SNF to Home Health Care- Shared Expectations

This document focuses on the transition from SNF to home health, outlining performance expectations of SNFs ("senders") and home health agencies ("receivers") as they accept a patient from the post-acute facility setting and initiate home health care. In addition, it outlines practices home health agencies will take as "senders," if a change in care setting is required.

This document is intended to be a work in process. This document was first drafted by a working group of Massachusetts home health agencies, facilitated by the Home Care Alliance of Massachusetts and subsequently iterated upon by engaging input of the Clinical Leadership committee of the Massachusetts Senior Care Association and a Pioneer ACO leader in early drafts. We welcome suggestions on how to improve this document to make it relevant to home health care agencies and referring providers, including ACOs, hospitals, skilled nursing facilities, physician practices, and others.

Possible users of this document may include: SNFs, Home Health Agencies, Accountable Care Organizations, Bundled Payment providers, hospitals at risk of readmission penalties, SNFs at risk of readmission penalties, and any other provider who bears financial risk for total cost of care and /or post-acute care outcomes.

Section 1
Pre-Discharge Transitional Care Planning Checklist
(SNF & Home Health)

Referral to Home Health: Early Patient Communication (Once decision between SNF and ACO/Bundled team has determined HH referral is indicated)	✓
SNF staff communicate to patients and caregivers that a referral to home health is being placed to address the patient's specific post-SNF needs and risks	
SNF asks patient which Home Health Agency they prefer, if applicable, to maintain continuity	

Pre-discharge care plan coordination	
SNF invites preferred Home Health Agency clinical liaison to participate in care planning meeting	
SNF identifies patient as ACO member	
SNF provides agency with ACO contact information	
SNF-HH-ACO team collaborate to identify needs, and readmission risk factors	
Specify in-home support needs	
Specify issues relating to cognition, behavior	
HH agency can identify known home-based issues, when known	

High Risk Medication Review	
SNF identifies any difficult to obtain medications, (not in stock, pre-auth required, costly)	
SNF, ACO and HH collaborate to identify lower-cost options if potential barriers identified – this may require ACO clinician, PCP or hospital d/c physician	
ACO may facilitate pharmacist or other clinician review of medications to ensure coverage, access	
Hard-copy prescriptions for controlled substances will be provided prior to discharge	
SNF to consider bedside delivery of medications prior to d/c	

Certification and Equipment Review (i.e., Face to face, wound vac, wound dressings, tube feeds, IV antibiotics, PICC placement, ostomy supplies, oxygen, hospital bed, etc.)	
SNF completes Face to Face form **Must photocopy discharge note or last note written by MD or RNP for Home Care Agency**	
SNF clearly identifies what equipment/materials are required	
SNF staff will ensure needed equipment has been ordered	
SNF staff will provide name of DME provider(s) to HH staff	
SNF, ACO and HH identify essential equipment (glucometers, scales, etc.) and directly provide, whenever possible	

Section 2
Day-of-Transfer Processes Checklist
(SNF & Home Health)

Pre-discharge clinical assessment	
SNF staff documents updated set of vitals	
SNF staff documents cognitive status (A+O x 3)	
SNF staff documents any known stable changes in cognitive status (i.e., sun downing)	
SNF staff assess pain within 4 hours of discharge	
If pain present, medicate patient prior to discharge home	
Warm handoff to receiving nurse, if known, or to liaison or other HH point of contact (identified by agency)	

Essential Information Elements

SNF provides standardized and prioritized information to home health agencies containing transitional care elements of most relevance to home health providers assuming care. Elements per SNF to Home Health Transfer Document include:

Patient and alternative contact information	
Primary Caregiver	
Diagnoses- identify those that are new	
Most recent vitals including cognitive status and pain	
Risk/needs assessment	
Medication dose, route, indication	
Allergies, intolerances to medications	
PT/OT/RT/SLP/HHA/SW referrals	
Equipment needs & whether ordered	
Tubes/lines/drains/wound information (i.e., PICC, IV, pleurex, wound vac, G or J tube, JP drain, etc.)	
Wound care instructions, supplies	
PCP name, phone and fax number	
Specialist(s) name(s), number(s)	
Date(s) of appointment(s)	
Code Status/MOLST	

Specific Point of Contact

SNF provides the name and number of a point of contact who can answer post-SNF questions (role varies by facility)	
ACO provides point of contact to coordinate regarding POC	

Section 3
Initial Review and Confirmation of Plan of Care - Checklist
(SNF & Home Health)

Timely Contact	
Initial visit within 24h of discharge if high-risk patient/ACO patient (i.e., same day admit, IVs)	
Non-high risk <48h (this will be determined by both SNF and Home Care providers at discharge meeting)	

Confirm & Clarify Plan of Care

If nurse identifies questions or discrepancies in plan of care, medications, supplies, the following steps will be taken the same day: call SNF point of contact, call ACO point of contact, and/or call PCP to resolve	
HHA will notify ACO point of contact weekly of care plan discrepancies remain unresolved	

Medication Review & Reconciliation

Perform in-home review of all medications, visualizing all medications throughout home	
Identify discrepancies in prescribed medication regimen	
Identify potential drug-drug interactions	
Contact SNF, ACO and/or PCP to clarify medication issues	

Assess Patient Needs

Ability to perform self-care	
Understanding of conditions, symptoms and red-flags	
Medication teaching	
Fall Risk	
Home Safety Evaluation	
Referrals	
• Physical Therapy	
• Occupational Therapy	
• Speech Language Pathology	
• Nutritionist, nutritional support	
• Home Health Aide	
• Medical Social Worker	
• Behavioral Health	
• Depression Screen	
• Pain Assessment	
• Readmission Risk Assessment	
• Assess social supports	
• Community referrals (ASAPs/Elder Service)	
• Flu and Pneumonia Vaccine status	
• Herpes Zoster Vaccine status	

Advanced Directives

Determine if patient has Advanced Directive and/or MOLST form	
HCP/Guardianship	

Section 4
Teaching and Care Coordination - Checklist
(Home Health Agency)

Patient and Caregiver Teaching	
Use ACO teaching materials, if any, for consistency OR	
Use hospital-provided teaching materials, for consistency OR	
Use SNF-provided teaching materials, for consistency	
Reinforce prior teaching and maintain consistency	
Personal Health Record	
Review readmission risks and plan for mitigating risks	
Medication teaching w/ teach-back	
Red flag symptoms with teach back	
Pain management plan	
Chronic disease self-management	
"Call me first" teaching	
Home care team will routinely coordinate care of patient and make referrals as needed	
If discrepancies persist in care plan or patient remains high risk to return to facility, Home Care staff will initiate a case conference with PCPs and specialists to coordinate plan	
ACO will initiate case conferencing if desired	

Section 5
Change in Clinical Status and Transfer of Care - Checklist
(Home Health Agency)

Transfer to "Home" (End of HH Episode)	
Agency adheres to OPT-IN practices including patients understanding of:	
• Known medications	
• Understand self-management role	
• Know symptoms to monitor	
• Know who to call	
• When next appointment(s) are	
• Connection with community services	
Agency will notify PCP and ACO that episode is over	

Transfer to Nursing Home (Family/Caregivers can no longer manage patient's needs at home OR re-admit to SNF for Skilled Care

HHA will inform PCP and ACO that patient's overall deterioration in patient's condition and/or family/caregivers are unable to manage the patients care at home OR if patient is a direct admit and within their 30 day Medicare window - HHA staff will assist family with referral for nursing home placement	

Transfer to Hospice

If indicated, agency will work with PCP and ACO to refer patient to hospice	

Known Transfer to ED/Hospital

Agency will send ED the following:	
• Advance Directives/MOLST	
• Most recent medication list	
• Home Health Agency contact	