Saskatchewan Health Authority

**Key Messages**
**Questions & Answers**

# Patient transfers between urban, rural and northern care teams

## Key Messages

- The Saskatchewan Health Authority (SHA) is taking a collaborative, provincial approach to addressing system pressure by facilitating the transfer of patients who no longer require specialized care in higher acuity urban centres to lower acuity rural and northern centres with available capacity.

- The transfers are part of an initiative to ensure that the right patient receives the right care in the right location. Patients who no longer require specialized care in a higher acuity urban centre (e.g. Saskatoon, Regina, Prince Albert), but still require ongoing care, will be required to transfer to a hospital or long-term care in rural or northern settings that can safely meet their needs as close to home, or the patient's family support person, as possible.

- Transfers are planned in consultation with the patient and family, and both the patient and the receiving hospital are provided with detailed information outlining the process and coordination of the transfer.

- This collaborative, provincial approach will support the needs of all patients in settings that meet their unique care needs, as well as contribute to reducing emergency department and inpatient admission wait times, and level the workload among healthcare teams across the province.

- The SHA understands that a transfer may be difficult for patients and their families. We appreciate your support as we work together as a province to meet the needs of all patients.

## Questions and Answers

**Q. Why are patients being transferred from urban hospitals to rural or northern hospitals?**
**A.** Urban hospitals like those in Saskatoon, Regina and Prince Albert are equipped to provide specialized care for the people of Saskatchewan that may not be available elsewhere in the province. When patients no longer require this specialized care, but still require ongoing care, they will be required to transfer to rural or northern hospitals/long-term care settings that can safely meet their care needs as close to home, or as close to their family support person, as possible.

**Q. Which patients are considered for transfers?**
**A.** Patients who no longer require the specialized care provided in higher acuity urban centres (e.g., hospitals in Saskatoon, Regina, Prince Albert), but still require ongoing care that can safely be provided in a lower acuity rural or nothern hospital/long-term care home, will be considered for transfer. Patients waiting for program beds (e.g., convalescent, rehabilitative, long-term care) may also be considered for transfer.

**Q. Who is involved in the patient transfers?**
**A.** Interdisciplinary care teams will assess patient care needs and identify when they no longer require the specialized care provided in higher acuity, city-based hospital settings. Once a patient is identified,

care teams collaborate with the rural and northern System Flow Coordination Centres to match patient care needs to a facility with the capacity to safely meet their needs. Each patient is assessed on an individual basis to ensure that their unique needs are fully understood and well matched to the centre that can best meet their needs.

Patient transfers will only be made with physician-to-physician and nurse-to-nurse consultation and handover. This allows for confirmation that each patient's unique care needs can be met, that the receiving care team is well positioned to continue the patient's treatment and care plans, and that the patient experiences a seamless transition. The patient's personal health information will only be shared with the healthcare team involved in each patient transfer, in compliance with legislation relating to the privacy and confidentiality of personal and health information (i.e., The Health Information Protection Act [HIPA] and The Local Authority Freedom of Information and Protection of Privacy Act [LA FOIP]).

**Q. Do patients have to accept the transfer?**
**A.** Yes. When capacity level triggers have been met, all patients in the higher acuity centre/area who can safely be transferred are required to accept the transfer given the significant strain on specialized hospitals in these centres. In high acuity centres not triggered, patients transfers can be requested and encouraged in order to match a patient's care needs to the right level of service; however, they will not be mandatory until triggers are met.

**Q. What if a patient refuses to accept the transfer?** If a patient refuses to transfer, please inform them of the appeal process for that area and arrange a formal meeting for them and their family to meet with their care team and a patient advocate to discuss further. If, during the appeal process, it is determined that the patient is able to safely transfer to another hospital, they will be required to accept this transfer.

**Q. Are patients who live in cities considered for transfer or just patients from rural and northern communities? Will patients be transferred to locations that may not be in their home community?**
**A.** Patients who no longer require the specialized care provided in higher acuity, city-based hospitals, and whose treatment can safely be provided in a lower acuity rural or northern centre, or patients who are waiting for program beds (e.g., convalescent, rehabilitative, long-term care), may be considered for transfer. Transfers will be arranged as close to the patient's home, or family support person, as possible.

**Q. What factors determine the location a patient will be transferred to?**
**A.** Patient safety is a priority in all transfers. Facilities being considered for transfer must have the necessary healthcare services, equipment and resources in place to safely meet the unique care needs of each patient. Wherever possible, transfers will be arranged to a hospital or long-term care home as close to the patient's home, or family support person, as possible.

**Q. How long will patients remain at the facility they have been transferred to?**
**A.** Patients will remain at the site they are transferred to until their new care team determines they are well enough to transition home or to an appropriate program bed, such as long-term care, convalescence or rehabilitation. Patients who accept a transfer will be assigned a Home Care Case Manager/Assessor Coordinator from their home Primary Health Care Network team to help them through their care journey and to stay connected with them until they are transitioned home.

**Q. How are the transfers made? Who will cover any costs associated with the transfer?**

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**A.** Healthcare teams will assist patients in identifying and arranging a safe form of transportation for transfers. This may include a private vehicle with a family member, taxi, ground ambulance or air transport. Transportation costs associated with transfers will be covered by the SHA, as will transportation costs to return home. This includes any additional transportation required for medical appointments, testing or procedures required while in hospital/long-term care.