Sullivan County Department of Public Health

Title: Administrative Review **Number**: AG-04 **Page Number:** 1 of 2	Original Approval: 12/03 Reviewed/ revised: 4/16, 3/24

Statement/ Purpose:
To review patients who no longer meet the criteria set forth in the agency's Admission and Discharge policies and in accordance with Codes, Rules & Regulations of New York State, Section 763.5.

Authority:
NYS Codes, Rules & Regulations, Section 763.5

Application:
SCDPH clinical staff

Terminology:

Responsible Party:
Director of Patient Services

Cross-Reference:
Admission to Certified Home Health Agency, Discharge from Certified Home Health Agency, Advanced Beneficiary Notice

Procedure:
1. If, upon assessment for admission to home care, or upon discharge from home care, or in the case of an established patient being admitted to an inpatient facility and the Case Manager or Intake Nurse feels the patient no longer meets the criteria as set forth in the agency's Care Plan Contract or Admission Policy, he/she will seek direction from a Supervisor or the Director of Patient Services (DPS).
2. The Supervisor or Case manager (with Supervisor oversight) will complete the Administrative Review template in the patient's electronic health record, notify Intake and write a note in the Clinical Event tab to alert staff that there is an Administrative Review in place.
3. Intake will add the patient's name to a list of patients who have Administrative Reviews. If necessary, a conference and/or home assessment with the patient/ caregiver/ family and a Supervisor will take place to offer a full explanation of eligibility criteria for home care and to review the Care Plan Contract. This will take place within 24 hours of an admission assessment and within 72 hours if a patient is admitted to an inpatient facility.
4. If the patient is admitted to a facility, the conference takes place, and it is deemed that the patient does NOT meet the criteria as set forth by the agency, the patient will be discharged. The patient will be notified and supplied with the appropriate Advanced Beneficiary Notice at that time and the patient's physician will be notified via phone.
5. In the event that the agency receives a new referral for home care for the same patient, the Intake Nurse will make the referral source aware of the patient's history and the reasons that the patient was previously deemed

ineligible to receive home care. If requested, a discharge conference or evaluation visit may be offered so that a Supervisor or other agency staff may assess if the patient's circumstances or behaviors have changed so that the patient is now eligible for home care.