ADMISSION CRITERIA AND PATIENT ACCEPTANCE

POLICY: Patients are accepted for treatment on the reasonable expectation that the agency can meet the patient’s anticipated medical, nursing, rehabilitative, and social needs in the patient’s place of residence in an appropriate and safe manner.

PURPOSE: To develop and maintain a policy for evaluating new patient referrals. This policy must be applied consistently to each prospective patient.

PERSONNEL: Administrator, Clinical Manager, Admissions Personnel

PROCEDURE:

I. The agency shall screen potential patients and make decisions on the acceptance of patients for care on an individual basis and have reasonable expectation that the home health agency can meet the referred patient’s needs.

II. Decisions are based on medical, nursing, rehabilitative, and social information provided by the physician/allowed practitioner responsible for the patient’s care, by institutional personnel and/or by agency staff, as provided by the patient and/or patient representative. Patient needs can be met adequately in the place of residence, including a plan to meet medical emergencies.

III. Considerations relevant to patient acceptance include:
   A. The agency’s ability to demonstrate compliance for each of the following processes:
      a. Capacity to provide patient care (i.e., staffing availability, geography)
      b. Anticipated needs of the referred prospective patient (i.e., availability of competent skilled staff, special clinical needs)
      c. Appropriate caseload and case mix (i.e., acuity, ability to staff higher levels of care)
      d. Adequate staffing levels (i.e., recruitment strategies, contract staffing to improve coverage)
      e. Skills and competencies of agency staff (see Competency and Training policy for additional staff training requirements)
      f. Make available to the public accurate information regarding the services offered by the HHA and any limitations related to types of specialty services, service duration, or service frequency and is updated when changed or annually (i.e., record keeping, review of

changes and public information through QAPI project and reviews)

B. Attitudes of the patient, caregivers, and/or patient representative toward receiving home care;

C. Comparative benefit to the patient of receiving health care at home versus receiving care in a hospital or an extended care facility;

D. If the patient's needs cannot be met adequately in the residence and the patient and/or representative choose to receive care in the residence, the patient and/or representative will be informed of the limitations of intermittent care and any addition costs of care, if applicable and,

E. Eligibility for payer source requirements, e.g., Medicare eligibility for the home health benefit.

IV. After determining the payer source for the patient, the agency will review the requirements for home health benefits and the patient and/or representative will be notified of the home care options available, including those services and supplies covered by the payer source and any additional services/supplies which would require private payment from the patient and/or representative.

V. The patient and/or representative will be educated on the qualifications for receiving Medicare home health benefits, including a current face-to face encounter with an eligible physician/allowed practitioner, homebound status, finite and predictable endpoint for daily skilled nursing visits, reasonable and necessary care and care provided under the orders of a physician/allowed practitioner. Patients who do not meet these requirements do not meet the qualifications of home health care under the Medicare benefit and will not be admitted for Medicare home health services.

VI. The patient is not accepted for service until all consent forms are signed, patient and/or representative agrees to the plan of care (POC), and admitting personnel determine that the patient meets admission criteria. The patient and/or representative will participate with admitting personnel and the physician/allowed practitioner in the development of the POC.

VII. If the agency does not have sufficient resources to provide the necessary care, the patient will not be admitted to the agency. The physician/allowed practitioner will be notified and the patient and/or representative will be directed to other resources in the community that may be able to provide the necessary care.

VIII. Geographic areas served are those approved by agency licensure.

IX. Case Load and Case Mix of the HHA: On average, the total patient case load for

all offices/providers of Renew Home Health is 1000 patients with an average case mix weight of 0.886.

X. Evaluate current patient caseload and mix to ensure the addition of a new patient will not compromise the quality of care.
   A. Consider the complexity of existing cases and the potential impact of new admissions.
   B. Utilize agency EMR and scrubbing software (SHP) to determine average case load and case mix.

XI. The HHA will provide up-to-date information about services offered and any limitations via agency website, patient education book and per request.

XII. The following represents clinical care limitations of the agency:

- Administration of blood or blood products (platelets or plasma)
- Administration/management/discontinuation of IV chemotherapy agents
- Management of new/recent tracheostomy (present for less than 1 year)
- Administration of 1st dose of IV antibiotics without the presence of anaphylaxis orders and anaphylaxis medications in the home prior to administration

The following represents possible care limitations of agency, based on variables including, but not limited to: availability of competent staff, availability of caregiver support, anticipated needs of the patient and specialty services.

- The availability of speech therapy services is limited in all areas of service
- Management of established tracheostomy (present for more than 1year) and/or ventilator supported patients;
- Administration/management of total parental nutrition (TPN);
- Administration of medications that require specialized training, such as IVIG.
- Skilled and aide services in outlying geographical areas, even those that are approved by the agency's licensure
- IV therapy
- Administration of injectable medications that are ordered at a frequency of daily or more frequently, unless a teachable caregiver is available and willing to assume the primary role of administration once teaching is performed.
- High utilization patients (such as insulin administration) if acceptance would cause agency to possibly exceed Medicare's 10% cap on outlier payments
- Specialty services (ex: management of Pleurx (or equivalent) catheter drainage systems, disposable negative pressure wound therapy)

- Interpreter needs: patient’s interpretation needs cannot be met by a family member or caregiver, a telephonic interpreter provided by the agency or by TTY relay services for the deaf.

XII. This policy will be reviewed for publicly facing information as frequently as services are changed, but no less than annually and updated as necessary to reflect changes in the HHA’s capacity and services.