CARE COORDINATION

Home Health Care Reducing Readmissions TOOLKIT

ALLIANT HEALTH SOLUTIONS | QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
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This toolkit is designed for home health care providers who want to reduce hospital readmissions. It aims to improve patients' understanding of home health care services and providers' knowledge of how to mitigate readmission risks. Hospitals and Nursing Facilities can also use some of these resources to improve care transitions to Home Health.

WHAT YOU'LL FIND:

Provider Resources:

- **Capabilities List** – A guide to creating a capabilities list to share with referral sources.
- **Referral Checklist** – A checklist of the required information for a home health referral.
- **Circle Back Tool** – A communication tool when an admission does not go as planned.
- **Risk Assessment Tool** – A guide to identify readmission risks in advance and create interventions to mitigate them.
- **SBAR For Change in Condition** – A tool to help providers communicate quickly on any change in condition.

Patient Resources:

- **What to Expect Guide** – A guide that explains home health services to patients.
- **My Home Health Care Plan** – A tool to help patients identify their health care concerns after their home health services end.
- **Hospital Decision Guide** – A guide to assist patients in determining whether to stay home or go to the hospital if their condition changes.

Thank you to the Providers that collaborated with us on this toolkit:
Absolute Health Professionals, AdventHealth Home Care Central Florida, AdventHealth Home Care West Florida, AdventHealth Orlando Hospital, AdventHealth Waterman Home Care, Amedisys Home Health, Concierge Home Care, Elevate Home Health Group, Florida Hospital Association, Mederi Caretenders, MSA Home Health, Orlando Health Home Care, Orlando Health Hospital, and Pinnacle Home Care.

Home Health
CAPABILITIES LIST

Home Health _____ Phone _____

Address _____

Contact person _____ Contact Cell _____

Fax # _____ Send referrals via _____

Mark with an "X" the services you provide and insurance you accept. Fill in where indicated.

Capabilities		**Insurances Accepted**	
Home Health Clinician Services		Medicare	
Skilled Nursing Care		Medicaid (circle)	
Physical therapy		- Sunshine – State, Allwell	
Occupational therapy		- Humana, Molina, Magellan	
Speech-language therapy		- Simply Healthcare, Oscar	
Medical social services		- Better Health, other	
Home Health aide		Humana (Circle) - HMO, PPO	
Diagnostic Testing		Aetna (Circle) – HMO, PPO	
Lab tests (nurse draws blood at home)		Blue Cross (Circle) – HMO, PPO	
Lab test PTIR at home by nurse		- Florida Blue, Out of state plans	
Portable X-ray		Cigna (circle) – HMO, Health Springs	
Portable ultrasound		United Health (circle) – HMO, PPO	
Bladder ultrasound		- Optum, UMR, Wellmed	
Portable Doppler		Wellcare	
Clinical Programs or Protocols		Bright Health	
Diabetic care and management		Freedom	
Cardiac care and management		VA (circle)	
Pulmonary care and management		- Contract, Champus, Tricare	
Chronic disease management		Other	
Pre- and Post-operative care		Other	
Palliative care		Other	
Psychiatric care		**Specialty Programs**	
Pain management		Remote patient monitoring	
Wound care and management		Respiratory therapy	
Infusion therapy		Cardiac Infusion drips	
Rehabilitation		Chemo take downs	
Low vision therapy		LVADS	
Fine motor/gross motor re-training		Other	
Fall/balance program		Other	
Incontinence therapy		Other	
Pulmonary rehabilitation		**Counties Served (list all)**	
Lymphedema therapy			
Vestibular rehabilitation			
Additional Information			
Accepts COVID positive patients			
Health & transitional coaching			
Data-driven risk assessment			
Electronic medical record			

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Home Health Referral CHECKLIST

THE ORDER:

- [ ] Signed and dated home health order indicating the types of skilled services to be provided and that the patient meets the requirement for homebound status.

DEMOGRAPHICS:

- [ ] Patient's home address and phone number
- [ ] Address and phone number where the patient will receive home health services (if different from home address)
- [ ] Names and phone numbers of the patient's emergency contacts
- [ ] Primary care physician's name and phone number
- [ ] Patient's insurance information

NOTES:

- [ ] Face-to-Face Encounter note/Progress note with the reason for skilled home health care
- [ ] Discharge summary, therapy notes and nurse's notes from recent hospital or skilled nursing facility/rehab stay
- [ ] Current medication list
- [ ] All pertinent diagnosis

ELIGIBILITY REQUIREMENTS FOR HOME HEALTH CARE

* All Medicare beneficiaries are 100% covered **IF** they meet the following criteria:
  - Must be under a physician's plan of care (must have a following physician).
  - Must be homebound.
  - Must require an intermittent skilled level of care **OR** Must require a skilled level of intermittent care.

* Patient cannot receive home health services while attending outpatient rehab.

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Preventable Readmissions Initiative Home Health
CIRCLE BACK TOOL

This tool guides communication between Home Health, Hospital and Skilled Nursing Facilities (SNF) to follow up or "circle back" when an admission does not go as planned. It assists in discussions about the necessary information needed for continuing optimal patient care, collaboratively addressing readmission risks, and identifying opportunities to improve communication during care transitions.

TIPS:

- Facilitate conversations if the Home Health team identifies the best times for each Hospital/SNF to receive calls and cluster calls to facilities where possible.
- In the early stages, conduct a virtual or a pre-call visit with the Hospital or SNF you receive the most admissions from to introduce yourself and establish open communication.
- Assign someone to regularly collect and analyze data from completed forms to identify commonly occurring issues that can impact the Home Health's ability to provide optimal patient care and address them with the Hospital/SNF partner.
- If any common issues/trends are identified, share them with your Hospital/SNF partners and discuss how the issue will be resolved to strengthen your partnership.

Patient Name: _____

Name of Hospital/SNF: _____

Date of Admission to HH: _____ Date of D/C from Hosp/SNF: _____

Information being discussed with:

☐ Case Manager: _____

☐ Social Service/Discharge Coordinator: _____

☐ Other: _____

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1. Was anything missing from the discharge paperwork/orders?
   ☐ Yes ☐ No

   If yes, what was missing?

2. Were there any discrepancies with the:
   a. Medication orders? ☐ Yes ☐ No
   b. Mediation reconciliation forms? ☐ Yes ☐ No ☐ form not present
   c. Narcotic prescriptions? ☐ Yes ☐ No ☐ N/A, no narcotics prescribed

   If yes for any of the above, describe the discrepancies:

3. Did you receive all the qualifying orders/referrals/paperwork for proper continuation of care?
   ☐ Yes ☐ No

   If no, what was missing?

4. If the patient requires further follow-up care for specialty services, were all the necessary information/orders provided?
   ☐ Yes ☐ No ☐ Patient does not require follow-up care

   If no, what services or appointments need clarification?

5. Is there anything the discharging facility could have done differently to help you provide excellent patient care?
   ☐ Yes ☐ No

   If yes, please describe what could have been done differently.

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Home Health Rehospitalization
RISK ASSESSMENT TOOL

The Home Health Rehospitalization Risk Assessment Tool provides a framework for interdisciplinary review, discussion, and individualized care planning for all admissions to a home health. The tool proactively identifies and implements mitigation strategies **to reduce readmission risk**.

Tips for using this tool:

1. Utilize readmission review documentation to identify any additional high-risk factors associated with the population served by your agency. Modify this form to include any additional clinical or social determinants of health risks.
2. Review readmission risk reports generated by the electronic health record (EHR). Reconcile reports with the risks identified on this assessment and ensure both tools reflect all identified risk for the patient.
3. Establish a process for regular monitoring and interdisciplinary review of patients with multiple readmission risk factors in daily stand-up meetings, case conferences and/or high risk meetings.
4. Establish a process to ensure interdisciplinary staff are aware of the risks and are closely monitoring and communicating changes in condition.
5. Consider both the readmission risk for this stay and for the transition to the next level of care.
6. Develop an individualized, person-centered care plan intervention for each identified risk.

Patient Name: _____ DOB: _____

Start of Care Date: _____

Primary Physician: _____ Certification Period: _____

Primary Focus of Care: _____

Clinical Risk Factors[1] (Check all that apply, both active and chronic conditions)		
☐ Cancer, on active chemo or radiation therapy	☐ Heart failure (HF)	☐ Infection with ongoing treatment
☐ High-Risk Medications ☐ Anticoagulant ☐ Diabetic Agent ☐ Opioids	☐ Congestive Obstructive Pulmonary Disease (COPD) or Dyspnea ☐ Cardia Disease (Hypertension, CAD, Angina)	☐ Infection with ongoing treatment, infected wounds, those receiving Negative Pressure Therapy or daily wound care, and Stage III and IV Pressure Ulcers
☐ Multiple active diagnosis and/or co-morbidities (e.g., HF, COPD and Diabetes in the same patient/resident) More than 2 secondary doses	☐ Diabetes	☐ End-Stage Renal Disease (ESRD) ☐ Neoplasm as primary diagnosis
☐ Polypharmacy (e.g., five or more medications)	☐ Fracture (hip)	☐ Surgical complications

Patient hospitalized in the ***past 30 days?*** ☐ No ☐ Yes *(List dates and reasons)*

_____

_____

Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(List dates and reasons)*

_____

_____

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Additional Factors That May Increase Readmission Risk		
☐ Current or previous difficulty adhering to plan of care	☐ Current or previous difficulty adhering to medication regime	☐ History of delirium
☐ No identified or engaged care partner; Lives alone and/or inadequate support network	☐ History of falls or fall with major injury; High fall risk	☐ Known home safety risk
☐ No Advance Care Planning documentation or identified goals of care	☐ Known conflict among family members around goals of care, health status or plan of care	☐ Prior declination of palliative care or hospice services
☐ Current or past complaints of poor pain control; severe pain or pain all the time	☐ Primary language other than English	☐ Low health literacy of patient/ resident and or health care agents
☐ Introduction of a new class of medication(s)	☐ History of C. Diff, sepsis or post-COVID syndrome	☐ No known primary care provider (PCP)
☐ Discharged from hospital or LTACH for more than five days in the past three months	☐ Assistance with medication management needed	☐ Depression (score of three or more on PHQ-2 or 10 or more on CSDD
☐ Two or more hospitalizations and/or ER visits in the past three months	☐ Adverse reactions, ineffective therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, and/or non-adherence revealed by drug regimen review.	☐ Overall poor status/prognosis (likely to remain in fragile health and have ongoing high risk for serious complications or death within a year)
☐ ADL assistance needed with inadequate caregiver assistance	☐ Pressure ulcer(s)	☐ Urinary catheter
☐ Dyspnea (with moderate or minimal exertion or at rest)	☐ Stasis ulcer	

Additional Resources for Proactively Mitigating Identified Readmission Risks
Alliant Health Solution's My Home Health Care Plan helps patients and caregivers document their questions and concerns prior to home health ending. Using this tool can help teams proactively implement mitigation strategies. **My Home Health Care Plan: My Questions**
Alliant Health Solution's bite-size video on the Scripps Gerontology Our Family Our Way free virtual and printable resources for family meetings and templates can help plan for care and support post-discharge. **Our Family Our Way**
Alliant Health Solution's library of zone tools can be used to initiate patient and care partner education beginning on admission and to engage patients and care partners in knowing and communicating changes in condition. **Alliant Zone Tools**
"Deciding About Going to the Hospital" resource can help guide proactive discussions with patients and health care agents around readmission risks, goals of care, agency capabilities and the decision process when a change in condition is identified. **Home Health Hospital Decision Guide**
INTERACT® resources for a quality improvement program to improve identification, evaluation and communication around changes in resident status. **INTERACT**

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SBAR for Resident Change in Condition

In Case of Emergency, Call 9-1-1

SITUATION

- My name is _____ I'm calling from _____
- I need to discuss [first name/last name], age _____
- I'm concerned about [his/her] change in _____

_____ *(signs/symptoms).*

BACKGROUND

- The resident was admitted on _____ *(date)* with the diagnosis of _____ *(current diagnosis).*
  - Previous vital signs taken on _____ (date/time)
    BP _____ HR _____ RR _____ Temp _____
    SpO2 _____ *(on room air or supplemental O2)*
- This started on _____ *(date).*
- The resident is allergic to _____
- The resident's advance care directive is _____

ASSESSMENT *(Describe Key Findings)*

- My assessment is that the resident is _____ *(state sign/symptom).* Here are my findings.
  - Current vital signs taken on _____ *(date/time)*
    BP _____ HR _____ RR _____ Temp _____
    SpO2 _____ *(on room air or supplemental O2)*
  - The resident has voided _____ times in the last 8 hours.
  - Mental status is (changed OR unchanged) from baseline: _____
  - Other findings related to my concern are: _____

RECOMMENDATION

- Would you like to order blood work, diagnostic tests or treatments?
- How soon can you see this resident?
- If the resident deteriorates or continues to show signs/symptoms, what is the next step? Start an IV or bolus?
- The physician should confirm, clarify and request additional information and then work with the nurse to take appropriate action with this resident.

Before calling the physician, NP, PA or other health care professional:

- Evaluate the resident and complete this form.
- Check vital signs; be alert for changes from baseline.
- Review the resident record: recent hospitalizations, lab values, medications and progress notes.
- Note any allergies.
- Be aware of the resident's advance care wishes.

Early Warning Signs

Below list additional abnormal findings found in: exam details, signs, symptoms, diagnostic information, blood work/labs, observations, resident statements/complaints, pain, mental status, medication changes, diet, bodily function concerns, input/output, time of onset or other changes in condition that are of concern.

Nurse Name *(Please print)*: _____ Date: _____

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MYTHS AND FACTS OF HOME HEALTH CARE

Myth: Home health care is for people without family support. I have a family caregiver.

Fact: Home health care professionals can lower the stress placed on loved ones to create a comfortable and healing environment for the patient.

Myth: I can't trust a stranger in my house.

Fact: Home health care companies perform fingerprinting, background checks, and competency tests on staff before they interact with patients, thereby ensuring patients are matched with a quality professional who can meet their needs and be trustworthy and reliable.

Myth: I don't want to lose my independence.

Fact: You will regain your independence quicker and have a better quality of life.

Myth: Home health care is too expensive.

Fact: Home health care is covered by Medicare, Medicaid and most private insurance companies. Non-medical care, such as meal prep, cleaning, sitter, and transportation, are typically not covered. That is private duty care.

KNOWN FACT

People who accept home health care tend to recover quickly and are less likely to be readmitted to the hospital due to complications. Let our team help in your recovery.

Visit www.medicare.gov/care-compare/ for more information on quality star ratings and home health care comparisons published by Medicare.

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What to Expect from Home Health Care Services

Choosing home health care is an important decision in your recovery journey, and there are many benefits to using this service.

Home health care is delivered by medical professionals who treat your medical condition. They do not cook, clean or serve as a sitter.

Many people transition to home health care after a stay in the hospital, rehab center or skilled nursing facility. The primary goals are to help you recover and stay as independent as possible.

This pamphlet will help you in answering many questions and more.

HOME HEALTH CARE IS:

Short-term intermittent services – such as skilled nursing, physical therapy, occupational therapy, speech therapy and a medical social worker – are provided in the comfort of your home. Skilled clinicians work with your physician to establish a plan of care based on your individual needs.

WHAT DOES "HOMEBOUND" MEAN?

Homebound means the patient's condition prevents them from safely leaving the home without assistance from others or assistive devices (e.g., canes, walkers, crutches, or wheelchairs). In most cases, patients are considered homebound even if they leave the home for medical treatments that cannot be provided at home. Brief and occasional non-medical absences, such as going to church, the beauty shop or special family events, may also be allowed.

WHAT CAN HOME HEALTH CARE PROVIDE?

Home-based services	Home Health Care	Private Duty
Skilled Nursing	✓	X
Wound Care	✓	X
Pain Management	✓	X
Medication Administration	✓	X
Medication Reminders	✓	✓
Disease Management	✓	X
Medical Tests	✓	X
Health Monitoring	✓	X
Social Worker	✓	X
Durable Medical Equipment	✓	X
Rehabilitation Therapies (PT, OT, ST)	✓	X
Patient & Caregiver Education	✓	X
Help with Bathing/ Dressing	X	✓
Bathroom Support	X	✓
Cleaning	X	✓
Sitter/Companion	X	✓
Meal Prep or Delivery	X	✓
Transportation	X	✓

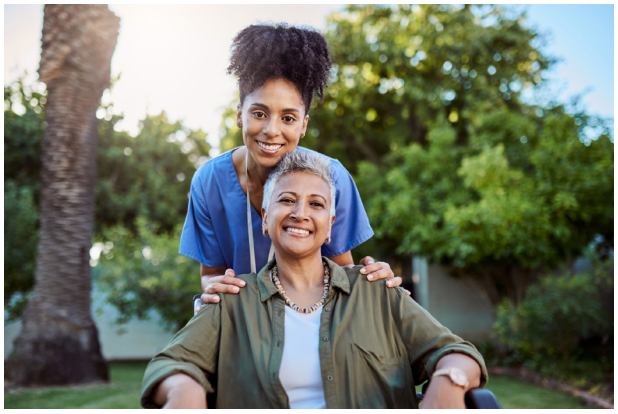
Disclaimer: Services may vary by Provider, Insurance and State.

BENEFITS OF HOME HEALTH CARE:

- Care is delivered directly in your home where you are most comfortable.
- Medical services are provided by skilled professionals.
- Home health staff follow your physician-prescribed plan.
- You regain independence and self-sufficiency at home.
- Home health care provides safety, comfort, and convenience by reducing the risk of infections, falls and hospitalizations.
- Home health care prevents avoidable trips to the hospital by monitoring and managing health conditions at home.

YOUR PLAN OF CARE

Family members are encouraged to assist in the planning process to help set and meet your goals while working with home health care professionals for your benefit.



COMMENTS: _____

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My Home Health Care Plan:
MY QUESTIONS

Everyone has questions about their care. We want to make sure all of your questions are answered. Here are some questions you may have. Tell us what matters most to you. Place a check in the "yes" box in each row that you have questions. Share with your nurse or social worker to get answers and support. If you have questions that aren't listed here, use the comments space for additional notes.

Let us know if you would like a caregiver or family member with you when we talk about your questions. If yes:

Caregiver/Family Member Name: _____

Phone Number: _____

I AM CONCERNED ABOUT...	YES	NO	COMMENTS
Follow-Up Medical Care			
Having all the information I need when Home Health ends			
Follow-up care			
Scheduling follow-up appointments and/or tests			
Who to call with questions or concerns			
How I will get to my doctor's follow-up appointment			
The type of medical equipment I still need (e.g., walker, crutches, insulin pump, oxygen) or contact for my medical equipment provider			
Paying for the additional care/services I may need			
Medicines			
Which medicines I should take			
When to take my medicines			
Taking my medicines as prescribed (e.g., swallowing)			
Understanding the side effects of my medicines			
Paying for my medicines			
Getting my medicines from the pharmacy			
Who Do I Call With Questions About My Medications			
Primary Care Physician:		Phone Number:	
Pharmacy Provider:		Phone Number:	
Activities of Daily Living			
Getting help with personal care (e.g., bathing, dressing)			
Cooking meals			
Getting help with grocery shopping			
Using medical equipment, changing a bandage, or giving an injection			
Caregiver/Family Member			
How my family or other caregivers will help me after Home Health ends			
How my family or other caregivers will manage my illness			
Maintaining contact with friends and family, and feeling isolated or left behind			

Enter comments on the back ▶

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Home Health Hospital Decision GUIDE

As a home health patient, if you develop new or worsening symptoms, you will need to decide if you want to continue care in the home or go to a hospital.

Research has shown that, in some circumstances, hospitalization may be unnecessary. Whether hospitalization can be prevented depends on your condition and the ability of the home health staff to provide the necessary care.

Since there are risks and benefits of care in a hospital, it is important to make the right decision. Your decision depends on several factors, such as the severity of your condition and your overall health status.

Contact your home health provider to discuss your wishes and the best option.

Home Health Agency: _____

Phone Number: _____

Contact Person: _____

How To Make Your Wishes Known

There are several things you and your family can do to ensure your wishes about hospital care are addressed:

- Participate in your plan of care (i.e., make a decision about your treatment preferences) with home health staff and your primary care provider (i.e., doctor, nurse practitioner or physician's assistant).
- Complete an **Advance Directive** document that provides instructions on how you want medical decisions to be made if you can't make them. Florida recognizes a **Living Will** and **Designation of a Health Care Surrogate** for care in emergencies and at the end of life.
- Learn about the home health resources available to treat your new symptom or condition (For example, lab, X-rays, oxygen, zone tools, wound care, intravenous (IV) fluids, and medications) and discuss the risks versus benefits of going to the hospital.
- Consider the financial burden and other factors of transferring to the hospital versus in-home treatment, if appropriate.

Benefits of Staying in Your Home with Home Health Care

There are benefits of staying in the home when a new symptom or condition occurs – assuming it is safe to treat the condition in the home and staying in the home is consistent with your and your family's preferences. At-home treatment allows you to:

- Have continuity of care. You will continue to receive care from staff members who know you and can respond to your individual preferences and needs.
- Remain in your home with your possessions and maintain your schedule and routines when possible.
- Avoid a trip to the hospital and long delays waiting in the emergency room.
- Avoid hospital-related complications and potentially being exposed to infections.

Reasons To Go to the Hospital

If you require clinical observation or more complex tests/treatments, such as abnormal vital signs or uncontrolled severe symptoms, the hospital offers:

- Sophisticated lab tests, X-rays and scans
- Access to doctors and specialists who are in the hospital every day
- Blood transfusions
- Intensive care units

Risks of Going to the Hospital

You could be at risk of additional complications while in a hospital. These complications can occur even in the best hospitals. Factors such as older age, chronic medical problems and your health condition, combined with the hospital environment, can put you at high risk for complications. These complications include:

- New or worsening confusion
- More time spent in bed, which puts you at greater risk of blood clots, skin breakdown, pressure ulcers, muscle weakness, loss of function and other complications
- Less sleep and rest due to noise levels
- Increased risk for:
  - Falls due to unfamiliar surroundings
  - New infections
  - Depression due to decreased socialization with friends and family

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