


**GUAM MEMORIAL HOSPITAL AUTHORITY  
SOCIAL SERVICES DEPARTMENT MANUAL**

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
 Florencio T. Lizama, MD Professional Support Division Administrator	Social Services Nursing	1/7/1999	6431-9	1 of 4
<b>TITLE: HOME HEALTH CARE SERVICES REFERRAL</b>				
<b>LAST REVIEWED/REVISED:</b> 9/2012, 10/2012, 3/2013; 2/2014				
<b>ENDORSED:</b> FP 1/2015				

**PURPOSE:**

Home Health Care referrals ensure that continuity of professional health and supportive care needs of patients prior to discharge are identified and met.

To provide patients with information on the availability of home health services and the opportunity to select the agency.

To delineate the Home Health Care referral process.

**POLICY:**

Patients and families shall be afforded the opportunity to select an individualized care program for home that will meet the special needs of the patient.

The discharge needs of the patients are identified through a coordinated multi-disciplinary process. The need for home care services shall be communicated to the attending physician and referral to the appropriate agency shall be in the Physician orders. If there is no agency identified by the Physician, a list of participating Medicare certified home health agencies as well as agencies that have a contract with the managed care organization is made available to the patients.

Should the patient defer selection of the home care agency to their physician, documentation of patient's choice to do so shall be documented by either nursing or social work.

Patient confidentiality shall be maintained and the patient's consent will be obtained prior to release of medical information.

**PROCEDURES:**

**HOME CARE REFERRAL PROCESS**

1. The discharge needs of the patient are identified through the hospital's multi-disciplinary discharge planning process. (See Home Health Care Referral Process Flow Chart).
2. The attending physician orders Home Health Care services. At times, physicians may select a Home Care agency they feel will be most congruent to the specific patient needs or the patient is already an established patient of a home care agency.
3. A referral to Social Services is initiated.
4. Unit nursing staff or the unit social worker provides a list of available home care agencies (see Attachment) to the patients if not already an established recipient of home care.

**REFERRALS TO:**

A. GMHA Social Services:

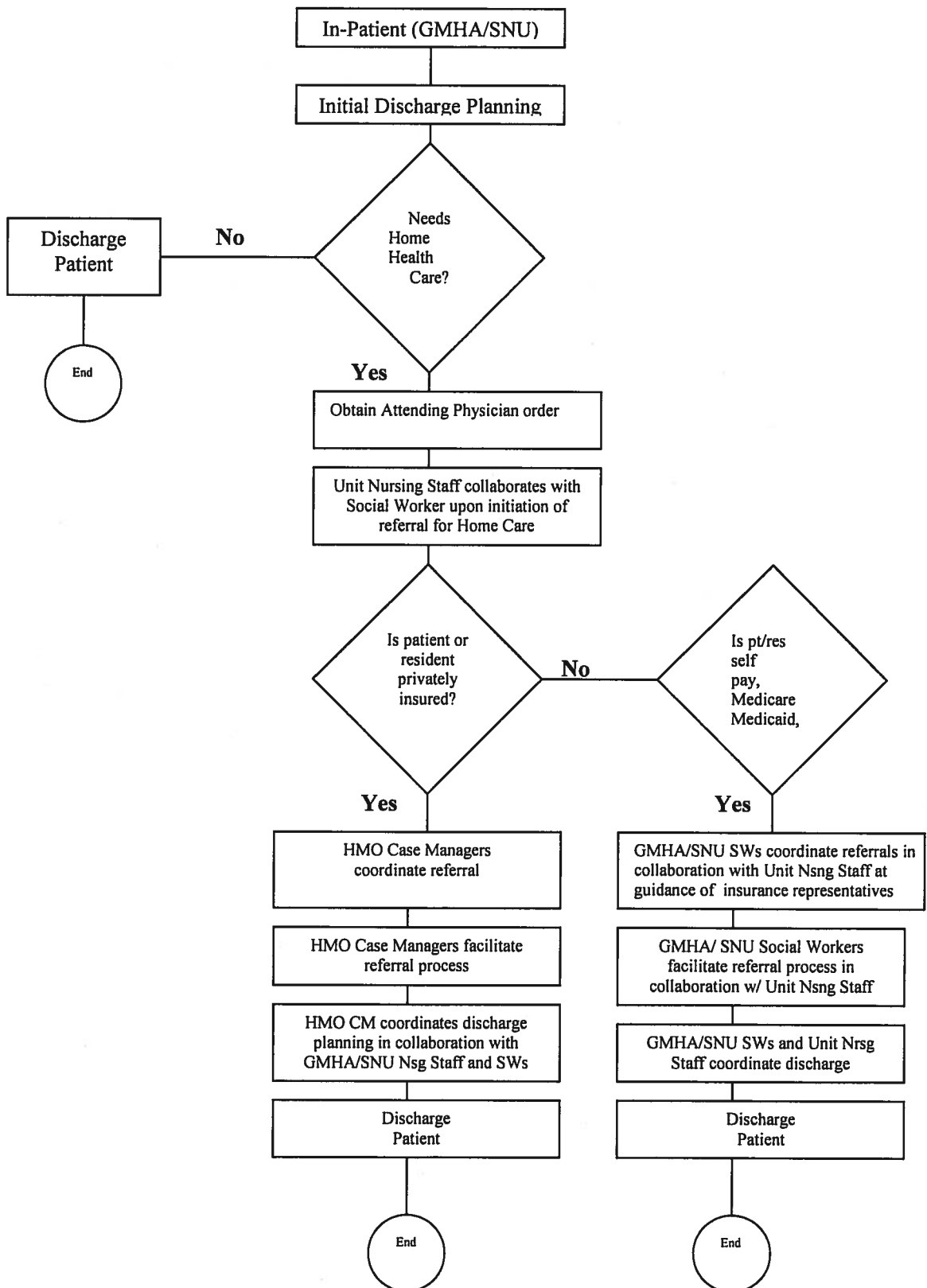
1. Social Worker in collaboration with unit nursing staff provides information on Home Care Services and gives the patient the opportunity to select the agency from the list of Home Care providers. In cases where physicians have selected an agency, the Social Worker in collaboration with the unit nursing staff shall learn from the patient if the physician's selection is acceptable but will also advise the patient/representative of their right to select another agency at any time. Documentation by MD, RN or SW shall reflect the decision reached by the patient/representative and which home care agency will provide patient's care at home.
2. Social Worker, in collaboration with unit nursing staff, facilitates the referral after having obtained consent for Release of Information from the patient/representative and is informed of their right to choose the home care agency (provided the Home Care agency has a provider agreement with the patient's insurance company). Documentation in patient's medical record shall reflect the selection of the Home Care agency by the patient/representative.

3. Coordinates discharge plans in collaboration with the unit nursing staff to ensure the patient's needs are addressed and referrals made. Both unit nursing staff and social worker shall communicate the reason for the selection of the home care agency and that the patient has confirmed the selection. Medical equipment needs shall also be coordinated and the patients/families shall be guided per health insurance protocol for authorization of home care services and medical equipment such as an oxygen concentrator, hospital bed, wheelchair, etc.
  4. Ensures patient is discharged to appropriate home placement and follow up is conducted within seven (7) days of discharge to ensure home care services are in place, referrals for other services are made and needs have been met.
- B. Managed Care Organization Case Managers:
1. Referrals shall be made known to Case Manager through the case review of their members' medical record, by either the unit nursing staff carrying out orders or the social worker when a referral is received.
  2. Case Managers provide patients with information/a list of Home Care service providers and explain home health care coverage per health insurance benefit package.
  3. Facilitates the referral to the respective Home Care service.
  4. Coordinates the discharge plans in collaboration with the GMHA unit nursing staff and social worker.
  5. Ensures patient is discharged to appropriate home placement, that home care service is delivered and patient's needs are met.

#### **EVALUATION AND MONITORING:**

Social Services shall monitor for GMHA's Performance Improvement program, the coordination of home health care referrals that are initiated at least forty-eight (48) hours prior to discharge to ensure there is sufficient coordination time to confirm home care admission of the patient in addition to communicating with unit nursing staff that patient/representative was properly informed and given the opportunity to select an agency. Participating departments may monitor the effectiveness and quality of Home Care providers through the Hospital's Performance Improvement program.

## Home Health Care Referral Process Flow Chart



# GUIDE

Policy #6431-9  
Attachment

## Home Health Care (HC) Agency Listing

<i>Agency</i>	<i>Contact Number</i>	<i>Medicare Certified Y/N</i>
Health Services of the Pacific (HSP)	647-5355	Yes
Guam Nursing Services (GNS)	649-2815/4000	Yes
FHP Home Health Services (FHP)	646-4933	Yes
Guam Visiting Nurses (GVN)	646-6877	Yes
Paradise Home Care (PHC)	475-4005	No

## Insurance Companies and Durable Medical Equipment (DME) Suppliers Listing

<i>Company</i>	<i>HC Providers</i>	<i>DME Providers</i>
Take Care/FHP	Only Take Care/FHP	Isla Home Infusion, MedQuest
Select Care	HSP, GNS, GVN, PHC	Isla Home Infusion, MedQuest, Guam Medical Supplies, Healthcare Specialties, HSP
NetCare	HSP, GNS, GVN, PHC, FHP	Isla Home Infusion, MedQuest, Guam Medical Supplies, Healthcare Specialties
Staywell	HSP, GNS, GVN, PHC, FHP	Isla Home Infusion, MedQuest, Healthcare Specialties
MIP/Medicaid	HSP, GVN	Healthcare Specialties, Guam Medical Supplies, MedQuest
Medicare	HSP, GNS, FHP, GVN	Isla Home Infusion, MedQuest, Healthcare Specialties, HSP
Others		Per supplier agreement

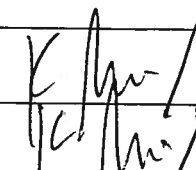
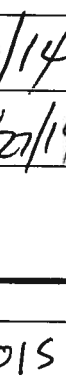
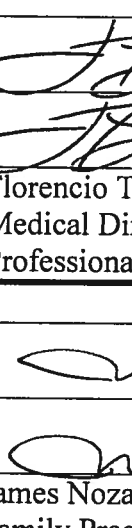
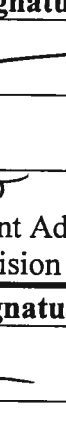
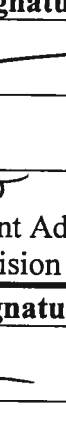
**REVIEW AND APPROVAL (CERTIFICATION)**

The signatories on this document acknowledge that they have reviewed and approved the following:

- Bylaws
- Rules & Regulations
- Policies & Procedures

Submitted by:  
 Department/Committee:  
 Title:  
 Policy Number (if applicable):

**Katrina Rosario-Sanchez, MPA, MSW**  
Medical Social Services Administrator  
Home Health Care Services Referral  
 6431-9

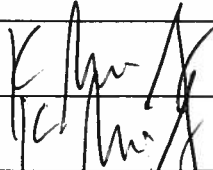

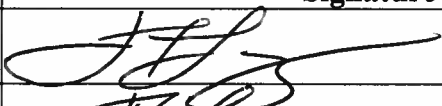

Reviewed	<b>Date</b>	<b>Signature</b>
	2/26/2014	
		Katrina Rosario-Sanchez, MPA, MSW Medical Social Services Administrator
Approved	<b>Date</b>	<b>Signature</b>
	2/27/2014	
		for Rhodora Cruz, RN, MSN Assistant Administrator Nursing Services, Acting
Reviewed	<b>Date</b>	<b>Signature</b>
	2/27/14	
		Florencio T. Lizama, MD Medical Director/Assistant Administrator, Professional Support Division
Approved	<b>Date</b>	<b>Signature</b>
	1/22/2015	
		James Nozaki, MD Family Practice Chairperson
Title	<b>Date</b>	<b>Signature</b>
	1/22/2015	
		James Nozaki, MD Family Practice Chairperson

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 Department/Committee: Medical Social Services Administrator  
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	1/22/2015	
Approved		
Title	1/22/2015	James Nozaki, MD Family Practice Chairperson