Primary Care Health Homes Transfer Protocols

Please note: All transfer requests are effective the first day of the month following the month in which the transfer was approved. All transfer request forms emailed to the Health Home Enrollment Coordinator must be sent in an **encrypted email or as a password protected Word document** to comply with HIPAA requirements. A separate document should be used for each form, and each should include some unique identifier (e.g. last name) on the file name. The words "PCHH TRANSFER" should be included in the subject line of the email.

Transfers from one Health Home to another can be initiated by:

- Patients/guardian
- The Health Home
- MO HealthNet

Transfers initiated by a patient/guardian

A patient without a legal guardian may request a transfer at any time from the currently assigned Health Home provider to another one. This is done by contacting Health Home provider either by phone or in the initial face to face meeting, or any time thereafter.

Transfers initiated by the Health Home

Providers may initiate the transfer of an enrolled patient to another Health Home if they believe the patient would benefit from the transfer, or if the patient is moving from one service area to another.

- Patient/guardian must be consulted to discuss and approve the transfer request. The transfer request form is completed by the current Health Home provider.
- The provider then contacts the director of the other Health Home and they consult with each other regarding the transfer request.

Transfers initiated by Mo HealthNet

- This should occur infrequently. The Primary Care Project Lead contacts the participant/ guardian, the current Health Home, and the prospective Health Home and completes the transfer request as appropriate. The Health Home Enrollment Coordinator emails it to the Health Home Directors of both Health Homes. The Health Home Enrollment Coordinator emails a transfer approval notification letter to the current Health Home and the Health Home they are transferring to, and mails one to the patient (and guardian, if applicable). Both Health Homes email the Health Home Enrollment Coordinator an acknowledgement of receipt of the completed transfer request form and the transfer approval notification letter.
- The provider the patient is transferring to must meet with the patient for an introduction to the new agency, and to review details of the transfer and assure continuity of care.

Transfer Procedures

- If the transfer request is agreed to by the other Health Home:
  - The current Health Home provider completes the HH transfer request form (making sure to check the box on the form indicating that the prospective Health Home has approved the transfer) and emails it to the attention of the HH Enrollment Coordinator to complete the transfer.
  - The HH Enrollment Coordinator completes the transfer request form and emails it to the HH Directors of both Health Homes. The Health Home Enrollment Coordinator emails a transfer approval notification letter to the current Health Home and the Health Home they are transferring to, and mails one to the patient (and guardian, if applicable). Both Health Homes email the Health Home Enrollment Coordinator an acknowledgement of receipt of the completed transfer request form and the transfer approval notification letter.
  - The provider the patient is transferring to must meet with the patient for an introduction to the new agency, and to review details of the transfer and assure continuity of care.
- If the transfer request is not agreed to by the other Health Home :
  - The current Health Home completes the HH transfer request form and emails it to the Health Home Enrollment Coordinator.
  - The Health Home Enrollment Coordinator refers the request to the Primary Care Project Lead for further review.

Transfers from one type of health home to another (e.g. Primary Care to Community Mental Health Center (or vice versa)

If a patient wants to transfer from a primary care Health Home to a community mental health center Health Home (or vice versa), this is treated as a discharge and enrollment. If the patient communicates this desire to the **original** Health Home, that Health Home contacts the **requested** Health Home to notify them of the patient's plans. The **original** Health Home completes a discharge form and submits it to Marcia Seabourne for processing. The **receiving/requested** Health Home contacts the patient to discuss enrollment and then completes an enrollment form and submits it to Marcia Seabourne.

If the patient communicates this desire to the **requested** Health Home, that Health Home contacts the **original** Health Home to notify them of the patient's desire and requests that Health Home submit a discharge form on the patient. The original health discusses and confirms the request with the patient. The **original** Health Home completes the discharge form and submits it to Marcia Seabourne. The **requested/ receiving** Health Home completes an enrollment form and emails it to Marcia Seabourne.

NOTE: Enrollment forms cannot be processed until discharge forms have been processed.