FINANCE, CLAIMS AND ACCOUNTS COMMITTEE
MEETING MINUTES

February 9, 2017

A regular meeting of the Chippewa County Board of Commissioners' Finance, Claims and Accounts Committee was held on Thursday, February 9, 2017 at the Chippewa County Courthouse in Sault Ste. Marie, Michigan. Chairman Martin called the meeting to order at 5:30 p.m. with a quorum present.

MEMBERS PRESENT: Jim Martin, Scott Shackleton, Don McLean, Conor Egan and Bobby Savoie

MEMBERS ABSENT: None

OTHERS PRESENT: Jim German, Karen Senkus, Lana Forrest, Margie Hank, Chuck Leonhardt, Michelle Robbins, Christine Lundquist, Sharon Kennedy, Donn Riley, Holly Kibble, Kathy Cairns, Tina Ojala, and Kelly Church

Approval of the Agenda

It was moved by Commissioner McLean, supported by Commissioner Savoie, to approve the agenda as presented. On a voice vote, the motion CARRIED.

Public Comment

No public comment was offered.

Correspondence and Informational Items

The Committee received the Treasurer's Investment report, the monthly travel report, the monthly Visa billing statement and information on the Animal Shelter Spay/Neuter Assistance Program that is currently being privately funded through donations.

AGENDA ITEMS

Senior Services and Programs Millage Renewal Proposal (approve)

The Committee received the proposed language for the August 1, 2017 – Chippewa County Senior Services and Programs Millage Renewal Proposal, to review and approve. This proposal, if approved by the voters, will permit the County to continue the millage previously authorized for Senior Services and Programs with the County. A brief discussion regarding Headlee took place.

It was moved by Commissioner McLean, supported by Commissioner Savoie, to approve the language as follows for the Senior Service and Programs Millage Renewal Proposal, to be voted on August 1, 2017.

> **Shall the expired previously voted increase in the tax limitation imposed under Article IX, Section 6 of the Michigan Constitution on general ad valorem taxes within CHIPPEWA COUNTY, MICHIGAN of .5 mill ($0.50 per $1,000 of taxable value) which was reduced to .4994 mill by the required millage rollbacks, be renewed at .4994 mill ($0.4994 per $1,000 of the taxable value) for a period of four years, being 2017, 2018, 2019, AND 2020, inclusive for the purpose of providing operating funds to continue and enhance Chippewa County Community Action Agency's Meals and Chippewa County Community Action Agency's Senior Services in Chippewa County, thereby raising in the first year (2017) ab estimates $551,000? YES NO**

On a voice vote, the motion CARRIED.

Health Department
Write-offs (approve)
The Committee had previously directed Administration along with authorizing additional hours for Chuck Leonhardt, to review and reconcile the Health Departments Accounts Receivable anticipated write-offs. The Committee was presented with an overview of the write-offs which range over a 9 year period, with the majority of the write-offs (77%) being in FY 2014 and FY2015. The main reasons for the write-offs were due to claims being denied because of 1) the wrong NPI physician number; 2) wrong primary insurance originally billed; 3) the payer was not mapped in Carefacts to Netwerks correctly; 4) Medicare billing request for Anticipated Payment had to many Q codes and 5) the rules changed for the notice of election for Hospice Medicare patients. A sample of the write-offs by reason were also broke down by write-off reason for the Committee to review as follows: Home Health Medicaid $81,195; Hospice Blue Cross Blue Shield $41,100; Hospice Medicare $57,120; Home Health Medicare $269,252.03; Home Health Blue Cross Blue Shield $81,723 and Hospice Medicaid $75,892. Carefacts also made adjustments that both increased and decreased billings which could not be followed so it was not removed from the general ledger resulting in $224,451.74 adjustment to the General Ledger. Total write-off and adjustments are as follow:

- Write-offs reconciliation worksheet 671,725.49
- Carefacts Adjustments 224,451.74
- Adjustment to decrease the A/R G/L balance 9/30/16 132,773.73
- Possible write-offs from existing Carefacts receivables 45,898.04
  - Total Amount of write-offs and adjustments As of September 9/30/2016 $ 1,074,849.00

The Commissioners all had questions for the Health Department's Administrative staff, seeking accountability for the issues with the rejections; questioning the number of meetings being held at the Health Department and letting the Health Department Administration know that it is not business as usual, and the business structure needs to change with the Health Department needing to be caught up. During the discussion Finance Director Christine Lundquist answered several questions regarding her Department, and she stated she only expected a $200,000 - $250,000 accounts receivable write-off due to the changes Carefacts made. Chuck Leonhardt further updated the Committee, as the Health Department is as of October 1, 2016 using Healthcare 1st, a third party provider, for home health billing, which appears to be going okay, but he advised that follow-up and having management trained, so that they know the procedure for input, how to check for rejections, correct rejections, have the ability to print and understand reports at any time so that they are not relying on other staff to get them the information.

It was moved by Commissioner Shackleton, supported by Commissioner McLean, to approve the Health Department write-offs and adjustments as presented, totaling $1,074,849.00, as follows:

- Write-offs reconciliation worksheet 671,725.49
- Carefacts Adjustments 224,451.74
- Adjustment to decrease the A/R G/L balance 9/30/16 132,773.73
- Possible write-offs from existing Carefacts receivables 45,898.04
  - Total Amount of write-offs and adjustments As of September 9/30/2016 $ 1,074.849.00

On a voice vote, the motion CARRIED.

Following a brief discussion with the Committee, it was consensus to continue to have Chuck Leonhardt providing oversight and direction with the assessment of the Health Department.

Health Department - Retiree Health Care Policy (Rescind 3.09.001 & authorize re-write; two parts A) effective immediately for new retirees and B) changing the current retirees

The Committee received information and recommendations on the Health Departments current Retiree Health Care Policy, which does not match the County policy, with different plans to go about bringing the HD in line with the County retiree health policy. The HD has thirty-six retirees currently receiving health care at no cost to any of them, of those fifteen should have been paying a portion to continue coverage based on County policy which indicates retiree's lifetime coverage is hired before January 1, 1984, based on years of service and age, those hired post January 1, 1984 have coverage limited to years of coverage not to exceed based on years of service and age too. Three pre 1984 current retirees should have been paying a 25% premium payment; seven others should no longer be receiving health care and should have also been paying either 25% or 50%; four can maintain coverage with premium payment necessary with the final nine maintaining 100% coverage with an added not to exceed premium payment. It was also noted that the Health Department policy has had many changes in the past few years. The changes will not change for the three Teamsters on the current listing. The Committee reviewed options and discussion followed.

It was moved by Commissioner Savoie, to rescind policy 3.09.001 and to re-write the policy to follow County policy utilizing the pre and post January 1, 1984 eligibility requirements and to have the change effective in 60 days for the current retirees. – The motion died from lack of support.

It was moved by Commissioner Egan, supported by Commissioner Shackleton, to rescind policy 3.09.001 and to re-write the policy to follow County policy utilizing the pre and post January 1, 1984 eligibility requirements and to have the change effective in 90 days for the current retirees. On a voice vote, the motion CARRIED. (See attached policy, which has been reviewed by legal.)

Health Department – Pink Ribbon Expenditure (approve)

The Committee reviewed a Pink Ribbon expenditure, which is all donated funds for hose clients diagnosed with breast and/or cervical cancer requiring assistance with travel and lodging related to treatment may apply for assistance, following policy 1.99.013.

It was moved by Commissioner McLean, supported by Commissioner Egan, to approve the Pink Ribbon expenditure of $2,808.47, as presented following policy 1.99-013. On a voice vote, the motion CARRIED.

Health Department – Human Resources Policy – Bumping Rights (approve)

Health Department Administration is seeking to have a Bumping Rights Policy approved as follows: Unless a position is governed by a collective bargaining agreement, no employees will be allowed to bump a less senior employee. This policy will clarify any past practices that may have transpired.

It was moved by Commissioner McLean, supported by Commissioner Savoie, to approve the Bumping Rights Policy 3.09.004 as presented. On a voice vote, the motion CARRIED.

Home Health & Hospice Policy – Admission Criteria & Process (authorize change, adding residency requirement)

The Committee reviewed above referenced policy which establishes standards and a process by which a patient can be evaluated and accepted for admission. Admission criteria #9 currently indicates within the geographical area that the EUP Home Health and Hospice service, upon discussion with Administration including the Health Officer and the Home Health & Hospice Director, a minimum of six month residency requirement is recommended. The Committee was also updated on future indigent cases as the Health Officer has reached out to establish a mutual agreement with EUP Hospice House and the EUP Home Health and Hospice, which will be brought back to the Committee for review and action, if required.

It was moved by Commissioner McLean, supported by Commissioner Egan, to approve changing Policy 8.03.005, the Home Health & Hospice Policy, to indicate #9 under Admission Criteria to read: The patient must reside a minimum of six months within the geographical area that the EUP Home Health & Hospice services. On a voice vote, the motion CARRIED. (See attached)

Authorized Signors for Central Savings Bank Account (approve)

The Committee, as the governing body of the Chippewa County Health Department was asked to authorize and approve that the County Treasurer and the County Clerk as authorized signors, as back up for the Health Officer and the Deputy Health Officer for the HD account at Central Savings Bank. The HD was asked to verify this approval with the auditors.

It was moved by Commissioner McLean, supported by Commissioner Shackleton, to authorize the County Treasurer Marjorie Hank and the County Clerk Cathy Maleport, as signors for the Chippewa County Health Department's Central Savings Bank account, as back-up signors to Health Office Senkus and Deputy Health Officer Forrest. On a voice vote, the motion CARRIED.

Sheriff Department – Grant 2017 Michigan Medical Marijuana Operation and Oversight Grant

The Committee was asked to approve, authorize and establish a special for a Medical MJ Grant in the amount of $8,203. The grant would be used for education of the Medical Marijuana Act, equipment to enforce the Act or Overtime to enforce the Act. The education portion would be spent on a new Sheriff's APP (iPhone and Android), that will be linked to the Medical Marijuana Law and to help offices better communicate with their communities. Questions regarding future annual subscription fees were brought up, and the Sheriff will be notified seeking clarification.

It was moved by Commissioner Savoie, supported by Commissioner Shackleton, forward to the full Board to approve the Medical MJ Grant, in the amount of $8,203 and to establish a special fund upon clarification from the Sheriff. On a voice vote, the motion CARRIED.

Drug Court – Service Contracts (approve)

The Committee received service contracts from McLean Consulting and Great Lakes Recovery for services to be provided from October 1, 2016 to September 30, 2017 to be approved. Circuit Court Administrator Tina Ojala notified the Committee of two recent graduates of the Drug Court.

It was moved by Commissioner Egan, supported by Commissioner Savoie, to approve the service contracts from McLean Consulting in the amount of $39,200, to provide case management services to the Drug Court and Great Lake Recovery in the amount of $16,950, to provide substance abuse and related counseling to participants of the Drug Court Program, both covering the period October 1, 2016 to September 30, 2017. On a voice vote, the motion CARRIED.

Central Dispatch – Instructor Coordinator Course for Chippewa County EMS (approve)

Director Michelle Robbins requested the approval to approve EMS training courses in Chippewa County, this course would train experienced EMS personnel to instruct and pass their EMS knowledge and experience to residents in Chippewa County to help them become EMS professional and to hopefully recruit additional responders. The cost of the course is $7,980, sponsored by the Consolidated Community School services, student cost would be $200 per student and the balance being paid by Chippewa County OES monies. This expense is budgeted.

It was moved by Commissioner Savoie, supported by Commissioner McLean, to approve the Instructor Coordinator Course for Chippewa County EMS, to help recruit and promote additional responders. The total cost of the course is $7,980, with per student cost of $200 and the balance being paid through the Office of Emergency Services (Fund 211). On a voice vote, the motion CARRIED.

Information Systems – 5 Star Armor Service Agreement - $3,000 (approve)
The Committee received a request from Information Systems to approve a service agreement from 5 Star Armor to temporarily support the LEMS system in the Sheriff's Office, during the gap, if issues arise, while the County waits to go live with the new state system.

It was moved by Commissioner McLean, supported by Commissioner Shackleton, to approve the 5 Star Armor Service Agreement in the amount of $3,000, to support software and hardware from February 1, 2017 to June 30, 2017, to cover the gap until the County goes live with the new state system. On a voice vote, the motion CARRIED.

Treasurer – Condemned City Property Agreement with City for "First Right of Refusal" (approve)
The Committee received information on 606 Eureka Street and 629 Magazine Street in Sault Ste. Marie that have been condemned by the City Commissioners, with an order for demolition; both properties will be foreclosed on March 31, 2017, if the taxes continue to not be paid. A meeting with the City and County was held to come up with a cost sharing resolution. It was determined that the City would take these properties at "First Right of Refusal" and the County would waive the minimum bid.

It was moved by Commissioner McLean, supported by Commissioner Savoie, to approve that 606 Eureka Street and 629 Magazine Street, "First Right of Refusal" and waived the minimum bid by the County and granted to the City so that the properties can be demolished at the most cost effective resolution. On a voice vote, the motion CARRIED.

Administrator
NACo FY2017 Dues - $770 (No recommendation)
The Committee was given the annual billing for NACo dues. No approval motion was offered and NACo membership will be cancelled.

FY2017 Equipment – Authorize Purchasing Policy Waiver for Budgeted Items
- **Sheriff – Protective Technologies – Metal Detectors - $10,999.98**
- **Central Dispatch – APCO Adviser – software - $12,937.50**
- **Probate Court – JAVS upgrade - $28,619.27**
- **Probate Court – Graphic Sciences – scanning project - $21,000**

The Committee reviewed the previously budgeted equipment, software and hardware upgrades and the scanning project for Probate Court. The Committee was requested to approve the projects and waive the County purchasing policy as these items were reviewed and approved during the budget process. The Committee discussed the metal detectors briefly, stating it is a step in the right direction, for something that is long overdue regarding security and safety.

It was moved by Commissioner Savoie, supported by Commissioner McLean, to approve the purchase of the metal detectors from Protective Technologies - $10,999.98; the purchase of software from APCO Institute - $12,937.50; to upgrade the Probate Court JAVS system - $28,619.27 and the Probate Court scanning project - $21,000 (the first of a three year project) and to waive the County Purchasing policy. On a voice vote, the motion CARRIED.

Request for Quotations – Release

- **Central Dispatch/Animal Control Vehicles Mid-size SUV's**
- **Sheriff – Dodge Charger Police Package**
- **Sheriff – Ford SUV Patrol Vehicle**

The Committee received the RFQ's for four vehicle purchases to be released to receive quotes for purchasing.

It was moved by Commissioner Savoie, supported by Commissioner Egan, to approve the release of RFQ's for two Mid-size SUV's, a Dodge Charger Police Package and a Ford SUV Patrol vehicle. On a voice vote, the motion CARRIED.

FINANCE - Claims and Accounts

The Committee reviewed the bills and payroll presented for approval.

It was moved by Commissioner McLean, supported by Commissioner Egan, to recommend the approval of December and January bills and payroll as follow: the general claims totaling $537,523.65, other fund claims $640,169.38, payroll $1,078,144.90, Health Department January claims $576,109.00; total claims $2,831,946.93 and vouchers H-1 through H-556. On a voice vote, the motion CARRIED.

Committee/Chairperson Comments

Administrator German let the Committee know that the Information Systems working at the Health Department was going well. Commissioner Egan having been on the Board of Health; acknowledged his portion of the responsibility for the issues at the Health Department.

Adjourn

It was moved by Commissioner Egan, supported by Commissioner Savoie to adjourn.

Chairman Martin declared the meeting adjourned at 7:55 p.m.

Kelly J. Church, Recorder

Jim Martin, Chairman

HUMAN RESOURCE POLICY

Category:	Employment	**Number:**	3.09.004
Subject:	Retiree Health Insurance	**Effective Date:**	March 13, 2017
Applicability:	All staff	**Supersedes:**	February 13, 2017
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PURPOSE:

To define the eligibility requirements for retiree health insurance through Chippewa County Health Department.

POLICY:

Eligible retirees who were full time, non-probationary employees of the Employer hired before January 1, 1984, shall be afforded health insurance benefits as follows:

Minimum Years of Service	Minimum Age of Retirement	Percent of Premium Paid
20	55	100%
15	55	75%
10	50	50%

Eligible retirees who were full time, non-probationary employees of the Employer hired after January 1, 1984 shall be afforded health insurance benefits as follows:

Minimum Years of Service	Minimum Age of Retirement	Percent of Premium Paid	Duration of Premium Payment
20	55	100%	Not to exceed 15 years
15	55	75%	Not to exceed 10 years
10	50	50%	Not to exceed 5 years

For current retirees who will see a change in their retirement healthcare, the changes will take effective June 1, 2017.

For all future retirees who retire on or after February 13, 2017, this policy is effective immediately.

Retiree health insurance is not available for employees governed under the Teamster union who were hired on or after January 1, 2007.

Retiree health insurance is not available for non-union employees hired on or after May 1, 2008.

This policy replaces policy 3.09.001and is incorporated into the Chippewa County Health Department Employee Handbook by reference.

HUMAN RESOURCE POLICY

Category:	Employment	**Number:**	3.09.001
Subject:	Retiree Health Insurance	**Effective Date:**	RESCINDED 2/13/2017
Applicability:	All staff	**Supersedes:**	9/30/2016; 12/2/15; 7/25/2014; 3/29/13; 5/30/08
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~~**PURPOSE:**~~

~~To define the minimum age at which a qualified employee may be eligible to receive retiree health insurance through Chippewa County Health Department.~~

~~**POLICY:**~~

~~For qualified employees who are MERS-eligible, the minimum retirement age to receive retiree health insurance is 55 years of age.~~

~~Retiree health insurance is not available for employees governed under the Teamster union contract who were hired on or after January 1, 2007.~~

~~Retiree health insurance is not available for non-union employees hired on or after May 1, 2008.~~

~~Union employees hired into a full-time position before January 1, 2007 or non-union employees hired into a full-time position before May 1, 2008, are eligible for retiree health insurance. An employee must have been an active employee at the time of his or her retirement at age 55 or older and MERS-eligible, in order to be eligible for retiree health insurance benefits.~~

~~MERS eligibility and/or MERS-allowed early retirement options are separate issues from retiree health insurance eligibility.~~

HOME HEALTH & HOSPICE POLICY

Category:	Clinical	**Number:**	8.03.005
Subject:	Admission Criteria & Process	**Effective Date:**	February 13, 2017
Applicability:	All nursing staff	**Supersedes:**	01/29/10; 04/22/99; 02/01/91
Prepared On:	10/10/08	**Page 1 of 7**	

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

1. EUP Home Health & Hospice will admit any patient with a life-limiting illness that meets the admission criteria.

2. Patients will be accepted for care without discrimination on the race, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

3. Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

4. While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.

5. The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

6. EUP Home Health & Hospice reserves the right not to accept any patient who does not meet the admission criteria.

7. A patient will be referred to other resources if EUP Home Health & Hospice cannot meet his/her needs.

8. Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.
3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.
4. The patient must desire hospice services, and be aware of the diagnosis and prognosis.
5. The focus of care desired must be palliative versus curative.
6. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.
7. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.
8. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.
9. The patient must reside a minimum of six months within the geographical area that the EUP Home Health & Hospice services.
10. Eligibility for participation will not be based on the patient's race, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.
11. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.
12. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for

service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.

2. The Clinical Supervisor will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

    a. Patient's geographical location

    b. Complexity of patient's hospice care needs/level of care required

    c. Hospice personnel's education and experience

    d. Hospice personnel's special training and/or competence to meet patient's needs

    e. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

    a. Such notification and approval will be documented.

    b. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:

    a. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

    b. Explain the patient's rights and responsibilities and grievance procedure.

    c. Provide the patient with a copy of EUP Home Health & Hospice notice of privacy practices.

d. Assess the family/caregiver's ability to provide care.

e. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

f. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

g. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

h. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

i. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

    a. Level of services required and frequency criteria

    b. Eligibility (according to organization admission criteria)

    c. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

    a. Nature and goals of care and/or service

    b. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

    c. Access to care after hours

    d. Costs to be borne by the patient, if any, for care

e. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

f. Safety information

g. Infection control information

h. Emergency preparedness plans

i. Available community resources

j. Complaint/grievance process

k. Advance Directives

l. Availability of spiritual counseling in accordance with religious preference

m. Hospice personnel to be involved in care

n. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating acceptance of services (informed consent) and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the interdisciplinary plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the interdisciplinary plan of care within two (2) days of start of care; this may be in person or by phone.

16. If the patient is accepted for hospice care, a comprehensive interdisciplinary plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care.

17. The initial written assessment will be completed within 24 hours of the initial assessment visit/admission visit. All documentation needed to develop the comprehensive plan of care will be completed and turned into the office no later than the next business day.

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. After admission into the hospice program, the initial psychosocial/spiritual assessments and bereavement risk assessment will be completed.

20. A clinical record will be initiated for each patient admitted for hospice services.

21. If a patient does not meet the admission criteria or cannot be cared for by EUP Home Health & Hospice, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

22. The following individuals should be notified of non-admits:

    a. Patient

    b. Physician

    c. Referral source (if not physician)

23. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

24. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator in consultation with the Medical Director, upon request of the referring party and/or the patient.

25. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.