BILL OF RIGHTS
Policy No. 9-005

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient may designate someone to act as his/her representative to exercise the patient's rights. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

If the patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction:

1. The rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf OR

2. The patient may exercise his or her rights to the extent allowed by court order

To assist with fully understanding patient rights, all policies will be available to the organization personnel, patients, and his/her representatives as well as other organizations and the interested public.

PROCEDURE

1. The patient will be informed verbally and in writing during the initial evaluation visit and in advance of furnishing care, of their rights.

2. The Patient Bill of Rights statement defines the right of the patient to:

    A. Have his or her property treated with respect.

    B. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

    C. Receive an investigation by the organization of complaints made by the patient or the patients family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient's property by anyone furnishing

services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint.

D. Be informed in advance about care to be furnished and of any changes in the care to be furnished.

E. Be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.

F. Be advised in advance of any change in the plan of care before the change is made.

G. The completion of all assessments and care to be furnished, based on the comprehensive assessment. The organization shall ensure that the patient receives all services outlined in the plan of care.

H. The establishment and revision of the plan of care, including the disciplines that will furnish the care and the frequency of visits as well as any changes in the care to be furnished.

I. The expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; as well as any factors that could impact treatment effectiveness.

J. Be advised in advance of the right to participate in planning the care or treatment and in planning changes in the care and treatment.

K. Be advised that the Home Health Agency complies with Subpart 1 of 42 CFR 489 and receive written policies and procedures regarding Advance Directives, including a description of an individual's right under applicable state law and how rights are implemented by the organization.

L. Receive Advance Directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided.

M. Confidentiality of the clinical records maintained by the organization.

N. Be advised of the organization's policies and procedures regarding disclosure of clinical records.

O. Be informed, verbally and in writing and before care is initiated of the extent to which:

1. Payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the organization

2. Charges for services that will not be covered by Medicare

3. Charges that the individual may have to pay

P. Be informed verbally and in writing of any changes in payment information as soon as possible, but no later than 30 calendar days from the date that the organization becomes aware of the change.

Q. Receive in writing, prior to the start of care, the telephone numbers for the State Home Health Hotline and the CHAP Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization.

R. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

S. Be informed of organizational ownership and control.

T. Patient privacy rights related to the collection of the Outcome and Assessment Information Set (OASIS):

1. The right to be informed that OASIS information will be collected and the purpose of the collection

2. The right to have the information kept confidential

3. The right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Federal Privacy Act

4. The right to refuse to answer questions

5. The right to see, review and request changes on their assessment

U. The right to privacy, security, and respect of property and person

V. The right to be free from mental, physical, sexual and/or verbal abuse, including injuries of unknown source, neglect, misappropriate of property, or exploitation

W. The right to voice a complaint or concern regarding care or service. The availability of other sources to receive questions and complaints and assist in resolution

X. The right to have communication needs met

1. The organization shall provide verbal notice of the patient's rights and responsibilities in the patient's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second (2nd) visit from a skilled professional (RN, PT, SLP, OT).

Y. The right to choose whether or not to participate in research, investigations or experimental studies or clinical trials

Z. The right to have cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected

AA. The organization's transfer and discharge policies

BB. The contact information for the agency administrator, including the administrator's name, business address, and business phone number in order to receive complaints

CC. The names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:

1. Agency on Aging
2. Center for Independent Living
3. Protection and Advocacy Agency
4. Aging and Disability Resource Center
5. Quality Improvement Organizations

3. Within four (4) business days of the initial evaluation visit, the organization shall provide written notice of the transfer and discharge policies, provide contact information of the administrator, provide verbal notice of the rights and responsibilities, and obtain signature from the patient or legal representative to confirm that they have received a copy of the notice of rights and responsibilities.

4. The admitting clinician will provide each patient or his/her representative with a written copy of the Patient Rights and Responsibilities on admission.

5. The Patient Rights and Responsibilities statement will be explained (verbal) and distributed to the patient prior to the initiation of organization services. This verbal explanation will be in a conversational language and tone and/or communication method he/she can reasonably be expected to understand.

6. The patient or legal representative will be requested to sign the Patient Rights and Responsibilities form. The original form will be kept in the patient's clinical record. A copy will be maintained by the patient. The patient's refusal to sign will be documented in the clinical record, including the reason for refusal.

7. The admitting clinician will document that the patient has received a copy of the Patient Rights and Responsibilities.

   A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

   B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

   C. Written information will be provided to patients in English and predominant non-English languages of the population served.

8. When the patient's representative signs the Patient Rights and Responsibilities form, an explanation of that relationship must be documented and kept on file in the clinical record.

9. The family or guardian may exercise the patient’s rights when a patient is incompetent or a minor.

10. Supervisory visits with clinical disciplines will be conducted to ensure these rights are honored and protected according to organization policy.

11. All organization personnel, both clinical and non-clinical, will be oriented to the patient’s rights and responsibilities prior to the end of their orientation program, as well as annually.

PATIENT PRIVACY RIGHTS
Policy No. 6-004

PURPOSE

To encourage awareness of patient privacy rights and ABF Home Health Services, LLC legal duties with respect to these rights and the use and disclosure of protected health information (PHI).

POLICY

ABF Home Health Services, LLC will respect and safeguard all protected health information of the patients it serves.

Each patient will be provided with information about his/her privacy rights at the time of admission to ABF Home Health Services, LLC.

To assist with fully understanding patient privacy rights and responsibilities, all policies will be available to the organization personnel, patients, and their representatives as well as other organizations and the interested public.

Definition:

Protected health information (PHI) is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual in ANY form (verbal, written, electronic). This is interpreted rather broadly and includes any part of a patient's medical record or payment history. Examples of identifiers are: names, all geographical identifiers smaller than a state (except for the initial three digits of a zip code), dates (other than year) directly related to an individual, phone numbers, fax numbers, email addresses, Social Security numbers, medical record numbers, Health insurance beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers and serial numbers including license plate numbers, device identifiers and serial numbers, web Uniform Resource Locators (URLs), Internet Protocol (IP) address numbers, biometric identifiers, including finger, retinal and voice prints, full face photographic images and any comparable images, and any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data.

PROCEDURE

1. The patient will be provided with information about his/her privacy rights in the organization's Notice of Privacy Practices, which will be given to the patient during the admission visit. The patient's privacy rights include:

   A. A right to adequate notice of the uses and disclosures of protected health information that may be made by ABF Home Health Services, LLC.

B. A right to request privacy protection for protected health information.

C. A right of access to inspect and retain a copy of his/her protected health information.

D. A right to request that the organization amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

E. A right to receive an accounting of disclosures of protected health information made by ABF Home Health Services, LLC in the six (6) years prior to the date on which the accounting is requested.

2. ABF Home Health Services, LLC will make a good faith effort to obtain the patient's written acknowledgment of receipt of this notice. A separate signature/initials line for this acknowledgment may be located on the consent form. If an acknowledgment cannot be obtained, the admitting clinician will document his/her efforts to obtain the acknowledgment and the reason why it was not obtained in the clinical note.

A. The notice will be promptly revised and distributed whenever there is a material change to the uses or disclosures, the individual's rights, organization's legal duties, or other privacy practices stated in the notice. A material change to any term of the notice will not be implemented prior to the effective date of the revised notice, unless required by law.

B. ABF Home Health Services, LLC will prominently post the notice and make the notice available through its website.

C. The patient's legal representative may exercise the patient's rights when a patient is incompetent or a minor.

D. When a patient has questions about his/her privacy rights, requests additional information, or would like to exercise one (1) of these rights, he/she will be referred to the appropriate individual or office designated by ABF Home Health Services, LLC on the Notice of Privacy Practices.

DISCHARGE PLANNING

Policy No. 1-010

UPDATED 04/2020

PURPOSE

To promote patient independence, safety, and use of community resources prior to patient discharge from the organization.

POLICY

Discharge planning will be initiated for every patient upon admission to the organization. Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in planning his/her discharge, including referral and transfer.

PROCEDURE

1. During the initial assessment, the clinician will:
    A. Assess the following and identify:
        1. Anticipated date of discharge
        2. Resources available, including persons and finances
        3. Anticipated changes in living situation
        4. Areas that might require assistance
    B. Document the patient discharge potential on the plan of care.
    C. Provide information regarding the patient discharge potential at case conferences with other team members, as appropriate.
2. Clinicians will assist patients regarding their discharge by:
    A. Consulting with the patient and family/caregiver regarding the need for discharge from the organization
    B. Serving as a referral source for patient and family/caregiver in obtaining follow-up support services
    C. Consulting with the patient and family/caregiver regarding the provision of discharge information
    D. Participating in a conference with the patient and family/caregiver regarding the patient discharge plans, if requested

E. Sending a post discharge letter/summary/report to the patient's physician

3. Clinicians will inform the appropriate Clinical Supervisor in the event that problems arise in discharge planning and obtain appropriate assistance.

4. If patients are being transferred to another HHA or being discharged to a SNF, IRF, or LTCH, the ABF Home Health Services, LLC will assist patients and/or caregivers in selecting a post-acute care provider by using and sharing data that includes but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.

5. The ABF Home Health Services, LLC will ensure that the post-acute care data on quality measures and resource use measures are relevant and applicable to the patient's goals of care and treatment preferences.

6. The ABF Home Health Services, LLC will ensure all necessary medical information pertaining to the patient's current course of treatment, treatment preferences, illness and post-discharge goals of care are sent to the receiving facility or health care practitioner to ensure a safe and effective transition of care.

7. The ABF Home Health Services, LLC will comply with all requests from the receiving facility or health care practitioner for clinical information as necessary for the treatment of the patient.

TRANSFER/REFERRAL CRITERIA AND PROCESS

Policy No. 1-022

UPDATED 05/2020

PURPOSE

To outline the process for transferring or referring a patient to another service provider.

POLICY

When a patient's needs change significantly and he/she requires care that cannot be provided by the organization, a transfer/referral to another service provider will be made.

When the patient's plan of care changes and this change results in a transfer or referral, the patient, his/her representative, as well as his/her primary physician or authorized licensed independent practitioner, will be notified and involved in planning decisions.

Transfer/Referral Criteria

Home health care services for a patient will not be arbitrarily terminated. They may be transferred/referred only for the following reasons, which will be documented in the clinical record:

1. Reasons for transfer
    A. A determination of the inappropriateness of continuing the services
    B. A change in the patient's medical or treatment program
    C. A change in patients' location outside of service area
    D. A change in the patient insurance that requires an in-network provider
    E. Patient request

PROCEDURE

1. The patient will be given immediate notice and assistance in selecting other health care. The organization will assist the patient and/or caregiver in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.
2. The organization will ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
3. When a patient is referred to another organization, service, or individual, the patient will be informed of any financial benefit to ABF Home Health Services, LLC.

4. The physician (or other authorized independent practitioner) will be notified of the transfer, reason for transfer and any other pertinent information and documented in the patient record.

5. The clinician or designee will:

   A. Inform the patient and family/caregiver of the physician (or other authorized independent practitioner) notification.

   B. Involve the patient and family/caregiver in the transfer.

   C. Serve as a liaison between the patient, the family/caregiver, and the physician (or other authorized licensed independent practitioner) relative to the transfer arrangements.

   D. Notify all internal or external providers of care for the patient.

6. All necessary medical information pertaining to the patient's current condition and treatment, post-discharge goals of care and treatment preferences will be sent to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

7. The organization will comply with requests for additional clinical information necessary for the treatment of the patient made by the receiving facility or health care practitioner.

8. All communication with the receiving provider, physician (or other authorized licensed independent practitioner), and patient will be documented in the clinical record.

9. The clinician will complete a transfer summary. (See "Transfer Summary" Policy No. 1-023.)

10. The clinical records clerk will send a copy of the transfer summary or clinical record to the receiving provider. (See "Transfer Summary" Policy No. 1-023.)

11. A copy of the transfer summary will also be sent to the physician (or other authorized licensed independent practitioner).

12. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.

TRANSFER SUMMARY

Policy No. 1-023

UPDATED 05/2020

PURPOSE

To define the requirements for the documentation of a patient transfer to another organization and/or internally to an affiliated organization.

POLICY

All patients transferred from the organization will have a transfer summary completed and filed in the clinical record.

PROCEDURE

1. The transferring clinician will complete a transfer summary that includes but is not limits to:

    A. All necessary medical information pertaining to the patient's:

        1. Current course of illness

        2. Treatments

        3. Post transfer/discharge goals of care

        4. Treatment preferences

2. Completed transfer summaries will be given to a clinical records clerk who will send a copy to the receiving organization or the health care practitioner who will be responsible for providing care and services to the patient within two (2) business days of a planned transfer if the patient's care will be immediately continued in a health care facility and will file the original in the clinical record.

3. Completed transfer summaries will be given to a clinical records clerk who will send a copy to the receiving organization or the health care practitioner who will be responsible for providing care and services to the patient within two (2) business days of becoming aware of an unplanned transfer if the patient is still receiving care in a health care facility at the time the organization becomes aware of the transfer and will file the original in the clinical record.

4. ABF Home Health Services, LLC will make available any additional necessary clinical information requested by the receiving facility or health practitioner, such as a copy of the patient's current plan of care or the most recent physician's (or other authorized licensed independent practitioner) orders.

DISCHARGE CRITERIA AND PROCESS

Policy No. 1-024

UPDATED 05/2020

PURPOSE

To outline the process for a discharging a patient from service.

POLICY

When the patient's plan of care changes and this change results in discharge or reduction of services, the patient or his/her representative, as well as his/her primary physician or authorized licensed independent practitioner, will be notified, and involved in planning decisions.

A discharge summary will be completed and filed in the clinical record.

Definitions

1. *Termination/Discharge*: Discontinuance of all organization services by the organization.
2. *Reduction of Services*: A change in the patient's service plan in which one (1) or more existing services are discontinued.

Discharge/Reduction of Services Criteria

1. Services will be terminated when the patient meets one (1) or more of the discharge criteria:
   A. The organization and the physician or allowed practitioner who is responsible for the home health plan of care agree that the organization can no longer meet the patient's needs, based on the patient's acuity.
   B. The patient or payer will no longer pay for the services provided by the organization.
   C. The physician or allowed practitioner who is responsible for the home health plan of care and the organization agree that measurable outcomes and goals set forth in the plan of care have been achieved, and the organization and the physician or allowed practitioner who is responsible for the home health plan of care agree that the patient no longer needs the organization's services.
   D. The patient refuses services or elects to be transferred or discharged.
   E. The organization determines that the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired.
   F. The organization ceases to operate.
   G. The patient expires.

PROCEDURE

1. The organization will verbally notify the patient of the decision to terminate or reduce services within one (1) visit prior to the time the change in service is to occur (i.e., prior to the last scheduled visit).

2. Prior notice will not be necessary when services are discontinued by the patient or physician or authorized licensed independent practitioner; however, action taken must be documented in the clinical record and a discharge summary completed. A copy of the discharge instructions will be mailed to the patient.

3. An update to the comprehensive assessment, including required OASIS data elements, will be completed, as required by regulation.

4. For a patient requiring continuing care, assistance will be given to the patient and family/caregiver in order to manage continuing care needs after the organization services are discontinued. Discharge instructions will be provided.

   A. Discharge planning will identify needs the patient may have.

   B. Arrangements for such services will be coordinated by the organization when applicable.

5. The decision to terminate services "for cause" must be documented in the clinical record citing the circumstances and notification to the patient, the responsible family/caregiver or representative, and the patient's physician or authorized licensed independent practitioner. Efforts to resolve problems prior to discharge/transfer will also be documented in the patient's record. The patient will be provided contact information for other home health agencies and providers if continued care is needed. The Clinical Supervisor or designee is accountable for the decision and the required documentation. If the decision to terminate services is due to the patient's behavior, the behavior of other persons in the patient's home, or situation, the clinical record must reflect the following:

   A. Identification of the problems encountered

   B. Assessment of the situation

   C. Communication with the organization management and the physician or authorized licensed independent practitioner responsible for the plan of care

   D. A plan to resolve the issues

   E. Results of the plan implementation

6. DISCHARGE FOR CAUSE: If the patient is being discharged for cause, the physician(s) issuing orders for the plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge will be notified.

7. Each clinician making the final visit for his/her discipline will complete the sections of the discharge notice for discontinuing a discipline. If more than one (1) discipline is providing care, the discipline being discontinued will notify the physician or authorized licensed independent practitioner.

8. A discharge summary will be completed for all discharged patients. A copy will be sent to the primary physician or authorized licensed independent practitioner. (See Discharge Summary Policy No. 1-025).

9. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.

10. The discharge record will be organized according to the organization policy regarding clinical record contents. Documentation will be reviewed by the Clinical Supervisor or designee and completed within 30 days of the discharge; at which time it will be removed from the active files.

PATIENT EDUCATION RELATED TO DISCHARGE PLANNING

Policy No. 2-032

PURPOSE

To provide guidelines for organization personnel in the planning for discharge and patient and family/caregiver education related to that discharge.

POLICY

Patient will be active participant in the planning of discharge from home care services and will be verbally informed of the date and reason for discharge. Patients will receive instructions upon discharge to facilitate self-care and health care follow-up.

PROCEDURE

1. Discharge planning and instruction will begin upon admission to the organization.
2. On admission, the clinician will inform the patient and his/her family/caregiver as to the expected length of service, emphasizing the need to resume, to the extent possible, a return to a functioning level of care and activity.
3. During subsequent visits, the patient and family/caregiver should be continually assessed as to his/her readiness to be discharged from home care, including instruction needed to assure a smooth transition.
4. As part of the discharge planning process, the clinician will focus patient instruction on care and service requirements when home care is no longer needed.
5. Organization personnel will assist the patient regarding his/her discharge by:
    A. Consulting with the patient and family/caregiver regarding the need for discharge
    B. Serving as a referral source for patient and family/caregiver in obtaining follow-up support services
    C. Consulting with the patient and family/caregiver regarding the need for discharge instruction
6. Discharge instruction will begin prior to the last visit. Instructions may include, but will not be limited to:
    A. Medication instruction
    B. Activities of daily living instructions
    C. Care instructions such as wound, diet, symptom control, etc.

D. Contaminated waste disposal

E. Standard precautions

7. Documentation of patient and family/caregiver instruction in the clinical record will include:

   A. Information taught

   B. Adaptations made to the environment

   C. Patient and family/caregiver understanding

   D. Return demonstration in use of equipment, if appropriate

   E. Response to teaching

   F. Additional learning needs

8. The clinician discharging the patient will provide written and verbal instructions. A copy of written instructions on a discharge instruction form will be given to the patient; the original will be maintained in the clinical record.