INTER-FACILITY TRANSFER

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive maintains policy regarding the transfer of patients between Department of Veterans Affairs (VA) medical facilities and transfers between VA medical facilities and non-VA facilities.

2. SUMMARY OF MAJOR CHANGES: This directive:
   
a. Updates responsibilities to senior level leadership (see paragraphs 5.a. – d.).
   
b. Removes a mandate for local policy (see paragraph 5.g.).
   
c. Clarifies the scope of the directive to include transfers to and from Emergency and Urgent Care Departments and Inpatient locations (including Community Living Centers).
   
d. Grants inpatient transfer authority to non-physician Advanced Practice Providers (APP) with appropriate training, experience, and privileging or scope of practice in limited circumstances (see paragraph 5.h.(3)).
   
e. Grants inpatient transfer authority to physician trainees, but only with the direct and immediate supervision of an attending physician and according to principles of graduated autonomy (see paragraph 5.h.(3)).
   
f. Provides guidance for inpatient transfer without consent during a state of emergency (see paragraph 5.h.(9)).
   
g. Requires that transfers comply with 38 U.S.C. § 1784A (see paragraph 3 and 5.i).
   
h. Provides new policy guidance for responsibility and payment of Veteran transfer. (see paragraph 7).


4. RESPONSIBLE OFFICE: The Director, Office of Specialty Care Services (11SPEC) is responsible for the contents of this directive. Questions may be referred to 202-461-7120.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of January 31, 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

CONTENTS

INTER-FACILITY TRANSFER

1. PURPOSE.................................................................................................................. 1
2. BACKGROUND........................................................................................................... 1
3. POLICY ..................................................................................................................... 1
4. DEFINITIONS........................................................................................................... 1
5. RESPONSIBILITIES ................................................................................................. 2
6. TRANSFER OF INDIVIDUALS WITH EMERGENCY MEDICAL CONDITIONS ........ 5
7. TRANSPORTATION ................................................................................................. 6
8. TRAINING ................................................................................................................ 6
9. RECORDS MANAGEMENT ...................................................................................... 6
10. REFERENCES .......................................................................................................... 7

APPENDIX A
ADDITIONAL GUIDANCE ......................................................................................... A-1

APPENDIX B
PROCEDURE FOR TRANSFERRING PATIENTS IN ACCORDANCE WITH THIS DIRECTIVE ............................................................................................................. B-1
INTER-FACILITY TRANSFER

1. PURPOSE

This Veterans Health Administration (VHA) directive provides national policy regarding the transfer of patients between Department of Veterans Affairs (VA) medical facilities and between VA and non-VA medical facilities. **AUTHORITY:** 38 U.S.C. §§ 1784A, 7301(b).

2. BACKGROUND

   a. Inter-facility transfers are frequently necessary to provide patient access to specific providers or services. The movement of people from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally, or even more, risky. VA is responsible for ensuring that transfers into and out of its medical facilities are carried out appropriately, under circumstances which provide maximum safety for patients and which comply with applicable standards.

   b. VHA national policies must have provisions applicable to outpatients and inpatients transferring both into and out of the facility. Transfers of inpatients from VA medical facilities to other VA medical facilities or non-VA medical facilities are considered discharges for documentation and statistical purposes. As such, discharge documentation guidelines as outlined in VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021, must be followed.

3. POLICY

   It is VHA policy that all transfers in and out of VA medical facilities of inpatients (including Community Living Center residents), Emergency Department (ED), and Urgent Care patients are accomplished in a manner that ensures maximum patient safety and, for ED transfers, compliance with the transfer provisions of 38 U.S.C. § 1784A. **NOTE:** This directive is not applicable to patients, visitors or staff in a Community Based Outpatient Clinic (CBOC) who present with or develop an emergency condition that requires 911 emergent escalation to a higher level of care.

4. DEFINITIONS

   a. **Inter-facility Transfer.** For the purposes of this directive, inter-facility transfer is both the physical movement of a patient between two separate VA-approved points of care and the accompanying transition of responsibility for ongoing care. This includes transfers of patients between VA facilities (including changes in the level of care), VA and non-VA facilities and between inpatient and outpatient settings. **NOTE:** See paragraph 7 and Appendix A for further guidance.

   b. **Electronic Health Record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA
software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. **NOTE:** The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.

c. **Qualified Medical Person.** A qualified medical person are individuals with the training and experience to meet the anticipated clinical needs of the patient during the transfer process.

5. **RESPONSIBILITIES**

   a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

   b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the program office with implementation and oversight of this directive.

   c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

      (1) Communicating the contents of this directive to each of the VISNs.

      (2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

      (3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

   d. **Director, Office of Specialty Care.** The Director, Office of Specialty Care is responsible for providing oversight and monitoring for VISN and VA medical facility compliance with this directive including responding to inquiries regarding implementation.

   e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

   f. **Veterans Integrated Service Network Chief Medical Officer.** The VISN Chief Medical Officer (CMO) is responsible for:

      (1) Contacting any VA medical facility or non-VA facility that may have transferred a patient to a VA medical facility in a manner that violates this directive.

      (2) Responding to any concerns of non-VA facilities regarding transfers from a VA medical facility.
(3) Initiating a fact-finding review in cases of possible inappropriate transfer to a VA medical facility from either another VA medical facility or from a non-VA facility using established protocols.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

1. Ensuring overall VA medical facility compliance with this directive and appropriate corrective action if non-compliance is identified.

2. Ensuring that written standard operating procedures ensure the safe, appropriate and orderly transfer of patients on a clinically appropriate timeline. These procedures must comply with applicable hospital accreditation organization and regulatory standards, particularly those standards pertaining to emergency and non-emergency transfers, and the requirements of 38 U.S.C. § 1784A.

3. Determining whether there is a state of emergency to warrant inter-facility transfer regardless of refusal.

h. **VA Medical Facility Chief of Staff and Associate Director for Patient Care Services.** The VA medical facility Chief of Staff and Associate Director for Patient Care Services are responsible for:

1. Ensuring only the ED physician, or designee on duty and in charge, makes decisions or actions related to transfer to outside medical facilities of patients in the ED and is not a post-graduate trainee (intern or resident).

2. Ensuring transfer-related decisions made by a non-physician designee regarding a patient with an emergency medical condition in the ED that has not been stabilized are finalized only after a physician is consulted and agrees with the action in accordance with 38 U.S.C. § 1784A. **NOTE:** The physician must counter-sign the certification approving the transfer as soon as possible. For clarification on the procedures between the ED and inpatient transfers, please refer to VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016 or subsequent revisions.

3. Ensuring only inpatient service physicians or non-physician APP’s with appropriate training, experience and privileging or scope of practice decide or act in relation to the transfer of inpatients. Post-graduate physician trainees (intern or resident) may accept or decline inpatient transfers only with the direct and immediate supervision of an attending physician and according to principles of graduated autonomy.

4. Ensuring no patient is transferred to or from a VA medical facility without prior approval from an accepting physician, non-physician APP or other qualified medical person at the receiving VA medical facility or non-VA facility.

5. Ensuring a paper copy of any State-authorized portable order for life-sustaining treatment, if available, accompanies patients on transfer. **NOTE:** For further information, see VHA Directive 1004.04, State-Authorized Portable Orders (SAPO), dated February 26, 2019.
(6) Ensuring all transfers covered by this directive are monitored and evaluated as part of VHA’s Quality Management Program, using Provider Certification and Patient Consent for Transfer to record data for both clinical and monitoring purposes for all locations.

(7) Ensuring the transferring and receiving physician or non-physician APP and transferring and receiving nurses speak directly with each other regarding the care of the patient before transfer occurs. Documentation must include the names of receiving providers and the time of communication.

(a) These verbal communications need to allow for questions and answers from both transferring and receiving facilities.

(b) Telehealth technology, if available, may be used to link the referring provider and patient with an accepting provider at a distance through interactive videoconferencing to facilitate the transfer, facilitating safe and appropriate transfers.

(8) Ensuring that, in the event a patient refuses to consent to transfer, that such refusal is properly documented in the EHR for all locations.

(9) If the reason for transfer is due to a State of Emergency as declared by the VA medical facility Director, the patient may be transferred regardless of refusal. In this instance, the EHR must clearly document both the nature of the emergency and the efforts to obtain consent.

(10) For transfers where the patient reports to or passes through the VA ED and the accepting physician or non-physician APP does not work in the VA ED, the accepting physician or non-physician APP must discuss the details of the transfer with the ED physician or non-physician APP.

(11) Assuming full responsibility, if acting as the transferring facility, for the patient during travel for all locations, including safety and security to protect against elopement. This means the transferring facility has full responsibility for determining stability for transfer and the appropriate services to maintain stability to accomplish a safe transfer.

(12) Ensuring transfer documentation is recorded on VA Form 10-2649A and the completed form accompanies the patient. **NOTE:** In the case of transfers from non-VA facilities, non-VA local forms meeting the requirements of 38 U.S.C. § 1784A are an alternative. Completion of a templated note in the patient’s EHR with electronic signature is acceptable in place of VA Form 10-2649A. Local or State forms which provide all the required information can be accepted as an alternative to VA Form 10-2649A and VA Form 10-2649B when a patient is being transferred to a VA medical facility from a non-VA facility. This includes, but is not limited to:

(a) The date and time transfer will occur.

(b) Reason(s) for transfer (e.g., service not provided, no bed available, long-term care, return to primary health facility).
(c) Details of the care delivered prior to transfer and care needs and the proposed level of care after transfer.

(d) Medical and behavioral stability of the patient for transfer.

(e) The mode of transportation and equipment needed. **NOTE:** The transferring VA medical facility ensures the appropriateness of care delivered during transportation. In most instances, patients transported by ambulance will have this requirement satisfied by the ambulance personnel. In cases requiring additional resources or those not being transported by ambulance, the VA medical facility transferring the patient has a responsibility to provide the appropriate health care personnel and include plans for returning such personnel to their duty station when the transfer has been completed.

(f) Documentation of the patient’s (or legally responsible person acting on the patient’s behalf) informed consent to transfer with VA Form 10-2649B, available as an iMedConsent form.

(g) Identification of the transferring and receiving physicians or non-physician APPs.

(h) All pertinent EHR information available, including an active patient medication list and any medications given to the patient prior to transfer, including documentation of the patient’s advance directive made prior to transfer, if any.

(i) Pertinent infection or isolation needs for safe transportation.

(j) Signature of referring physician, non-physician APP, or other qualified medical person, certifying the need for transfer, in accordance with 38 U.S.C. § 1784A.

i. **Medical Director, VA Medical Facility Emergency Department.** The Medical Director, VA medical facility ED is responsible for ensuring that the VA medical facility ED is compliant with 38 U.S.C. § 1784A, which requires that if any individual comes to a VA medical facility (the hospital or the campus of the hospital) and a request is made on behalf of the individual for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the ED, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists as defined by 38 U.S.C. § 1784A(e)(2). **NOTE:** The statute requires that care be provided to any “individual”; accordingly; its application is not limited to Veterans. The intent of these provisions is to prevent a facility from transferring a patient with an emergency medical condition being evaluated in the ED to another facility before the acute condition has been stabilized. This includes proper stabilization of the pregnant patient and emergency delivery of the fetus or newborn, if possible, prior to transfer.

6. TRANSFER OF INDIVIDUALS WITH EMERGENCY MEDICAL CONDITIONS

   a. The responsibilities outlined in paragraph 5 apply to the transfer of individuals with emergency medical conditions, with the following modifications:
b. Completion of VA Forms 10-2649A and 10-2649B (or templated note in the patient's EHR) should not delay emergent transfer but must be completed as soon as possible thereafter.

c. If an individual refuses to consent to transfer, all reasonable steps are taken to secure the patient’s written informed refusal (or a health care agent’s or surrogate’s acting on the patient's behalf) and include this in the EHR.

(1) The written document must indicate the person has been informed of the risks and benefits of the transfer and must state the reasons for the individual's refusal.

(2) The EHR must contain a description of the proposed transfer that was refused by or on behalf of the individual.

d. Individuals with emergency medical conditions must be stabilized prior to transfer except in the following instances:

(1) The individual or surrogate, after being informed of the obligations of the hospital under this section to provide stabilizing medical treatment, requests in writing to be transferred to another medical facility.

(2) A physician has determined, based upon the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child, from effecting the transfer, certified by signing VA Form 10-2649A as described above.

7. TRANSPORTATION

a. For transfers between VA medical facilities, the transferring (sending) VA facility bears the responsibility for transportation arrangements and costs.

b. For transfers between a VA medical facility and non-VA medical facility, the VA facility should provide transportation arrangements and costs if needed. This includes transportation from a non-VA Emergency Department or Urgent Care to a VA facility.

c. For patients discharging from a VA medical facility (including Emergency Department), the VA facility should provide transportation arrangements and costs if no other reasonable alternatives are available.

8. TRAINING

There are no formal training requirements associated with this directive.

9. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records
Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

10. REFERENCES

   a. 38 U.S.C. § 1784A.


   d. VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016.

   e. VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.
ADDITIONAL GUIDANCE

1. This directive applies to the following instances of inter-facility transfer:

   a. Department of Veterans Affairs (VA) facility Emergency Department (ED), Urgent Care (UC) or Inpatient to another VA facility Inpatient (level of care may change as determined by transferring and accepting clinicians).

   b. Non-VA facility ED to VA facility ED or Inpatient

   c. VA facility Inpatient to or from non-VA facility Inpatient

2. This directive does not apply to transfers of veterans between non-VA Emergency Care settings and non-VA inpatient locations. **NOTE: For additional information, please visit** [https://vaww.va.gov/communitycare/](https://vaww.va.gov/communitycare/). **This is an internal VA website that is not available to the public.**

3. This directive does not apply to patients moving between two outpatient care locations. For example, a patient, family member or VA staff at a Community Based Outpatient Clinic who develops a medical condition needing evaluation in an ED would not be considered inter-facility transfer, as these are both outpatient locations and often a part of the same facility.

4. Following inter-facility transfer between two VA medical facilities, the transfer back to the original VA medical facility need not be as an inpatient. Return transportation is authorized independent of the level of care determined by the treating clinicians. For example, a patient transferred from a rural VA medical facility for procedures not available at the original VA can be transferred back to the original VA medical facility as an inpatient if ongoing inpatient care is needed or as an outpatient if inpatient care is no longer needed.

5. Transportation following discharge from a VA Inpatient or ED location is not considered inter-facility transfer but rather the completion of an episode of care. Transportation is authorized if no other reasonable alternatives are available.
PROCEDURE FOR TRANSFERRING PATIENTS IN ACCORDANCE WITH THIS DIRECTIVE

1. Determine the clinical needs of the patient and whether inter-facility transfer is indicated.

2. Locate an accepting facility and ensure direct communication around clinical needs, safety and acceptance of the patient at the receiving facility as outlined in this directive.

3. Obtain signature informed consent from the patient and complete associated documentation as outlined in this directive.

4. Refer to paragraph 7 for guidance on transportation roles and responsibilities.