EDDY VISITING NURSE AND REHAB ASSOCIATION

STANDARD OPERATING POLICY

CATEGORY: Referral/Assessment
NUMBER: 401
SUBJECT:
POLICY NAME: Acceptance of Patients to Service/Admission/Readmission (Resumption of Care) and Continuation of Care Criteria

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Eddy VNRA's will consistently apply the criteria outlined in this policy to each prospective patient referred for certified home health care services, as well as continuation of care/resumption of care.

Eddy VNRA's accepts prospective patients to services, continues care and resumes care of admitted patients based upon the:

- agency's capacity to provide patient care,
- anticipated needs of the referred prospective patient,
- agency's caseload and case mix,
- agency's staffing levels,
- skills and competencies of the agency's staff.
- Patient and ordering physician/APP agree to start of care or resumption of care date.
- The patient must be under the care of an ordering physician/APP who holds a valid license to practice in the State of New York and who will provide medical supervision of the plan of care and serve as the certifying provider for the patient.
- 1. A referral may be accepted from out of state providers as long as the patient agrees to be followed by a New York State provider or by a bordering state as per Policy 114A, who will provide medical supervision of the plan of care and serve as the certifying provider for the patient.
  2. Prospective patients referred without an ordering physician/APP or existing patients who are discharged by the ordering physician/APP and do not have a new ordering physician/APP will be referred to a local emergency room, or a local on-call/urgent care facility or other appropriate service because Eddy VNRA, as a certified home health agency, may only provide services in accordance with orders from a physician/APP.
  3. Patients who sign out of a hospital or facility AMA (Against Medical Advice) will be reviewed by the Director of Patient Services or the Executive Director to determine whether appropriate for CHHA on a case by case basis.
- The patient must reside in the Certificate of Need NYSDOH approved geographic area served by the agency. Exception: If a patient lives outside our geographic area and other home health agencies are unable to service the patient's needs, the executive director, DPS, or designee must contact the Department of Health for approval and follow the DOH request process.

- The patient's health and supportive needs are assessed to be safely and adequately met at home and the patient's condition requires the services of the agency. Factors to be considered when making this determination include, are but not limited to:
    1. The physical and mental condition of the patient, or their ability to be self-directing.
    2. The ability of the patient to provide necessary self-care or the availability of a support system able willing and able to provide needed care, support and other services to the patient during periods when Agency personnel are not present.
    3. The patient's ability to obtain emergency help when unattended.
    4. The patient's and family's desire for home care and their willingness to participate and cooperate in carrying out the plan of care.
    5. Agency services are not appropriate for meeting the care needs of the patient. For example, if a patient needs 24-hour care and this is not currently provided by the family/caregiver and may not be provided by the family/caregiver for as long as the patient will require such support.
    6. A reasonable expectation that the patient's medical, social, functional, other skilled needs can be met adequately *and safely* by the Agency in their place of residence.
- The safety of Agency personnel will not be jeopardized while providing services.
- The patient or designated representative consents to treatment in writing.
- The patient and/or family are willing to disclose financial information when care needed or desired is not funded by third party payor and the patient is requesting services.

Eddy VNRA will review this policy, at a minimum, on an annual basis and update, as necessary.

Eddy VNRA will post information on its website (Visiting Nurses | St. Peter's Health Partners) for the public and will provide this information upon request related to Acceptance of Patients to Service, including the following:

- Eddy VNRA's Policy on Acceptance of Patients to Service
- Caseload/volume of patients served
- Case mix/complexity of patients served
- Specialty programs and services offered, including information about specialty programs that have achieved accreditation
- Staffing levels
- Staffing skills and competencies
- Limitations related to the types of specialty services, service duration, service frequency

Patients are accepted to service without regard to age, sex, race, creed, national origin, disability or source of payment.

Eddy VNRA assesses the patient's appropriateness for services utilizing a two-step process:

(1) Eddy VNRA's nursing intake and liaison team completes an initial review of prospective patient referrals and resumption of care referrals based upon the criteria listed above.
(2) In accordance with Policy #410 Patient Assessment, Eddy VNRA licensed clinicians perform an in-home assessment (which is ordered by the patient's physician/APP) based upon the criteria listed above. The assessment shall be conducted by a registered professional

nurse except in those circumstances where physical therapy is the sole service ordered by the patient's provider (Provider includes Physicians, Nurse Practitioners and Physician Assistants). COP 484.18 – Patients are accepted for treatment on basis of a reasonable expectation that the patient's medical, nursing and social needs can be adequately met by the agency in the patients place of residence. Care follows a written plan of care established and periodically reviewed by a Provider.

II. If a question arises regarding the acceptance of a patient, *resumption of services or continuation of care* for home care, the referral source (if appropriate) and the ordering physician/APP will be contacted. Notification will be provided to the patient's physician/APP and the referral source if Eddy VNRA determines that the patient cannot be accepted to services

III. Any patient who is assessed or reassessed as not meeting acceptance criteria (e.g., patient needs cannot be safely and effectively met, etc.) for agency services shall be assisted by the Agency in collaboration with the discharge planner (case manager), local social services (Adult Protective) and any other case management entity, as appropriate. After obtaining the services of an alternate provider, if needed, the patient's physician/APP will be notified. If alternative services are not immediately available, the local Adult Protective Services program, Office of Persons with Development Disabilities, the Office of Mental Health and/or other official Agency may request that home care services be provided on an interim basis to address minimally essential patient health and safety needs for a period of time agreed upon by the Agency and the requesting entity, provided that the patient/family/informal supports have been fully informed of the Agency's intent to transfer the patient to an alternate service, when available, and have been consulted in the development of an interim plan of care and home health regulatory criteria are met (e.g. agency has signed Provider orders for care/treatment).

REVIEW DATE: 4/09, 12/2015
REVIEW DATE: Reviewed and approved by the Board annually unless otherwise revised
REVISE DATE: 3/10, 9/2012, 8/2013; 11/2013; 3/2015; 1/2017; 1/2020; 5/2020; 8/2022 6/2024; 11/2024

COVID 19
Addendum: Policy # 401 – Acceptance of Patients to Service

Effective Date: March 1, 2020 End Date: _____

Homebound Definition Changes with COVID-19 Patients:

- **A patient is considered homebound:**
  - When their provider advises that they cannot leave the home because of a confirmed or suspected COVID-19 diagnosis, or
  - If the patient has a condition that makes them more susceptible to contract COVID-19 if they leave the home.
- If a Medicare beneficiary is homebound due to COVID-19 and needs skilled services, a HHA can provide those services under the Medicare Home Health benefit.