Name of Policy: Home Health Care Referrals **Policy Number**: 3364-131-03 **Approving Officer**: Chief Operating Officer, **Responsible Agent**: Administrative Director, Outcome Management **Scope**: University of Toledo Medical Center	UTOLEDO HEALTH **Effective date:** **Original effective date**: 11/1997
Key words: Home Health Care, Referrals, Level of Care, Continuity of Care, Outcomes	

☐	New policy proposal	☐	Minor/technical revision of existing policy
☒	Major revision of existing policy	☐	Reaffirmation of existing policy

(A) Policy Statement

Arrangements for post-discharge home health care services will be set up when determined to be the most appropriate next level of care to meet the patient's needs.

(B) Purpose of Policy

The purpose of this policy is to establish a standardized process for referring patients to home health care services. The goal is to ensure that patients who are eligible for home health services receive appropriate, timely, and coordinated care in their home environment, promoting continuity of care and improving health outcomes. Coordinate the discharge planning process and arrange for the patients continuation of care through Home Health Care Services.

(C) Procedure

1. The decision for referral to a home health care company will be based on the following factors:
    a. Skilled Care Needs: the patient must require one or more of the following skilled services
        i. Skilled nursing care (eg., wound care, medication management, IV therapy)
        ii. Physical therapy (eg., rehabilitation following surgery, injury, or illness)
        iii. Occupational therapy (eg., training in daily living activities)
        iv. Speech therapy (eg. After a stroke or with swallowing difficulties)
        v. Medical social service (eg. Counseling, community resource coordination)
    b. Need for intermittent care:

~~1.~~2. The Discharge Planning Assessment ~~form~~section will be completed to determine base line information for discharge planning purposes. Collaboration will occur with the Social Worker, Resource Utilization Coordinator, Lead RN and other medical staff to identify the patient's post discharge needs that support the need for Home Health Care.

3. The patient and or representative ~~family~~ will be given a list of available Home Health Care Services along with the Post Acute Welcome Letter based on the county location. Three

referral options will be requested. The Outcome Management Staff will make referrals to the preferred Home Health Care Services and strive to secure the placement based on preferred choices identified.

2.4.Once home care needs are identified, the patient's insurance benefits will be reviewed to determine ifwhat financial insurance coverage is available. Outcome Management staff will take the necessary steps to secure the approval of the referral prior to patient discharge. The service arranged for home care follow up is the patient and or family's preference. A list of Home Health Care agencies by county will be provided.

3. Completion of the Discharge Instructions (printed and signed) will be requested to identify the patient's clinical needs for Home Health Care services.

5. Outcome Management will make a referrals to the chosen Home Health Care Services Agency and fax the Discharge Instructions and any other pertinent information needed for the HHC to determine if the patient is appropriate for acceptance and verify insurance coverage..

6. When HHC has been secured Outcome Management Staff will notify the patient and or representative r family, the physician, and other medical staff that approval has been obtained.

7. Outcome Management will place approved Home Health Care Agency on completed discharge instructions and request electronic signature from attending to be sent to the Home Health Care Agency

4.8.When the discharge is set by the physician, a transfer packet will be compiled if necessary, medical necessary transportation will be arranged if patient meets criteria for transportation, the patient's hospital departure time will be coordinated with the patient, representative family, medical staff and conveyed to the Home Care service for home care service activation.

5.9.Outcome Management will convey all arrangements to the patient, family and staff.

6.10.Outcome Management will document a final entry in the patient medical record, addressing all pertinent information. Documented information will include discharge plan, mode of transportation if necessary, HHC that is accepting patient and services provided, and patient and representative family notification of discharge plan. Referral information will also be documented in the Outcome Management Referrals section on the in the patient's medical record and document discharge services on the Discharge Instructions form.

Approved by: _____ Christine Stesney-Ridenour Chief Operating Officer _____ Date _____ Angela Ackerman Administrative Director, Outcome Management _____ Date *Review/Revision Completed by:* *Administrative Director, Outcome Management*	**Policies Superseded by This Policy:** • *17-03 Home Health Care Referrals* Initial effective date: 11/1997 Review/Revision Date: 11/97 8/99 8/02 1/05 4/08 10/14 Next review date: