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| Non-Admit Process | **Last Revision:** | August 2020 |
| **Last Reviewed** | August 2020 |
| **Applies to the following THA Group of Companies:**  | * Island Health Care
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| **Included in the following THA Manual:** | Administrative Policy and Procedure ManualProvision of Care, Treatment, & Services |

**PROCESS**

It is THA Group's practice to admit all qualified referrals for service as ordered by the physician.

1. Any decision to not admit a patient is a collaboration and cannot be made independently by staff at any step in the referral/admission process.
2. Patient/Family Refusal
	1. **Refusal at the Point of Referral from the Hospital or Other Facility**If patient/family refuses at the point of referral from the hospital or other facility, the Liaison or Territory Representative will involve the Discharge Planner, or other facility staff, as well as the ordering physician, in educating the patient on the necessity of home health as ordered by the physician.
		1. First, determine what the patient understands about home health services.

		*"Tell me what you understand about the home health care ordered by your doctor."*
		2. Ask and document the specific reason(s) why the patient refuses services. Explore why the patient feels the way he/she does.

		*"Help me understand why you feel that you don't need home health services at this time. Have you or someone you know had a bad experience with home health? Have you or someone you know been told something negative about home health care?"*
			1. If the patient is concerned about the timing or length of visits:

			"*Island Health Care does not provide housekeeping services. We provide skilled nursing, therapy, and home health aides, all determined upon your need and the orders of your physician. Home visits usually last about 30 minutes to an hour, depending on the type of service."*
			2. If the patient is concerned about the cost of home health:

			*"Home health care is a Medicare covered benefit. Additionally, we can provide any kind of medical equipment that is ordered by your doctor and is covered by your health plan."*
			3. You must respect a competent patient's decision to refuse home health care for cultural or religious reasons, even if you believe the patient's decision is wrong or irrational. You may advise the patient of your clinical opinion, but you must not put pressure on them to accept your advice. You must be careful that your words and actions do not imply judgment of the patient or their beliefs and values. You may help the patient look for treatment options that will accommodate their beliefs.
		3. Explain in detail why the MD ordered the treatment, procedure or plan of care.
		 *"Your doctor has ordered home health care so that you may continue your progression towards wellness. Your doctor is concerned about your recovery and wants you to have the best possible outcome."

		"I respect your wish to \_\_\_\_\_\_\_\_\_\_\_\_\_, but home health services offer more than just \_\_\_\_\_\_\_\_\_\_\_\_\_."*
		4. If high risk medications are listed, mention these as well as their potential for serious side effects.

		*"Your doctor has ordered some high-risk medications that potentially have serious side effects. Your physician wants our agency to teach you how to use these medications safely, as well as monitor your response to the medications and possible effects on your [blood pressure, heart rate, oxygen saturation, infection, etc.]."*
		5. If safety is an issue, reiterate ways to increase functionality, mobility and safety in the environment.

		*"I can teach you to [ambulate more safely, transfer safely, decrease your chances of falling, etc.]."

		"One of the main goals of home health care is to prevent you from having to go back to the emergency room, hospital or skilled nursing facility. We will provide you with a phone number at which you may contact a nurse 24 hours a day, seven days a week, in the event you have any concerns that need to be addressed."*
		6. Take the time to explain the consequences of refusing services in language the patient understands. Focus on how refusal can endanger the patient.

		*"What could happen if…"*

		Validate that the patient understands the risks for refusing care by having him/her repeat, in his/her own words, the consequences you've given.
		7. Use visuals such as brochures, pamphlets, etc. to help the patient have a better understanding of how we can positively promote a better outcome vs. not receiving services. Focus on the benefits of care and on assessment of "red flags" of exacerbation and the benefit or early, just-in-time intervention.
		8. Engage the MD or MD's nurse, if needed, for possible reiteration/explanation.
		9. Sample Educational Script:

		*"Home health care is less expensive, more convenient, and just as effective as the care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury in the comfort of your own home. Home health care helps you get better, regain your independence, and become as self-sufficient as possible. Your health care can be personalized and consistently monitored, reducing your chance of re-admittance to the hospital. Home health care allows you to receive better follow up care, promotes more communication between you and your doctor, and reduces your chances of medication errors – which can make a big difference in your outcomes."*
		10. **If the patient adamantly refuses care, an Informed Refusal Form must be completed.** Refer to the Informed Refusal Form located in the Approved Forms > Island Health Care folder on the G: Drive.
	2. **Refusal at the Point of Intake's Contact with Patient**If refusal occurs at the point of Intake establishing contact with the patient to verify referral information, Intake staff will follow the Patient Refusal Script guidelines above to educate the patient on the reason for home health. **If the patient still refuses, the Clinical Leader must be notified, or if on the weekend, the Admin on Call is notified.** The State Director or Admin on Call will also call the patient's physician for assistance. Documentation should occur under the Communication tab in the Electronic Health Record (EHR).

	Scripting Guidelines for Intake Staff:
	*"Good afternoon, Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_. My name is \_\_\_\_\_\_\_\_\_\_\_\_ and I'm calling from THA Group's Island Health Care.

	"Dr. \_\_\_\_\_\_\_\_\_\_\_\_ has asked us to contact you about the home health services he/she has ordered for you. Your physician would like for us to provide \_\_\_\_\_\_\_\_\_\_\_\_ services to help you recover from your recent hospitalization for \_\_\_\_\_\_\_\_\_\_\_\_.

	"We need to go ahead and schedule the [discipline] to come out and visit you within the next day or two. What day and time works for you?"*

	If the patient consents:
	*"The [discipline] will call you to confirm the day and time of their visit. Until then, you may call us for any reason – we have a nurse available 24 hours a day to take your call and answer any questions or concerns you may have. If you need a nurse, our On-Call RN will come to your home."*

	If the patient declines:
	*"I understand that you feel that you don't need/want home health services, but Dr. \_\_\_\_\_\_\_\_\_\_\_\_ has requested that we help in your recovery to prevent any problems that might cause you to have to go back to the hospital. We will be teaching you about your medications and disease processes, as well as helping you get stronger and back to your normal activities."*

	If the patient still declines:
	*"Okay, Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_. Would you allow the [discipline] to come out for just one visit to see how you are doing? Dr. \_\_\_\_\_\_\_\_\_\_\_\_ has requested that we report back to him/her on your progress.*"

	If the patient still declines:
	*"Okay, Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_. I understand that you don't feel that you need our services right now. I will call Dr. \_\_\_\_\_\_\_\_\_\_\_\_'s office and let him/her know that you are declining home care. I will call you after I talk with Dr. \_\_\_\_\_\_\_\_\_\_\_\_. Please don't hesitate to give us a call if you change your mind or have any further questions."*Contact the patient's doctor. If the doctor agrees with the patient's decision to refuse services, contact the patient, and tell them, "*Please don't hesitate to give us a call if you need us."***If the patient adamantly refuses care, an Informed Refusal Form must be completed.**
	3. **Refusal at the Point of Clinician's Contact with Patient
	If refusal occurs at the point of contact by the clinician to arrange for the visit, a scripted educational conversation should occur.**

	Sample Educational Script:

	*"Home health care is less expensive, more convenient, and just as effective as the care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury in the comfort of your own home. Home health care helps you get better, regain your independence, and become as self-sufficient as possible. Your health care can be personalized and consistently monitored, reducing your chance of re-admittance to the hospital. Home health care allows you to receive better follow up care, promotes more communication between you and your doctor, and reduces your chances of medication errors – which can make a big difference in your outcomes."*If the patient still refuses:
	*"Okay, Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_. I understand that you don't feel that you need our services right now. I will call Dr. \_\_\_\_\_\_\_\_\_\_\_\_'s office and let him/her know that you are declining home care. I will call you after I talk with Dr. \_\_\_\_\_\_\_\_\_\_\_\_. Please don't hesitate to give us a call if you change your mind or have any further questions."*Contact the patient's doctor. If the doctor agrees with the patient's decision to refuse services, contact the patient, and tell them, "*Please don't hesitate to give us a call if you need us."* **If the patient still refuses care, the State Director must be notified, or if on the weekend, the Admin on Call is notified. The Clinical Leader or Admin on Call will also call the patient's physician for assistance. Documentation should occur under the Communication tab in the EHR. If the patient adamantly refuses care, an Informed Refusal Form must be completed.**
	4. **Refusal at the Time of Clinician's Visit
	If refusal occurs at the time of the clinician visit to the patient's home, the same educational script is followed, and the Clinical Leader should be contacted from the patient's home befo*re making a determination to not admit****. Documentation should occur under the Communication tab in the EHR.

	Sample Educational Script:

	"Home health care is less expensive, more convenient, and just as effective as the care you get in a hospital or skilled nursing facility. In general, the goal of home health care is to provide treatment for an illness or injury in the comfort of your own home. Home health care helps you get better, regain your independence, and become as self-sufficient as possible. Your health care can be personalized and consistently monitored, reducing your chance of re-admittance to the hospital. Home health care allows you to receive better follow up care, promotes more communication between you and your doctor, and reduces your chances of medication errors – which can make a big difference in your outcomes."* ***If the patient adamantly refuses care, an Informed Refusal Form must be completed.***
	5. *The physician/referral source should be notified any time the patient refuses care, as they may be able to help the patient understand why home health was* requested.
3. No Skill
	1. If during the admission visit, the clinician believes there is no qualifying skill, **the Clinical Leader should be contacted from the patient's home before making a determination to not admit. Documentation should occur under the Communication tab in the EHR.**
		1. Medicare has changed their in-home health care policy regarding degenerative diseases. In the past, Medicare would only cover home health care services if the patient were expected to make a full recovery. Now Medicare will pay for in-home physical therapy, nursing car*e* and other services to beneficiaries with chronic conditions like multiple sclerosis, Parkinson's or Alzheimer's disease to maintain their condition and prevent deterioration.
4. Not Homebound
	1. If during the admission visit, the clinician believes that the patient does not meet homebound criteria, **the Clinical Leader should be contacted from the patient's home before making a determination to not admit**. Documentation should occur under the Communication tab in the EHR.
		1. To be covered for in-home health care, Medicare requires that the patient be "homebound." This does NOT mean that the patient must be "bed bound." To be homebound means the following:
			1. Leaving home isn't recommended because of the patient's condition.
			2. The patient's condition keeps him/her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person).
			3. Leaving home takes a considerable and taxing effort.
		2. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services.
		3. A patient can still receive home health care if he/she attends adult day care; the patient would get the home care services in his/her home. Being homebound could also mean that the patient has a condition in which leaving the home may cause more harm and is not advised by the physician, or symptoms of the patient's disease process (such as pain, shortness of breath, or confusion) get worse when the patient leaves home.
5. Reporting
	1. Leadership and Marketing staff generate a weekly report of all non-admits and the reasons for not admitting.
	2. Investigation of non-admits will be conducted by the Vice President of Operations by examining documentation in the EHR to ensure the process was followed correctly.