Team Name: Home Care Leadership Team Team Lead: Regional Director, Home Care Approved by: Executive Director - East	Reference Number: CLI.5410.PL.003 Program Area: Home Care Policy Section: Access
Issue Date: January 25, 2018 Review Date: Revision Date:	Subject: Referral and Intake Process for Home Care Services

POLICY SUBJECT:
Referral and Intake Process for Home Care Services

PURPOSE:
- To define the intake/referral process for Home Care services.
- To define the Case Coordinator /designate responsibilities in response to Home Care referrals/intake.
- To identify criteria to prioritize referrals.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) Treatment of Clients

POLICY:
Referrals for Home Care Services are accepted from individuals in the community, health care professionals, hospitals, primary care provider, significant others or the individual themselves. Referrals will be responded to by a Case Coordinator or designate within two (2) working days of receipt of referral.

IMPORTANT POINTS TO CONSIDER:
Applications/referrals to Home Care received from an individual or significant other will be accepted verbally by the Case Coordinator. Referrals received from a community health care facility/program/health professional or hospital will only be accepted in writing using a designated Home Care referral form.

Where an application/referral is being made on behalf of an individual, the individual must be in agreement to the application/referral.

Applications /referrals for Home Care Services are accepted for all Manitoba residents regardless of age.

DEFINITIONS:
Non-admission - is the process whereby a clinical decision based upon specified criteria is made, or other circumstance (e.g. primary care provider refuses service, patient/client refuses service, person not eligible, person deceased) which results in an individual not being admitted to Home Care.

Essential Services - Services which are vitally essential to sustain health which, if not provided, would pose a serious and immediate risk to and/or deterioration in a client's health status or caregiver network. While determined on a case by case basis, these services include palliative care, diabetic management, ventilator care, post-stroke or post-operation care, wound care, tube feeding, medication management and respite for high complex needs.

Informal Support Network - Primary care provider members and significant others (friends, etc.) who:

- Reside in the same household or in close physical proximity to the home care client;
- Have been identified as providing regular and sustained support to the home care client;
- Provide assistance without payment; and/or
- Provide assistance which includes activities that the home care client is unable to perform independently and that contribute to his/her well-being or safety.

Substitute Decision Maker – In the context of Home Care are services, Substitute Decision Maker includes committee and proxy.

PROCEDURE:

1. Applications/referrals for Home Care including the date of the referral will be received by the Case Coordinator and recorded on one of the following forms:
   - Home Care Referral & Intake Process - Manitoba Home Care Basic Information Form - Individual / Community Referrals (MG-50) CLI.5410.PL.003.FORM.01;
   - Home Care Referral & Intake Process - Home Care Referral - Hospital CLI.5410.PL.003.FORM.02
   - Home Care Referral & Intake Process - Manitoba Home Care Program Short Term Assessment/Hospital Discharge Form and Basic Information Form (MG-8080) CLI.5410.PL.003.FORM.03
   - Home Care Referral & Intake Process - Home Care Treatment Clinic Referral Steinbach CLI.5410.PL.003.FORM.04
   - Home Care Referral & Intake Process - Home Care Treatment Clinic Referral Portage CLI.5410.PL.003.FORM.05
   - Home Care Referral & Intake Process - Home Care Treatment Clinic Referral Manitou CLI.5410.PL.003.FORM.06

2. The Home Care program shall identify a Case Coordinator /designate in each Home Care office as the intake person for referrals.

3. The Case Coordinator /designate responsible for intake shall:
   - Receive the referral and forward to the appropriate Case Coordinator (offices with > one Case Coordinator) based on geographical area, the same day the referral was received by the intake person.
   - Document the following on the Home Care Referral & Intake Process - Home Care Referral Intake Log CLI.5410.PL.003.FORM.07:
     - Date, time and office referral was received by;
     - Name of client;
     - Date and time referral was forwarded to appropriate Case Coordinator. If referral is not forwarded to another Case Coordinator document date and time referral was received.

4. The Case Coordinator will:
   - Contact the client within two (2) working days of receipt of referral to complete the initial assessment for eligibility and service needs;
   - Make arrangements with the client/primary care provide/Substitute Decision Maker for an in-person interview to complete the Home Care assessment within 3 working days from the initial client contact for hospital referrals and 5 working days for community referrals;
   - Enter date and time of initial client contact made on the Home Care Referral & Intake Process - Home Care Referral Intake Log CLI.5410.PL.003.FORM.07;

- Open client in Procura registration department, document referral date and source in procura;
- Document all client contact attempts, discussions and outcomes on the Client's Interdisciplinary Progress Notes (IPN).

5. Where multiple referrals or limited Case Coordinator availability impact the timeliness of response, the Intake Case Coordinator shall in consultation with Regional Manager Case Coordination prioritize the sequence of response with consideration given to the following :
   - Client is at risk of hospitalization as a result of declining health problems;
   - Clients enrolled on the Palliative Care Program and is in crisis;
   - Recent discharge from hospital (within 30 days) and requires essential services to support client in the community safely;
   - No family /social supports available to help meet needs essential to safety and security.
   - Shortage of hospital beds and need identified to discharge clients who can be supported with home care services in the community safely.

6. Treatment Clinic referrals are forwarded to the treatment clinic where service is requested: The Resource Coordinator Nursing/Direct Service Nurse/designate will:
   - Register the client in Procura;
   - Forward the referral to the treatment clinic the day referral is received;
   - Contact client and advise of appointment time;
   - Where multiple referrals or limited treatment clinic appointments impact the ability to schedule client appointment as requested, consult with Nursing Supervisor.

7. Should the client/primary care provider/Substitute Decision Maker not be eligible for Home Care services or refuse Home Care assessment/services the Case Coordinator will:
   - Clients <u>without</u> a Dementia diagnosis:
     - Provide client/primary care provider/Substitute Decision Maker with their contact information;
     - Document on Integrated Progress Note the reason;
       - Client/primary care provider/Substitute Decision Maker declined service and reason if provided;
       - Client assessed as not eligible for Home Care services.
     - Attach Integrated Progress Notes to the referral form and file in archive files.
     - Provide written notification to the referee and/or primary care provider/Substitute Decision Maker (SDM) of referral outcome e.g. client ineligibility; assessment or service refusal;
     - Document as "Non Admit In Procura"
     - Enter date and outcome on Southern Health Santé Sud Home Care Referral Intake Log.
   - Clients <u>with a</u> Dementia diagnosis:
     - Open client to Registration in Procura.
     - Document "yes" for Dementia Diagnosis in Procura Reference numbers. Complete follow up by telephone with the primary care provider/Substitute Decision Maker every three months until client is either deceased, admitted to a Personal Care Home, transferred to another region. Document follow up calls on Integrated Progress Notes.
     - If primary care provider/Substitute Decision Maker declines follow-up the Case Coordinator shall;
       - Advise Regional Manager Case Coordination and Regional Director Home Care;
       - Document the reason for decline of service on the Integrated Progress Notes;
       - Close client to Registration in Procura;
       - Enter date and outcome on Referral Intake Log.
       - Provide written notification to the referee of the primary care provider/Substitute Decision Maker's decision to decline follow up.

SUPPORTING DOCUMENTS:

CLI.5410.PL.003.FORM.01	Home Care Referral & Intake Process - Manitoba Home Care Program Basic Information Form (MG-50)
CLI.5410.PL.003.FORM.02	Home Care Referral & Intake Process - Home Care Referral - Hospital
CLI.5410.PL.003.FORM.03	Home Care Referral & Intake Process - Manitoba Home Care Program Short Term Assessment/Hospital Discharge Form and Basic Information Form (MG-8080)
CLI.5410.PL.003.FORM.04	Home Care Referral & Intake Process - Home Care Treatment Clinic Referral Steinbach
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CLI.5410.PL.003.FORM.07	Home Care Referral & Intake Process - Home Care Referral Intake Log