AH3600 – Repatriation Policy

1.0 PURPOSE

This policy outlines the standard operating procedure and performance expectations for Patient Repatriation activities originating at Interior Health (IH) acute care facilities. It is expected that interdisciplinary teams will engage proactively and in a collaborative fashion to coordinate Patient Repatriations in a seamless and timely fashion across the continuum of care.

2.0 DEFINITIONS

ALC (N) and (P)	Alternative Level of Care Patients no longer require acute care services but are either awaiting placement to residential care (ALC-P) or unable to move from acute care for another reason (ALC-N). ALC days are a systems issue, reflecting challenges in different parts of the healthcare system, including acute, community, and/or long-term care.
ASP	Alternate Service Provider. Contracted stretcher service provider for non-medical inter-facility transportation.
BCAS	British Columbia Ambulance Service. The BCAS provides public ambulance service in British Columbia under the authority of the BC Emergency Health Services (BCEHS).
EDD	Estimated Date of Discharge. The likely date that a Patient completes their tertiary or acute level of care and is ready for discharge or Repatriation to their home (with or without additional home and community care support), or to the health care facility located closest to the Patient's residence.
HCC	Home and Community Care. Service offering a variety of at-home and community services to people with acute, chronic, palliative or rehabilitative health care needs.
Home Health Facility	The IH facility in the closest geographic proximity to the Patients' home address at the time of admission. In rural areas there may be more than one option of home health facility that can provide the appropriate level of care or access to services. This choice should be influenced by the available and most appropriate choice of MRP.
LHA	Local Health Area. Describes the catchment boundary that follows generally accepted Patient referral pathways.
MRP	Most Responsible Practitioner. The single designated health professional who has primary responsibility for the care of a Patient within an IH facility or program. In most cases, this will be the physician of record or the admitting physician.
Patient	All persons (adult, child, or infant) who receive or request health care or services from IH and its health care providers.
Patient Residence	The Patient's home address at the time of admission (i.e. private residence, residential care facility or assisted living facility).
Receiving Location	The location to which the Patient is being transferred as determined by: geography (closest appropriate service to the Patient's home); the clinical and psychosocial needs of the Patient; and accessibility to the appropriate

	service.
Repatriation	Transferring a Patient to a facility or residence with the most appropriate service closest to the Patient's home community.
Repatriation Planning	A series of cumulative Repatriation Planning activities undertaken during the Patient's acute care phase of hospitalization.
RMS	IH Repatriation Management System. The set of processes to support proactive Planning and coordination of Patient Repatriation activities across the continuum of care. The IH Patient Transport Office (IH PTO) manages the system. The system includes but is not limited to: a) an electronic Planning tool to enable inter-disciplinary/inter-facility Repatriation transition Planning[1]; and b), daily Repatriation Planning teleconferences with IH transition planners.
Sending Hospital	The acute care hospital where the Patient is currently receiving services.
TL RN	Transition Liaison Registered Nurse. This person works collaboratively with stakeholders to assess and plan appropriate health care resources to support the transition of Patients between a higher level of care and the most appropriate setting in the Patients' home community.

3.0 POLICY

A "One IH" standard approach to Repatriation Planning facilitates seamless transitional care across the health continuum; optimization of resources; and the ability to track and monitor performance of the RMS. Intra-health authority Patient Repatriation Planning is the responsibility of the Health Authorities[2].

Proactive Repatriation Planning provides the inter-disciplinary team with sufficient time to prepare resources and transitional plans in advance of the Patient's Repatriation. This ensures Patients will be managed safely and effectively throughout the transitional period. The Repatriation procedure is outlined in Appendix A. Considerations for Repatriation Planning include:

- Ensuring acceptance of a MRP for Patients who are to be repatriated. The optimal MRP notification period is 72 hours prior to transfer.
- Direct MRP to MRP verbal and written transfer of care report[3].
- Sending/receiving Patient care unit(s)/representative(s) to complete a verbal handover report prior to Repatriation.
- Sending Patient care unit(s)/representative(s) to send standard or appropriate inter-disciplinary clinical report prior to Repatriation.

[1] Teamsite Repatriation Tool Privacy Impact Assessment 863380 – approved September 26, 2013
[2] Draft Provincial Repatriation Policy, 2016
[3] IH Verbal Communication – Interactive Hand-Overs September 2015

- Receiving facilities will pre-plan contingencies in advance of the transfer to ensure clinical resources and supplies are in place upon receipt of Patient.

- As required, the sending hospital will provide sufficient resources (e.g. temporary supply of pharmaceuticals) to support Patient care until the Receiving Location acquires the necessary supplies.

3.1 Policy Objectives

- Achieve a standard regional approach to Repatriation Planning.
- Define expectations, timelines, and supporting systems for Repatriation.
- Outline operational processes and procedures, including an escalation pathway to resolve issues.
- Define a standard process to address Patient safety and quality concerns.

3.2 Policy Scope

3.2.1 Repatriation Planning includes Patient care transitions between:

- Acute facilities
- Acute facility and Patient's residence
- Acute facility and Patient's residence with additional HCC support.

3.2.2 The mode of transport used is dependent on the Patient's clinical needs as outlined in the Provincial Policy for Inter Facility Transfers[4];

3.2.3 All IH employees, members of the medical staff, students, volunteers and other persons acting on behalf of IH (including contracted service providers) must comply with this policy.

4.0 OPERATING PROCEDURE and PRINCIPLES

4.1 This policy supports proactive Repatriation Planning (i.e. early notification of the intent to Repatriate a Patient) for the purpose of achieving a seamless transition of care between MRPs and facility staff. The IH MRP Policy[5] provides an overview of the accountabilities and responsibilities of the MRP's involvement in the transition and handover of Patient care. An overview of MRP Repatriation processes is outlined in Appendix B.

4.2 The Sending Hospital and Receiving Location will develop a Repatriation Plan that leverages a network of facilities, beds, and clinical services across IH.

[4] Ministry of Health Policy Communique on Inter Facility Patient Transfers, 2010
[5] IH Policy MSQ0100 - Most Responsible Practitioner

4.2.1 If the Patient's home community cannot provide the required clinical services, the Sending Hospital and MRP will refer the Patient to the next "closest" appropriate health care facility/service.

4.2.2 Where clinically appropriate, the Patient will be repatriated to their Patient Residence with appropriate home care supports coordinated by Hospitals and Communities Integrated Services (HCIS);

4.2.3 Consideration will be given to Repatriating the Patient directly to their Home Health Facility under the care of the Patient's general practitioner for the purpose of ensuring continuity of Patient care.

4.2.4 Within 24 hours of the decision to Repatriate, one of the following will occur:

(a) A collaborative plan for transition is developed between the Sending Hospital and Receiving Location whereby:

i. Both parties negotiate a mutually agreeable timeframe for Repatriation; or

ii. Both parties develop a mutually agreeable alternative destination (i.e. next closest hospital or alternative care setting in the community); or

iii. If a mutually agreeable alternative arrangement cannot be reached within 24 hours, the matter is escalated for resolution to senior decision-makers per Appendix C.

4.2.5 The Patient is Repatriated to the most appropriate level of care.

4.2.6 If within 24 hours of the Patient's arrival at the Receiving Location, the MRP determines the Patient's care needs exceed local capacity, the MRP will determine an appropriate alternative destination for the Patient. Such cases will be referred to the Access Care Transitions Steering Committee (ACTSC) and the Medical Director of Patient Access and Flow, for a quality review.

4.3 Stakeholders will escalate Repatriation challenges and barriers to senior leadership within 24 hours of the planned date and time of the Patient's Repatriation[6] (Appendix C).

4.4 This policy aligns with Ministry of Health and IH's strategic goals and objectives; and complies with provincial and health authority policies related to Patient accessibility to health care services.

4.5 That the policy adheres to the provincial framework for inter facility Patient transfers[4].

4.6 That the policy considers incidents of hardship per IH Policy AH 0900 - Hardship Assistance for Clients and/or Accompanying Caregiver.

[6] IH Support Action Plan

4.7 That access to long term residential care from an acute care site is approved through the Program Access Coordination Committee (PACC), IH Policy HCCK 0900: Access to Long Term Residential Care Practice Standard.

4.8 Role of the IH PTO

4.8.1 Accountable to the ACTSC for defining, building, implementing, and maintaining the IH RMS.

4.8.2 Accountable for collaborating with stakeholders on the design, implementation and management of the RMS.

4.8.3 Responsible and accountable for:

(a) Regional Repatriation TL RN role

- Facilitates the Repatriation Planning process including, but not limited to system monitoring and issues resolution during operational hours (Monday-Friday 0800-1600);
- Provides the central point of contact for real time escalation and problem-solving of complex Patient transfers during operational hours (Monday-Friday 0800-1600).

(b) Coordinating all routine, scheduled inter-facility transfers and performance monitoring related to same;

(c) Collaborate and coordinate with the BCAS and ASP for scheduled, preplanned movement of Patients requiring medical or supportive transportation (ground or air);

(d) Performance monitoring and reporting; and

(e) Communication of relevant Patient Repatriation and transportation policies and procedures with IH stakeholders.

4.8.4 The IH PTO is not responsible or accountable for:

(a) Operational management of facility and home and community care services including bed allocation, scheduling of health care appointments, human resource management, assignment of MRP, and coordination of clinical service delivery (e.g. ensuring required medical supplies are available); or

(b) Operational management of BCAS resources (air and ground), including the dispatch and coordination of resources, and availability of services.

4.9 Role of HCIS

4.9.1 Supporting the IH RMS, including but not limited to:

(a) Regular information updates on the electronic Repatriation Planning tool;

(b) Ensuring appropriate representation and active participation in the daily regional inter-facility Repatriation Planning teleconference; and

(c) Identification and escalation of any issues and barriers to timely Repatriation (Appendix C).

4.9.2 Accountable and responsible for:

(a) Collaborating with the IH PTO and Receiving Location to identify the most appropriate destination of the Patient based on the Patient's care needs;

(b) Developing internal procedures and protocols to appropriately identify an MRP in a timely manner[3];

(c) Developing internal procedures and processes to plan and manage complex Repatriation requests within timeframes outlined in this policy (Appendix A);

(d) Ensuring sending/receiving Patient care unit(s)/representative(s) complete a verbal transition of care report and completion of standard Patient transfer form(s); and

(e) Logistical planning to ensure a seamless transition in care.

4.10 Inclusions and exclusions

4.10.1 Inclusions

(a) Patients admitted to a tertiary, regional or community hospital within or outside the LHA of their Patient Residence and now require Repatriation to their Receiving Location.

(b) Intra-IH Repatriation transfers.

(c) Repatriation of Patients whose Patient Residence at the time of admission is a residential care or assisted living facility.

(d) Patients accepted per the AH0300 – No Refusal Life Limb Threatened Organ (LLTO) and Psychiatric Behavioral Emergency Patient Policy are to be Repatriated to their home facility within 24 hours of being deemed appropriate for Repatriation.

(e) Out-of-town Patients whose home is located in IH and are designated ALC.

4.10.2 Exclusions

(a) Patients currently meeting or anticipated to meet ALC-P with the exception of 4.10.1 (e).

(b) Inter-health authority transfers[7].

(c) Repatriations to a facility or residence located out of province/country[7].

4.11 Reporting

4.11.1 IH PTO will provide regular reports to the ACTSC and other stakeholder groups as requested.

4.11.2 The ACTSC is accountable to review reports and work collaboratively to address any issues or challenges.

Note: *Ability to report on activity requires staff compliance with the RMS.*

4.12 Quality Assurance

4.12.1 The Receiving Location will file a Patient Safety Learning System (PSLS) report in the event of a clinical incident or quality of care concern associated with the Patient's transition between facilities. The handler is identified as the most responsible person at the location of the Patient.

4.12.2 The IH PTO will flag quality and Patient safety events to the ACTSC and Medical Director for Patient Access and Flow.

4.12.3 The IH PTO will generate regular Repatriation performance metric reports (Appendix D) for the ACTSC and other stakeholder groups as requested.

5.0 REFERENCES

1. Teamsite Repatriation Tool Privacy Impact Assessment 863380
2. Draft Provincial Repatriation Policy, 2016
3. IH Verbal Communication – Interactive Hand-Overs September 2015
4. Ministry of Health Policy Communique on Inter Facility Transfers, 2010
5. IH Policy MSQ0100—Most Responsible Practitioner
6. IH Support Action Plan
7. Provincial Repatriation Policy (pending)
8. *Access Repatriation Coordination Centre (ARCC) Concept Document (Draft)*
9. *IH Policy HCCK 0900 - Access to Long Term Residential Care Practice Standard*
10. *IH Policy AH 0900 - Hardship Assistance for Clients and/or Accompanying Caregiver*
11. *IH Acute Care Patient Transfer Form (826374)*
12. *48/6 Assessment Forms*
13. *AH0300 No Refusal – Life Limb Threatened Organ (LLTO) and Psychiatric Behavioral Emergency Patient*

[7] Provincial Repatriation Policy pending

14. *Bryant MacLean, L. (2015), Transitions in the Care and the Role of Transitions Liaisons: An Overview of the Peer-Reviewed Evidence, Interior Health Knowledge Support*
15. *Brown, S. (2005, August). A Centralized System to Access Acute Healthcare Services: The Pros and Cons. In Healthcare Management Forum (Vol. 18, No. 2, pp. 34-37). Elsevier.*
16. *List of referred documents:*
    - Alberta Health Services – Patient Repatriation Procedure – HCS-04-01
    - Repatriation Guide, Critical Care Services Ontario, 2014
    - NHS Wales Policy for the Repatriation of Patients, 2013
    - NSW Care Coordination – Admission to Transfer of Care, 2011

6.0 APPENDICES

Appendix A - IH Repatriation Procedure
Appendix B - Most Responsible Practitioner Repatriation Process
Appendix C - Repatriation Escalation Pathway
Appendix D - Performance Metrics

Appendix A
IH Repatriation Procedure

A.1 Prior to admission to a Higher Level of Care (HLOC), the Sending Hospital submits the appropriate transfer form, and where possible, identifies the Patient's repatriating MRP. In most cases, the repatriating MRP will be the Patient's family practitioner.

A.2 At the time of admission to a HLOC, the inter-disciplinary team determines an EDD. This information is entered into the IH Repatriation Planning Tool.

A.3 Patient Care Coordinators or facility designated staff provide regular updates in the electronic Repatriation Planning tool.

A.4 Each facility ensures appropriate representation to participate in daily region-wide Repatriation Planning teleconference(s).

A.5 Planning activities include:

a) Identification of the most appropriate destination of the patient based on their ongoing care needs in collaboration with the home hospital;

b) Identification of the MRP at the receiving facility (Note: Ideally, the MRP is notified up to 72 hours in advance of planned repatriation activity).

A.6 A minimum of 24 hours prior to the Patient being ready for Repatriation, the Sending Hospital updates the IH Repatriation Planning tool with:

a) The anticipated discharge date;

b) Receiving Location (if not yet determined);

c) Clinical service requirements;

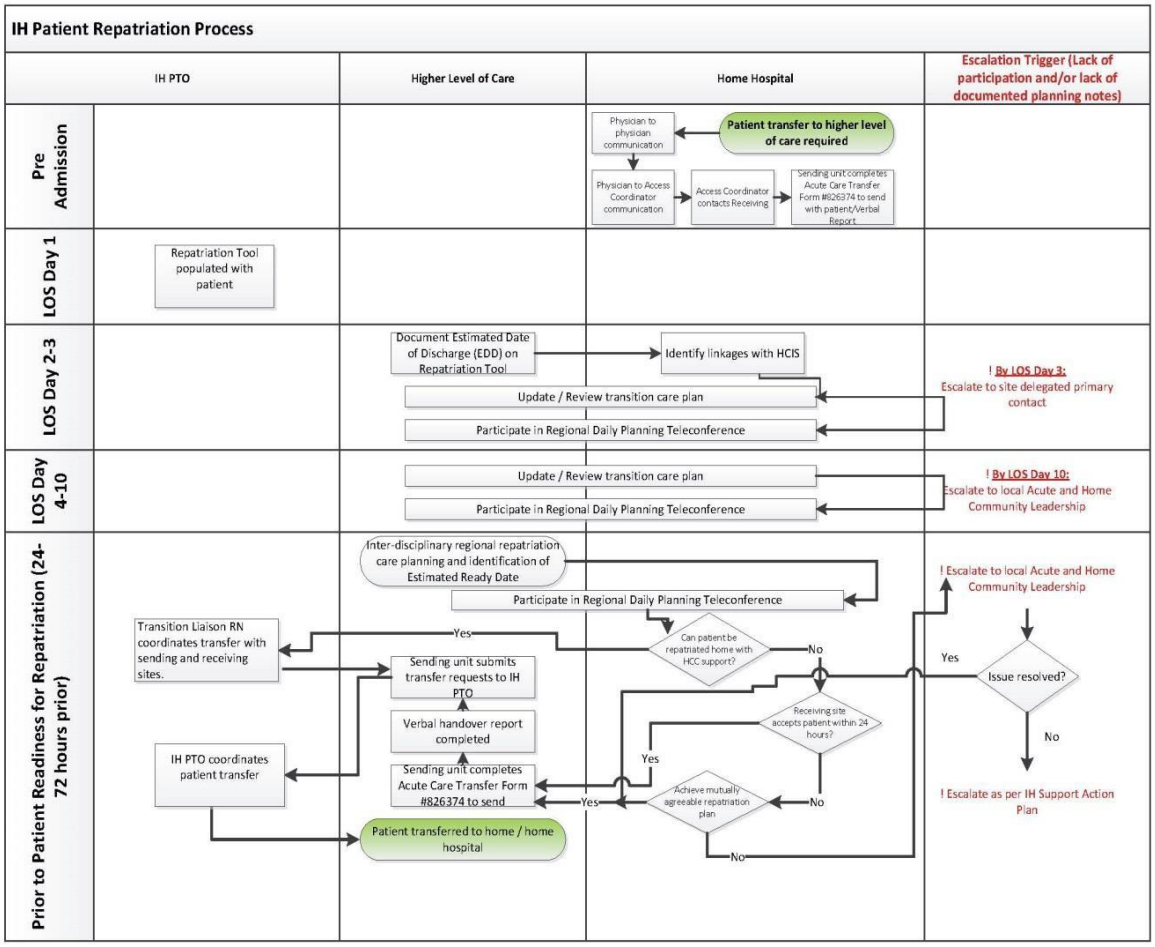
d) Planning and logistical details as required (if not yet determined).

A.7 If the appropriate receiving location cannot accommodate the Patient within 24 hours, then one of the following may occur within 24 hours:

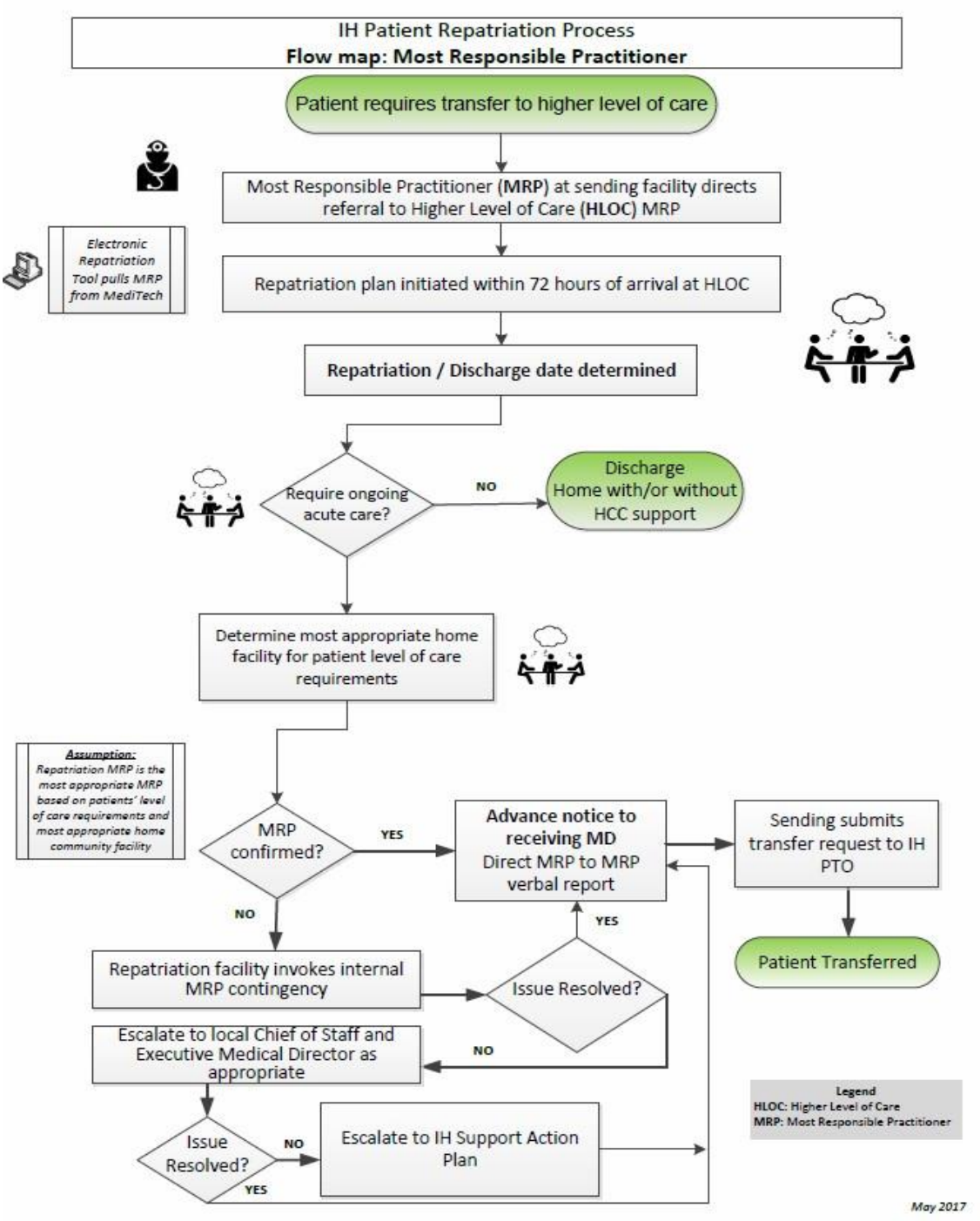
- Both facilities negotiate a mutually agreeable timeframe for Repatriation, or
- Both facilities develop a mutually agreeable alternative destination (e.g. next closest hospital or alternative care setting in the community), or
- If a mutually agreeable alternative arrangement cannot be reached, the matter is escalated for resolution to senior decision-makers.
- Outcome of alternative Planning will be documented on the Repatriation tool.

A.8 When the Repatriation plan is confirmed with a Receiving Location, the following will occur:

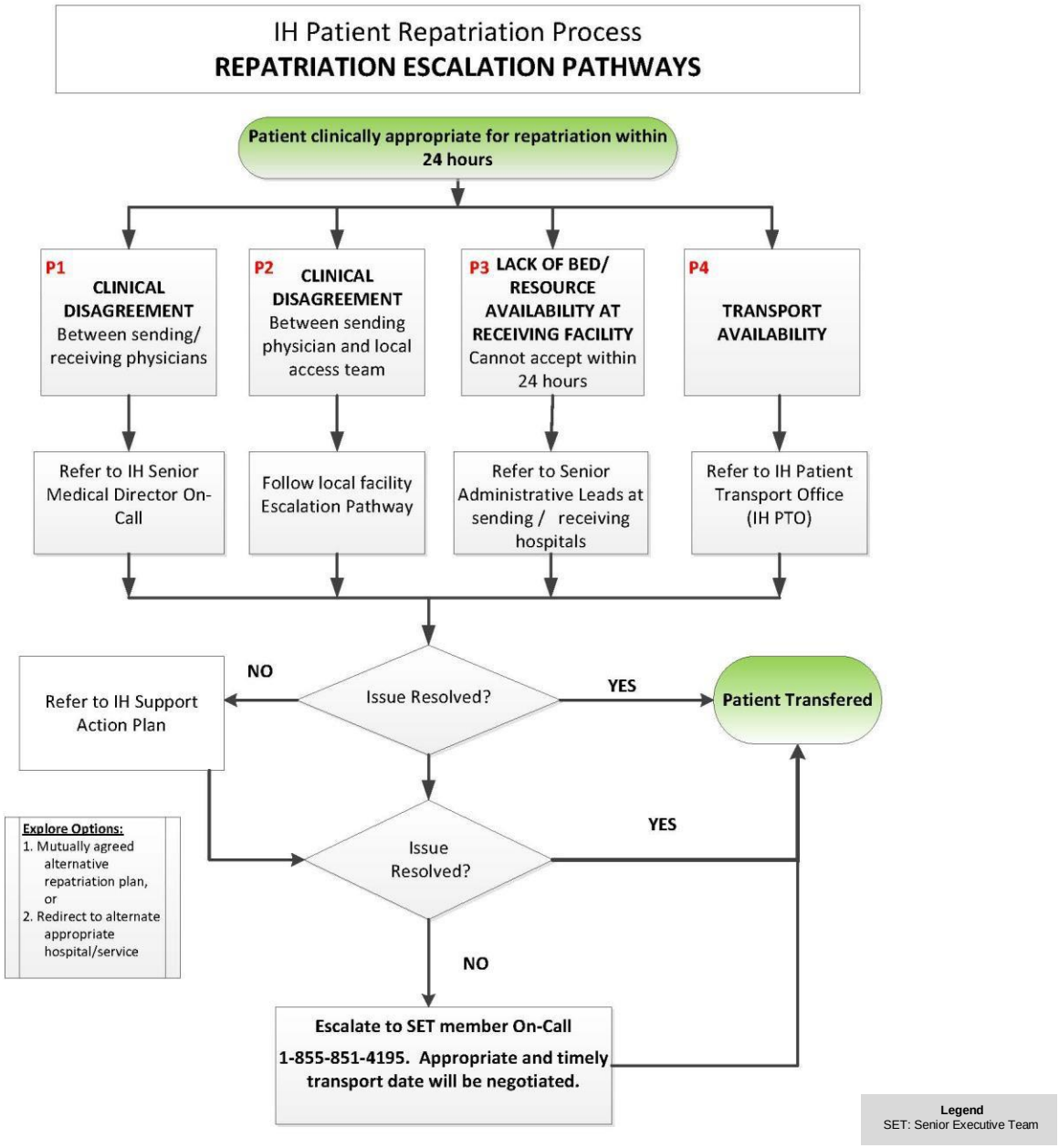
- Direct verbal and written transfer of care report between sending and receiving MRPs;
- Sending/ receiving Patient care unit(s)/representative(s) to complete verbal handover report;
- Sending facility submits Patient transfer request to IH PTO online at https://Patienttransport (air or ground ambulance);
- Sending facility ensures the Patient and family are updated on the plan of care;
- Sending facility completes Acute Care Patient Transfer Form (826374);



Appendix B
Most Responsible Practitioner Process



Appendix C Repatriation Escalation Pathway



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Appendix D
Performance Metrics

The following metrics to be delivered weekly to facility leadership for review and follow-up:

- % participation by facility: goal 100%
- % Patients with a Repatriation plan documented at LOS 3 days: goal 90%
- % Patients with a Repatriation plan documented at LOS 10 days: goal 100%
- % Patients with updated Repatriation plans every 3 days: goal 100%
- % Patients with EDD (increasing trend over time).

The following success metrics will also be monitored and evaluated alongside the above performance metrics in relation to TL RN role.

Value Indicator	Success Metric	Source
Decrease length of stay (LOS) for out of town patients	Average LOS(ALOS) , based on patient case mix group (CMG), should be equal to or less than ALOS for local patients with same case mix.	Discharge Abstract Database (DAD)
Decrease ALCN rate at hospitals for out-of-town patients	Decrease ALCN trend (Yr over Yr)	Repatriation Management System (RMS) and Meditech Data
Increase number of repatriations coordinated to patient residence vs. community hospital	Increase trend of repatriations to HCC (Yr. over Yr, using FY2016/17 as baseline)	RMS and Meditech Data
Increase rate of acceptance at repatriation site	90% patients repatriated within 24 hrs. of planned date and time of acceptance	RMS Data
Improve interconnectedness between IH facilities and HCC	1) 100% participation in RMS process	1) RMS Data
	- Electronic care plan documentation	2) Qualitative Research Study (proposed)
	- Participation at daily teleconference	3) As above
	2) Increase trust between facilities	
	3) Increase understanding of cross facility services	
Increase rate of patient transfer vehicles booked with > 24 hour notice	1) 90% repatriations by ambulance booked with 24 hour notice	1) On Line Patient Transportation Information System (OTIS) Data
	2) Financial savings (BC Ambulance charges IH at a lower rate for transfers booked with > 24 hrs.)	2) BC Ambulance Service Invoice Data