treatment plan. The treatment plan shall be documented on the MCC or discharge summary and placed in the patient's health record.
   2) If the patient is to remain at the treating institution for longer than 30 calendar days, the patient shall be seen by a PCP at the treating institution within 14 calendar days of arrival. The PCP shall continue to see the patient no less than every 30 calendar days until the patient returns to the home institution. For participants in the Mental Health Services Delivery System who are not in a psychiatric and return status, a routine referral shall be made to the Mental Health Program for follow up per timeframes in the Mental Health Services Delivery System Program Guide by the PC and/or Primary Psychiatrist. Psychiatric and Return patients are seen daily until the patient returns to his or her home institution.
   3) If a permanent transfer to another institution or retention at the treating institution is medically necessary to access to care, the CME or designee at the treating institution shall complete a new MCC indicating the level of care based on the patient's need if the current MCC does not accurately reflect the patient's level of care needs.
   4) When a patient is cleared for return to the home institution, the treating institution's CME/CMH/SD or designee shall complete an MCC or Mental Health LOC Chrono.
   5) The R&R RN shall complete the Health Care Transfer Information form and specify any necessary follow-up. The R&R RN shall place the Health Care Transfer Information form and any additional medical documentation in the

White Transfer Envelope. Transfer packets shall be completed in accordance with the interfacility transfer process described above in Section III,B,2.

d. Arrival at Home Institution
   1) The R&R RN at the home institution shall see the Medical/Psychiatric and Return patient immediately upon return and complete the interfacility transfer process as described above in Section III,B,2. The R&R RN shall immediately forward a copy of the Health Care Transfer Information form and any additional documentation to the CME (and CMH, as appropriate) and UM Nurse.
   2) Within 14 calendar days of a patient's return to the home institution from a Medical/Psychiatric and Return appointment, the patient shall be seen by the PCP/PC to ensure necessary follow-up is accomplished. Psychiatric and Return patients returning from a Mental Health Crisis Bed (MHCB), Alternative Housing, Mental Health Outpatient Housing Unit, or DSH placement shall be seen within 24 hours by the PC.

4. Transfer from Home Institution to a Higher Level of Care
   a. Unscheduled Transfer: Unscheduled transfers will normally occur as a result of the activation of the Emergency Medical Response at the institution; however, there may be occasions where an immediate transfer to a higher level of care is indicated that are not the result of an Emergency Medical Response.
      1) Patients transported to the TTA. Health care staff shall intervene as necesssary and notify the appropriate medical or mental health on-call provider.
      2) Staff shall notify 911/Emergency Medical Services (EMS) without first contacting the on-call provider, if clinically indicated.
      3) The on-call provider shall provide an order for an emergent transfer to a higher level of care, possible admission and observation/interventions.
      4) The TTA RN may authorize transport to a higher level of care in urgent/emergent situations, if clinically indicated. (Refer to Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12.2, Emergency Medical Response Procedure).
      5) The TTA nursing staff shall contact custody staff for transportation and assist in the completion of all required custody transfer documention (e.g., CDCR 7252, Request for Authorization of Temporary Removal for Medical Treatment).
      6) The TTA nursing staff shall continue to monitor the patient, implement Physician's Orders and appropriate nursing interventions until care is assumed by the EMS provider.
   b. Scheduled Transfer: Transfer packets shall be completed in accordance with the interfacility transfer process described above in Section III,B,2.

5. Transfers to and Returns from a MHCB or DSH Program.
   a. All Transfers to and Returns from a MHCB or DSH program shall be conducted and communicated as outlined in the Mental Health Services Delivery System Program Guide, Chapter 5, Mental Health Crisis Bed, and Chapter 6, Department of Mental Health Inpatient Program, or relevant departmental procedure updates and court documents.

b. The TTA RN shall complete an assessment for patients returning from a MHCB or DSH program and shall ascertain any additional health care needs of the patient. The assessment shall be documented in the patient's health record.
c. The TTA RN shall notify the PC or, if after-hours, the on-call provider, that the patient has returned to the institution. The appropriate provider (PC/on-call provider) shall indicate orders for appropriate housing. If the patient has medical needs, the PCP or, if after-hours, the on-call PCP shall also be notified that the patient has returned to the institution and orders obtained as necessary.
d. The TTA RN shall utilize the scheduling system to ensure the patient receives follow-up medical appointments per policy (Refer to Section III,E,13). The RN shall communicate follow up care ordered by the PC/on-call mental health provider to the mental health scheduler using approved institutional procedures.
e. If the patient requires five-day daily follow-ups, the TTA RN shall ensure that this information is immediately reported to the institution's designated mental health point of contact for five-day daily follow-ups. This referral shall be documented in the patient's health record.

D. Medical Hold

1. The Medical Hold process shall be utilized when a patient requires medically necessary health care services, and it is medically prudent to provide these services at the CDCR institution where the patient is currently housed.
2. The following patients require licensed health care (RN or higher licensure) evaluation for Medical Hold:
   a. Patients scheduled for major surgery, or recovering from major surgery and requiring close post-operative review by the surgical team.
   b. Patients having chemotherapy or radiation therapy treatment.
   c. Patients undergoing a diagnostic workup including biopsies of suspicious lesions, cancer, or other high risk conditions for which time sensitive evaluation is medically necessary.
   d. Patients being fitted for a major prosthetic, requiring temporary prostheses adjustments and frequent visits.
   e. Patients awaiting delivery of major DME.
   f. Patients scheduled for a specialist visit, which cannot easily be duplicated elsewhere (e.g., surgical subspecialties such as retinal surgery, or specialized oncology surgery).
   g. All patients who have pending urgent Request for Services or specialty appointments.
   h. Hemophiliac, Hemodialysis, Hepatitis C virus, post-transplant, or human immunodeficiency virus/acquired immunodeficiency syndrome patients requiring close management of medication access and continuity.
   i. Patients in the middle of a speech therapy, occupational therapy, or physical therapy regimen that would be adversely impacted by transfer.
   j. Patients for whom an immediate denture was recently inserted.
   k. Patients at a Program Facility awaiting completion of endodontic treatment.
   l. Patients awaiting or in the middle of care for jaw fractures.
   m. Patients with untreated Dental Priority Classification 1A conditions.
   n. Patients receiving Clozapine.

o. Patients awaiting court or other hearings for health care-related matters.
p. Patients with high risk pregnancies, in late second trimester or third trimester.
q. Patients on quarantine or isolation for a variety of conditions, including but not limited to the following:
   - TB.
   - Influenza-like illness.
   - Gastroenteritis.
   - Sexually transmitted diseases under treatment.
   - Source cases until clearance obtained.
   - Contact cases until clearance obtained.

3. If a medical hold is necessary, the designated health care staff shall complete a MCC at the time of the patient's evaluation. If an RN completes the MCC, he or she shall notify the PCP/PCT.
4. If the sending RN identifies a patient who requires a medical hold at the time of departure, the CME and Chief Nurse Executive or designees shall be notified.

E. Return from a Correctional Treatment Center, Skilled Nursing Facility, or Community Medical Hospital to the General Population

1. The UM Nurse shall conduct a level of care assessment and notify the CME/CMH/SD or designee that a patient is ready to be discharged from a Correctional Treatment Center (CTC), SNF, or community medical hospital.
2. In order to expedite the return of the patient, the UM Nurse shall request the sending location to fax discharge documents (active problems, medication, comprehensive treatment plans, equipment needs, and follow-up) to the UM office.
3. Transfers within the CDCR: The sending UM Nurse shall advise the receiving institution UM Nurse and CME/CMH/SD or designee of the clinical condition/needs of the patient and, if the patient needs placement in a specialized medical bed, notify HCPOP regarding the need for placement.
4. Transfers from Community Medical Hospitals: The UM Nurse shall participate in daily hospital rounds, communicate with hospital case managers to obtain relevant clinical information, and coordinate a call between the CME/CMH/SD or designee and the treating physician at the hospital to facilitate discharge of the patient back to the institution.
5. The UM Nurse shall coordinate the transfer of the patient with the appropriate staff and communicate all discharge information and discharge plan of care to the patient's PCT.
6. Patients accepted to return, must be reviewed in a timeframe that ensures patient safety, continuity of care, and optimal clinical outcomes, but in all cases, no more than five calendar days after discharge, through a direct PCP and/or psychiatrist encounter to assess the patient's health care needs.
7. The UM Nurse shall identify medical equipment needs and applicable training issues and notify the SRN II or designee of transfer and health care needs of the patient. The SRN II or designee shall obtain or facilitate procurement of necessary equipment and shall coordinate required training. The patient shall be educated regarding necessary DME.
8. Prior to transfer of the patient, the CTC or SNF staff shall complete an assessment and document the discharge diagnosis and instructions. The discharge documentation

shall indicate any additional health care needs of the patient. The discharge summary and any other relevant documentation shall be transferred with the patient.

9. Upon return from the CTC, SNF or community medical hospital, the patient shall be processed through the TTA. The TTA RN shall review the discharge plan and any other documentation.
10. The TTA RN shall complete an assessment for patients returning from a CTC, SNF or community medical hospital and shall ascertain any additional health care needs of the patient. The assessment shall be documented in the patient's health record.
11. The TTA RN shall notify the PCP/PC or, if after hours, the on-call provider, that the patient has returned to the institution. The appropriate on-call provider shall indicate orders for appropriate housing.
12. The TTA RN shall utilize the scheduling system to ensure the patient receives a follow-up appointment, including referrals to mental health as appropriate.
13. The patient shall receive a follow-up appointment with his or her PCP/PC in a timeframe that ensures patient safety, continuity of care and optimal clinical outcomes, but in all cases, no later than five calendar days from discharge from a CTC, SNF or community medical hospital to provide follow-up and evaluate the need for chronic care or other medical needs.

F. Annual Review

The C&PR submits the Endorsed List to Health Information Management, Pharmacy, the Mental Health Program, and R&R at regulars intervals negotiated and documented in the LOP.

1. The annual review list shall be reviewed by the R&R RN utilizing the Patient Summary Sheet to pre-screen and determine those patients who should be on a medical hold. The R&R RN accesses the Master Registry via the Quality Management Portal and reviews the Patient Summary Sheets for each patient on the Transfer List. If the patient does not have a medical condition that requires necessary health care services, the R&R RN shall verify that the patient does not meet the medical hold criteria on the proposed Transfer List and send a copy of the list to the C&PR.
2. Patients who meet medical hold criteria or have a medical condition that requires necessary health care services shall have a medical hold initiated utilizing the approved medical classification chrono/hold process as described below:
   a. The R&R RN reviews the health record.
   b. The R&R RN coordinates with the appropriate PCTs to resolve discrepancies identified in the initial review that impede the patient's eligibility for transfer. If the discrepancies are resolved, the R&R RN clears the patient for transfer and communicates the information to the C&PR.
   c. If a medical hold needs to be placed on the patient's transfer, the R&R RN shall identify the patient as NOT appropriate for transfer on the proposed Transfer List and communicate the medical hold to the C&PR.
   d. If there is disagreement regarding the health care appropriateness of the patient transfer, the R&R RN shall elevate the case to the SRN II. The SRN II shall follow the institution's problem resolution process.
3. If a patient does not meet the need for a medical hold but has relatively complex patient care issues (e.g., multiple co-morbidities, special equipment needs), the R&R

RN shall notify the PCT for further evaluation of the patient for transfer and to facilitate transition of care, hand-off communication as indicated.

a. Transitions of care occurs regularly under many conditions within CDCR including, but not limited to:
   - The result of a change in the patient's level of care (e.g., from a clinic to the TTA or from CTC back to general population housing).
   - The transfer of patients from one housing location to another within an institution.
   - The transfer of patients between institutions.

b. Hand-off communication is:
   - The sharing of information necessary to support the transition of care for a patient from one care team to another.
   - An interactive communication process of passing specific, essential patient information from one care team to another by appropriate means such as direct verbal communication, Patient Summary Sheets, and Transfer Checklists based on the transition of care and the patient's acuity.

c. For patients with complex care issues (e.g., multiple co-morbidities, special equipment needs), the institution shall consider direct verbal communication (e.g., CME – CME, Chief Nurse Executive (CNE) – CNE, or CMH – CMH) as part of the hand-off process when the transition of care involves movement of the patient between institutions or levels of care.

4. The R&R RN shall identify on the proposed Transfer List all patients who are NOT medically cleared for transfer and return a copy of the annotated list to the C&PR.
5. If the patient is cleared for transfer, the PCT shall ensure all medications within 14 days of expiration are reviewed for cancellation/renewal and the MCC is current.

IV. REFERENCES

- California Code of Regulations, Title 22, Division 7, Chapter 12, Article 3, Section 97520.13, Patient Transfer
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 4, Chapter 1, Complete Care Model Policy
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 4, Chapter 8, Outpatient - Specialty Services
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 4, Chapter 11.6, Medication Continuity with Patient Movement: Transfer/Parole/Release Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12.2, Emergency Medical Response System Procedure.
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 4, Chapters 29.1 and 29.2, Medical Classification System Policy and Procedure
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 4, Chapter 32 and 32.1, Durable Medical Equipment and Medical Supply Policy and Procedure

- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 9, Chapter 39, Transfer Medications
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 10, Chapter 3, Tuberculosis Program Policy
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures Volume 13, Chapter 13.1, General Use and Disclosure of Protected Health Information Policy
- California Department of Corrections and Rehabilitation, Department Operations Manual, Section 62080.15.2
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 5, Mental Health Crisis Bed
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 6, Department of Mental Health Inpatient Program
- California Department of Corrections and Rehabilitation, Inmate Dental Services Program Policies and Procedures