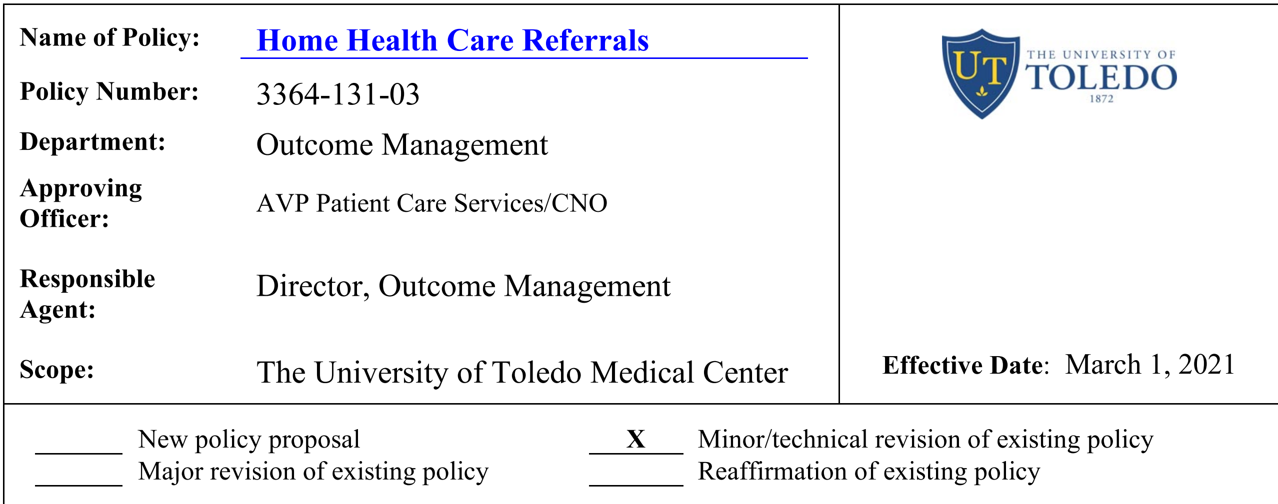

Name of Policy:	**Home Health Care Referrals**	
Policy Number:	3364-131-03	
Department:	Outcome Management	
Approving Officer:	AVP Patient Care Services/CNO	
Responsible Agent:	Director, Outcome Management	
Scope:	The University of Toledo Medical Center	**Effective Date**: March 1, 2021

_______	New policy proposal	___X___	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

Coordinate the discharge planning process and arrange for the patients continuation of care through Home Health Care Services.

(C) Procedure

1. The Discharge Planning Assessment 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.

2. The patient and or family will be given a list of available Home Health Care Services 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.

3. Insurance benefits will be reviewed to determine what financial coverage is available. Outcome Management staff will take the necessary steps to secure the approval of the referral prior to patient discharge. .

4. Completion of the Discharge Instructions (printed and signed by the attending) 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 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 family, the physician, and other medical staff that approval has been obtained.

7. When the discharge date is set by the physician, a transfer packet will be compiled if necessary, medical necessary transportation (if medical necessary) will be determined and the

patient's preference will be identified. The patient's departure time will be coordinated with the patient, family, medical staff and the Home Care service for home care service activation.

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, discharge disposition and patient/family notification of discharge plan. Referral information will also be documented in the Outcome Management Referrals section on the Discharge Instructions.

Approved by:		Review/Revision Date:
/s/ Monecca Smith, RN, MSN AVP Patient Care Services/CNO	Date	11/97 8/99 8/02 1/05 4/08 10/14 10/17 3/21
/s/ Angela Ackerman MBA, BSN, RN Administrative Director of Orthopaedic Services and Outcome Management	Date	
Review/Revision Completed by: Angela Ackerman 3/2021		**Next Review Date:** 3/1/2024
Policies Superseded by This Policy: 17-03 Home Health Care Referrals		

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.