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Issues in Patient Information Transmission: Standardizing Home Health Admission

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Clinical Leadership Theme

This project is based on Essential 3: Quality Improvement and Safety with a focus on Competency 8: Evaluate patient handoffs and transitions of care to improve outcomes (American Association of Colleges of Nursing, 2013). The handoff period is one of the most important factors for healthcare personnel to consider in assuring safe, efficient and personalized care for all patients. Patient handover among healthcare settings must be addressed to prevent patient harm during transitional periods. Standardized quality measure tools should be set into place to assess the discharge and admission process between healthcare settings and to serve as quality indicators needed to assess and improve the quality of care provided in various settings (Jeffs, et al 2013). This project focuses on standardizing the admission process within this home health agency's microsystem. The goal is to create a standardize "Patient Screening Tool" that will enhance the intake and continuum of care process and train the intake staff on using this tool efficiently by the end of December 2016.

Statement of the Problem

As a growing and cost-effective delivery system within the healthcare industry, home health care is an alternative option many patients, mostly elderly, who have qualifying health diagnoses choose in lieu of the traditional skilled nursing facilities (SNF). Home Health agencies (HHAs) give patients the opportunity to receive personalized patient-centered care that meets their medical needs at home from well-trained clinicians. Between 2000 and 2010, a 57% increase was noted in Medicare and Medicaid (CMS) certified agencies resulting in 4,272 additional new agencies. In 2011, Medicare and Medicaid, which for many elderly are the primary health insurance providers, paid \$18.4 billion in home health care for approximately 3.4

million people at no cost to the patient (Talaga, 2013). With many people being admitted to home health care, effective communication, efficient screening and proper education are imperative in reducing re-hospitalization risk and increasing positive patient outcome and satisfaction.

A lack of patient education during hospital discharge or physicians' office referral about home health agency services was noted from random interviews with 54 newly admitted home health patients between May 1st and June 4th 2016, and 30 former patients between February and April 2016. These patients state that they were not well informed about how the process would take place and thus felt very anxious during their transitioning period. Inappropriate physician referrals, information inconsistency from healthcare providers, and failure to screen effectively, lead to unrealistic patient expectations of home health care services, poor adherence to treatment, revenue loss related to low utilization payment adjustment (LUPA), and increase risk of committing CMS fraud. Agrawal, et al (2013) state that physicians' lack of knowledge of the CMS program increases their chances of making inappropriate referrals and submitting inappropriate claims that eventually create a domino effect, causing other providers and suppliers to unknowingly submit false claims to CMS and becoming part of CMS fraud schemes.

Project overview

Nowadays, the elderly are seeking healthcare instruction that help in extending their longevity, and allow them to stay healthier and independent within their living environments and communities. The growth of the elderly population, people 65 years and over, is expected to rise to 83.7 million in 2050 which is approximately twice the 43.1 million it was in 2012 (Ortoman, Velkoff, & Hogan, 2014). For many of these baby boomers, home health care is the most preferred medical settings for many reasons. First, they are in control of the environment. Next,

they feel more included in the decision making process. Thirdly, they feel heard as they get one to one teaching. Lastly, they do not feel rushed as they get clinicians' full attention during each visit's allotted time. Such particular attention makes home health more appealing for many as it boosts their confidence and empowers them to safely care for themselves.

As patients are overloaded with last minutes essential information during hospital discharge, they feel rushed and not well educated about home health care service. In such situations, home health agency personnel can start educating potential patients about CMS and agency regulations during the screening process which is the patients' first contact with agency staff.

The goal of this project is to enable smooth transitioning from referring points (hospitals or physician offices), to admission to this home health agency. It focuses on creating a "Patient Screening Tool" that will allow the intake staff to screen all referrals efficiently and ensure that all patients are indeed qualifying, well informed consumers of home health care services. This screening tool will enhance the admission process by reducing communication gaps that might occur during the transition process between the referring setting and patient's home setting.

Rational

No direct data, audits, and failure mode and effects analysis (FMEA) results led to this project. The necessity of this project was determined after follow up with this agency's patients who complained of lack of information and misinformation about home health services. They felt they were not well informed by anyone involved in their care transition and they reported that their initial conversation with intake staff was not specific as to what to expect from this particular service. This resulted in many new admits failure to return clinicians' phone calls regarding visits, causing multiple missed visits; these frequent missed visits most often resulted

in early termination of patients' medical care, resulting in low utilization payment adjustment (LUPA) which occurs in case with 4 or fewer visits within a 60 day certification period.

Annually this home health agency suffers a loss of approximately \$573,000 in LUPA (Agency Patient-Related Characteristics Report, HCHB 2015). Although several reasons lead to LUPA, many of them could have been prevented with a more efficient screening process. The cause and effect analysis (Appendix A) assesses the necessity of the screening tool. The SWOT analysis stakeholders (Appendix B) elaborate on the SWOT analysis of this project.

Methodology

Although the agency is CMS certified and provides care to CMS patients in majority, the implementation of this project will not target CMS patients only. It will apply to all referrals regardless of the patient's insurances including uninsured and charity care patients. The goal of this "Patient Screening Tool" is to facilitate a uniform screening process of all potential patients. As a field clinician directly interacting with patients and other staff on a regular basis, the selected best way to approach this project is with an experience of work (EOW) perspective that invites everyone's input for successful patient experience and staff satisfaction during that transition period.

Peter Senge's 1990 'Learning Organization' theory (Appendix C) and his ladder of inference (Appendix D) will be applied to initiate this project as it focuses on developmental process and application of learning material that could eventually lead to: staff ability to manage change, promote independent thoughts, and improve quality. It will be implemented by continuous support and coaching of the intake staff.

Patients' interviews will remain the main source of data collection to assess the effectiveness of this project. Communicating with interdisciplinary staff via emails about their

experiences during the start of care (SOC) visit with the patient will be another way to assess the effectiveness of the screening tool. With the use of this patient screening tool, intake could prevent admission of non-qualified patients and those who are at high risk of cancelling appointments that would not be compliant with CMS regulations.

Data Source/ Literature Review

This “Patient Screening Tool” will be beneficial in assessing patients’ qualification for home health care as well as appropriateness of referrals. It will reduce this home health agency risk of participating in CMS waste, abuse and fraud. More importantly, it will allow the intake staff to alleviate patients’ anxiety by providing specific clarification to concerns they might have prior to the SOC visit.

Agrawal, et al(2013) explain that many healthcare providers are directly or indirectly participating into CMS waste, abuse and fraud. They state that fee-for-service providers, physician office or home health agency, are more commonly involve in such fraud than providers in cost-based settings such as skilled nursing facility or nursing home. Therefore, as a home health agency, the use of this screening tool will prevent the agency from being directly or indirectly part of CMS fraud.

Jeffs, et al (2013) argue that patients’ risk of negative outcomes increases during the transition process because no specific and efficient ways exist within the healthcare system to provide a safe handoff from one setting to another. They back up their statement based on a study they conducted and argue that the creation of quality measures tools are important and necessary in promoting accountability and quality improvement within the healthcare industry.

Levinson (2012) suggests that CMS scrutinizes all payment claims received from home health agencies to prevent payment of inappropriate, unnecessary, and over utilization of home

care services. He further states that CMS should focus in reviewing the legitimization of documentation supporting all home health agencies' admissions during a certification period.

Talaga (2013) defines home health care services and patients admission criteria based on CMS regulations. He emphasizes CMS expenditure of \$ 18.4 billion in 2011 for home health care patients only during that year and explains CMS's different types of reimbursement to CMS certified home health agencies. Applying the screening tool during the intake process will reduce this microsystem's chances of admitting inappropriate patients who could result in LUPA for the agency.

As a growing force within the healthcare field, home health care agencies are receiving referrals from a wider variety of sources and admitting numerous patients with diverse medical concerns who require a broad variety of services daily. Torpey (2014) anticipates a growth of 60% of the home health care business by 2022 as well as a growth of 40% among people of 65 years and older, meaning that at some point most people will receive home health care during some part of their lives for medical interventions. For this reason, a uniform screening tool will be essential to screen all potential patients as referrals are anticipated to rapidly increase.

The success of this "Patient Screening Tool" relies on the cooperation of everyone involved in the intake process because intake staff are the first people within the agency to reach out to the patients. Tsui, et al (2015) believe that early personalized education and preparation for medical services not only leads to more adherence to recommendation, but also promotes participation in self-care as they stress the importance of using open ended questions to assess patients' understanding of healthcare related concerns.

Each one of these articles as well as other research references support the PICO question "Will a standardized 'patient screening' tool improve safe transition period/ patient transfer from

a medical setting to home health care?” Each article focuses on specific situations encountered in home health and gave suggestions on how these events can be prevented; these articles indicated that home health is necessary for people who qualify and prefer to receive medical care within the familiar environment of their homes through home health agencies.

Timeline

The timeline (Appendix E) necessary for this project “Patient Screening Tool” is six months, from July through December 2016. It has begun the process of several revisions from different stakeholders after initial presentation to the quality coordinator (QC) in early July. Each version will be presented to the QC, intake staff, and office administrator every Thursday for suggestions from July 14th till August 31st. From September 5th till end of October, interdisciplinary staff will be informed of the tool. With approval of upper management the screening tool will be distributed to referring hospitals, SNF and physicians during the month of November. Intake staff will begin training in December, and the screening tool will be used by all staff to screen all referrals starting January, 2017.

Expected Result

The anticipated outcome is for intake staff to use this screening tool 60 percent of the times during the implementation period, from January to April 2017. Anyone within this unit who makes that first contact phone call to the patients will be expected to be referring to this screening tool to assess patients’ qualification and understanding of home health care services ensuring understanding of CMS regulations. Reduction of LUPA related to misunderstanding of CMS regulations and agency policies is another anticipated outcome that could result from use of this tool.

Nursing Relevance

Once this tool becomes the legitimate patient screening form within the unit, the hope is that other offices within the organization will use it as well. Having a uniform screening process within this home health agency will greatly reduce patients stress during the transition period. The screening tool will promote open communication between patients and intake staff and will positively enhance patients experiences during the admission process.

Evaluation

This home health agency's microsystem is part of a not-for-profit organization which has been providing a variety of types of medical care such as: home health nursing care, maternal and child care, home infusion therapy, advance illness management, social services and rehabilitation therapy (OT, PT, ST) throughout the County's 820 square miles. The staff consists of various experienced field clinicians: nurses, certified wound care nurses, licensed vocational nurses, occupational therapists, physical therapists, speech therapists, registered dietician, medical social workers, and home health aide. The office staff is made of clerical personnel, intake nurses, clinical supervisors, QC, preceptor, director of patient service and administrator. This microsystem oversees the care of approximately 300 to 350 patients within the community with the elderly making up the majority of its patients. The agency does serve people within all age ranges, however younger people rarely need or qualifying for home health services. New graduates health professionals are not hired within this microsystem due to the independent nature of this care delivery system.

This project was initiated after 84 patients, current and former, reported lack of information about agency services within a 5 months period. These patients not only felt poorly informed during their transition period, they complained that the agency staff did not prepare them well for their admission. For instance, many reported that they were unsure of what to

expect from the clinicians during the admission visit and unaware of financial coverages.

Because surveys are being collected currently, fictitious graph and chart (Appendix H & I) are made to hypothesize on possible outcomes regarding patient education about agency services.

The Clinical Nurse Leader (CNL) initiated the research of this project with an experience of work (EOW) perspective that avoided defensive reactions and friction between staff and the CNL. This approach invites everyone's input, staff and patients, for successful creation of "Patient Screening Tool." Effectuation of the tool will enhance patient experience and staff satisfaction during the stressful transition period and improve the admission process.

This project is still in process. Current meetings with several stakeholders such as administrator, director of patient service, supervisor, quality coordinator and intake staff to discuss the proposed screening tool are scheduled an ongoing. Pre-assessment surveys are sent to patients (Appendix J). Clinicians are asked to fill anonymous surveys (Appendix K) to give their inputs on the current admission process. Getting people to see the benefits of this project is challenging. Managing staff anxiety, preventing conflict and resentment are at times overwhelming. Fortunately, the QC of this microsystem is the unit champion for this project and a trusted ally. She sees the benefits of this screening tool in term of quality improvements and wants it to become the main screening tool use for all patient referrals. The quality coordinator will advocate for this "Patient Screening Tool" (Appendix L) to become the standard referral questionnaire within this microsystem. She will assist with continuous staff education and will help with chart audits and surveys review to determine progress of project

Peter Senge's 1990 'Learning Organization' theory and his ladder of inference has been the driving force behind this project. This theory has no endpoint. It stimulates commitment to continuous learning and supports adaption to changes. Its nonlinear structure promotes flexibility

for the CNL in facilitating back and forth teaching for agency stakeholders and supports changes at any time during project. According to Hoyle, et al (2012), incorporation of the Learning Organization's four themes (inquiring, deciding, relating, and interpreting) are beneficial in sustaining organizational changes within a microsystem. They state that while clinical system change requires organizational modification through organizational learning, the organizational learning manifest itself through new organizational routines leading to measurable effects.

The shared vision step of this theory allows the CNL to relay patients and clinicians dissatisfaction with the admission process and explain the rationale of the proposed screening tool to the agency and its population. This step promotes discussion in which everyone can voice their concerns and give positive feedbacks. Mental model step facilitates the evaluation of people readiness in accepting and using this tool. During this step, the CNL can build understanding of the benefits of this project while evaluating people assumptions, fears and values. Another step of this theory, which might be a principal aspect of the theory, is personal mastery. This is where people's values get challenged while they learn about self-awareness. This is where people learn that everyone's participation in collaboration is needed and important for successful implementation. Following the mental step is the team learning step in which everyone within the interdisciplinary team, home health agency and referral sources, agree to work as a unit.

Lastly, system thinking allows for internal and external evaluation of outcomes within and across this microsystem. This is where the patient survey responses will be evaluated to determine positive or negative outcomes of the screening tool and chart audited to assess frequency of tool usage during screening process.

The ladder of inference on the other hand, facilitates the CNL to gather and interpret data while continuously assessing the microsystem reaction to this proposed tool. The reflexive loop

of this ladder allows the CNL to make informed decision for changes made with the aim statement and timeframe of this project. After few meetings with the QC and some stakeholders, it was noted that: firstly, the tool would not be effective for staff to use in December as anticipated; the date was changed to January 2017. Secondly, it was noted that the most efficient way to evaluate successful implementation of this “Patient Screening Tool” within its first few months of launching is by having 60% consistent usage of it within the first 4 months of its implementation, from January till April 2017 as stated in the Aim statement. In months to come, patient satisfaction with the admission process will be reevaluated with random post-assessment surveys.

Conclusion

Successful implementation of this “Patient Screening Tool” will benefits all stakeholders within and across this Home Health Agency not only in term of patients and clinicians satisfaction but financially as well. Originally, the objective of this project was to reduce inappropriate referrals and reduce LUPA rate. Conversations with the QC, clinical supervisors, several intake staff, schedulers, colleagues and patients, prove that the most pressing action to take now is to improve the admission process within this unit by using a standardize “Patient Screening Tool.” While the creation of this screening tool is in process, information has been gathered from everyone within the unit to get them involved and interested in this project. Once implementation of this screening questionnaire begins in January 2017, continuous effort will be made to help maintain the usage of this tool within the unit. The professional contribution of the QC to this project and the CNL application of Essential 3: Quality Improvement and Safety, competency # 5: Promote a culture of continuous quality improvement within a system (AACN, 2013) will help sustain the proposed “Patient Screening Tool” within the unit once it is shown to

be effective. This competency promotes continuous assessment and education that continue to improve outcomes. According to Peter Senge (2006) being able to learn faster and communicate better than the competitor is one of the most sustainable competitive behaviors a microsystem needs to thrive. As a point of care system engineer, the CNL of this unit will continue to reassess the vitality of this “Patient Screening Tool” and make needed change to keep this tool living and adapting for years to come.

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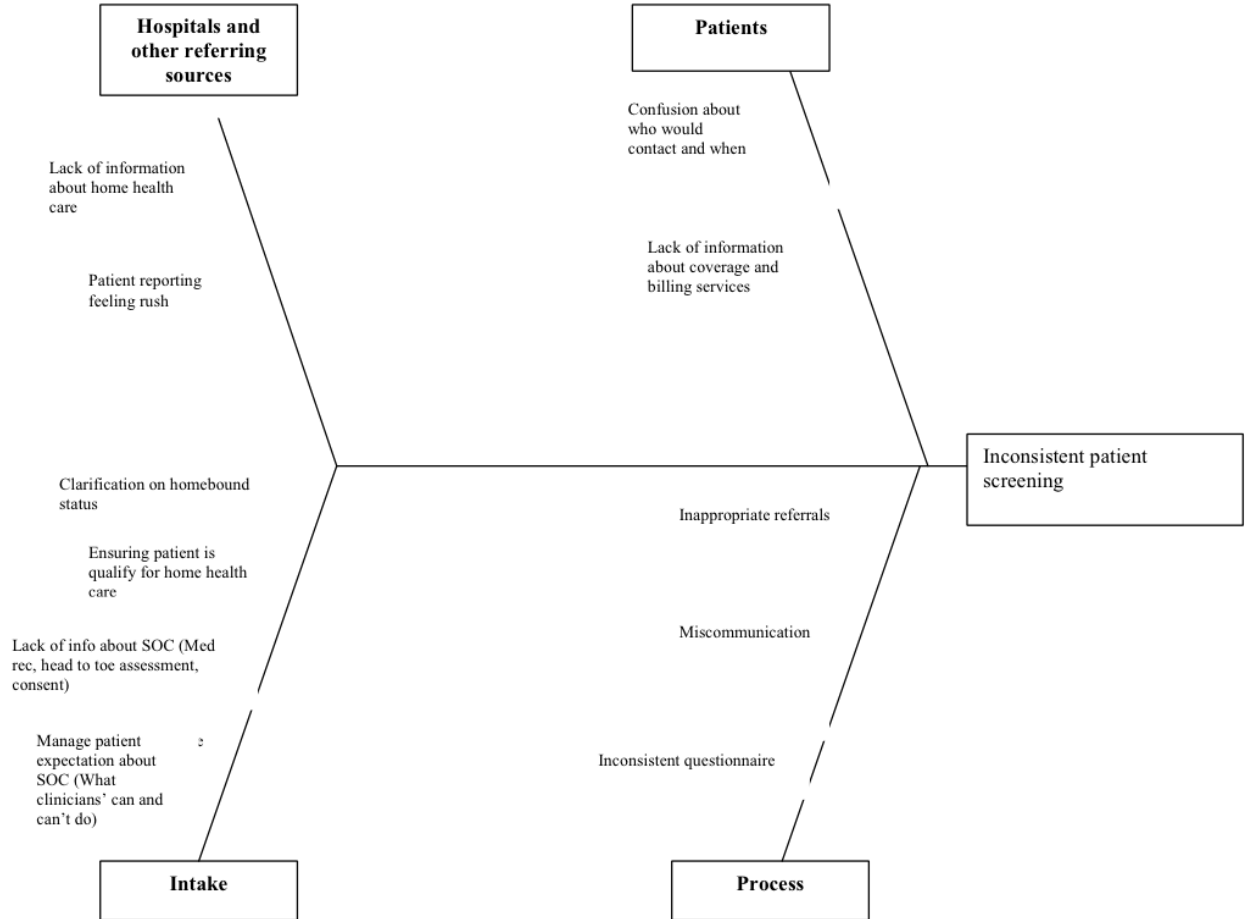
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Appendix A

Cause and effect analysis/ fishbone diagram



Appendix B

SWOT Analysis/ stakeholders analysis (Agency/Patients/Providers)

STRENGTHS

-
- Reduce risk of committing CMS abuse & fraud
- Provide care to homebound patients within the community regardless of insurance status
- Work with hospitals and other medical settings within and outside the community

WEAKNESSES

- Lack of documentation supporting personalized information given to patients during screening
- Intake staff asking individual questions

OPPORTUNITIES

- Screening tool becomes agency official "Patients Screening Tool"
- Patients well aware of CMS regulations for home health services
- Patients reporting satisfaction with agency intake process
- Providers aware of screening process reduce referrals of non qualify patients

THREATS

- Providers persisting with inappropriate referrals.
- Losing providers referrals
- Losing patients to competitors
- Patients cancelling services early leading to LUPA

Appendix C

Peter Senge’s (1990) Learning Organization theory

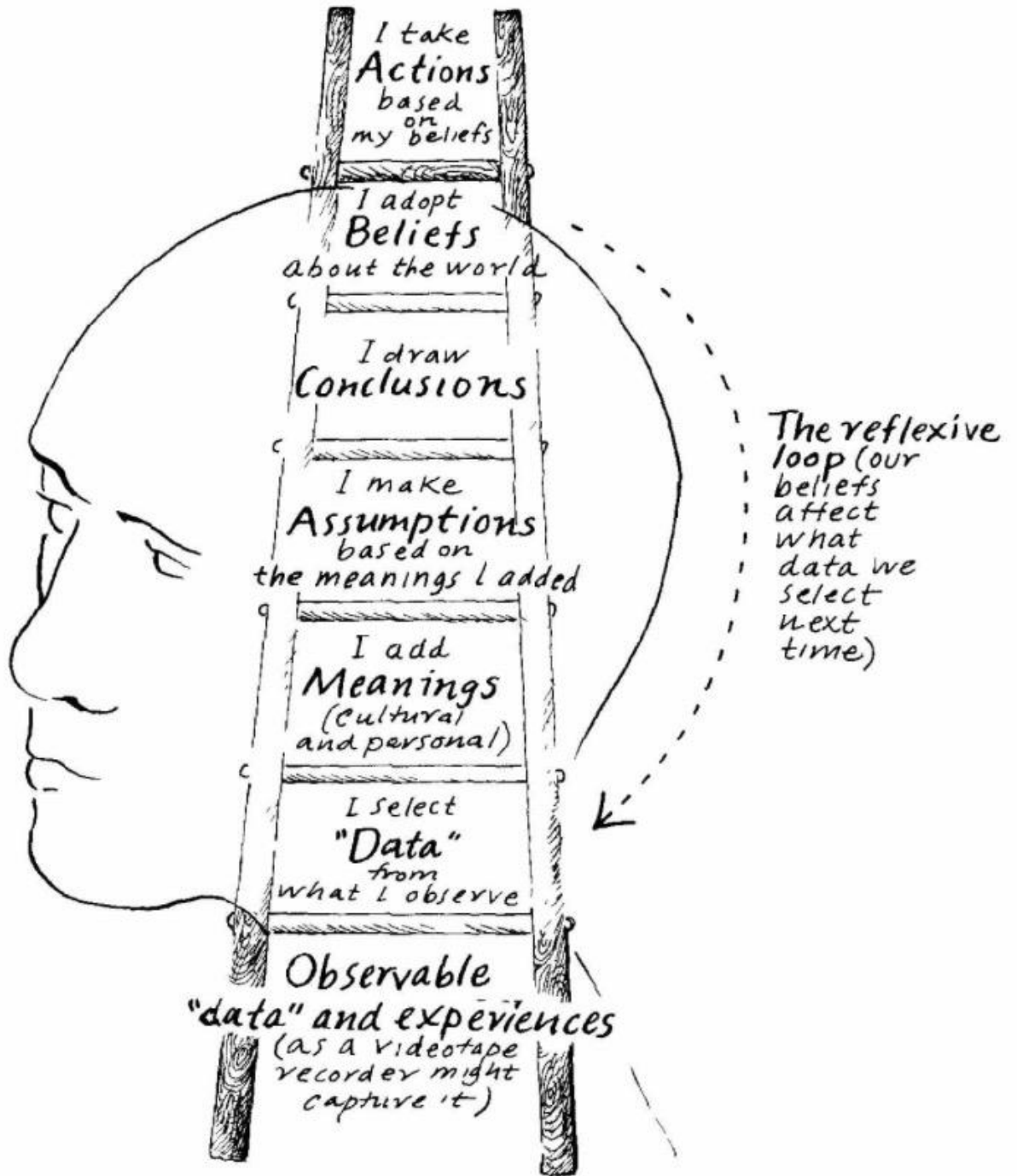
Peter Senge (Characteristics)	Argyris and Schon (Units of learning)
Systems thinking: The idea of the learning organization developed from a body of work called systems thinking.	Individual learning is the smallest unit at which learning can occur.
Personal mastery: The commitment by an individual to the process of learning is known as personal mastery	Group learning is the next largest unit at which learning can occur.
Mental models: The assumptions held by individuals and organizations are called mental models.	Organizational learning is the way in which an organization creates and organizes knowledge relating to their functions and culture.
Shared vision: The development of a shared vision is important in motivating the staff to learn, as it creates a common identity that provides focus and energy for learning.	Interorganizational learning is the way in which different organizations in an alliance collaborate, share knowledge, and learn from one another.
Team learning: The accumulation of individual learning constitutes team learning.	

Learning organization https://en.wikipedia.org/wiki/Learning_organization

Organizational learning https://en.wikipedia.org/wiki/Organizational_learning

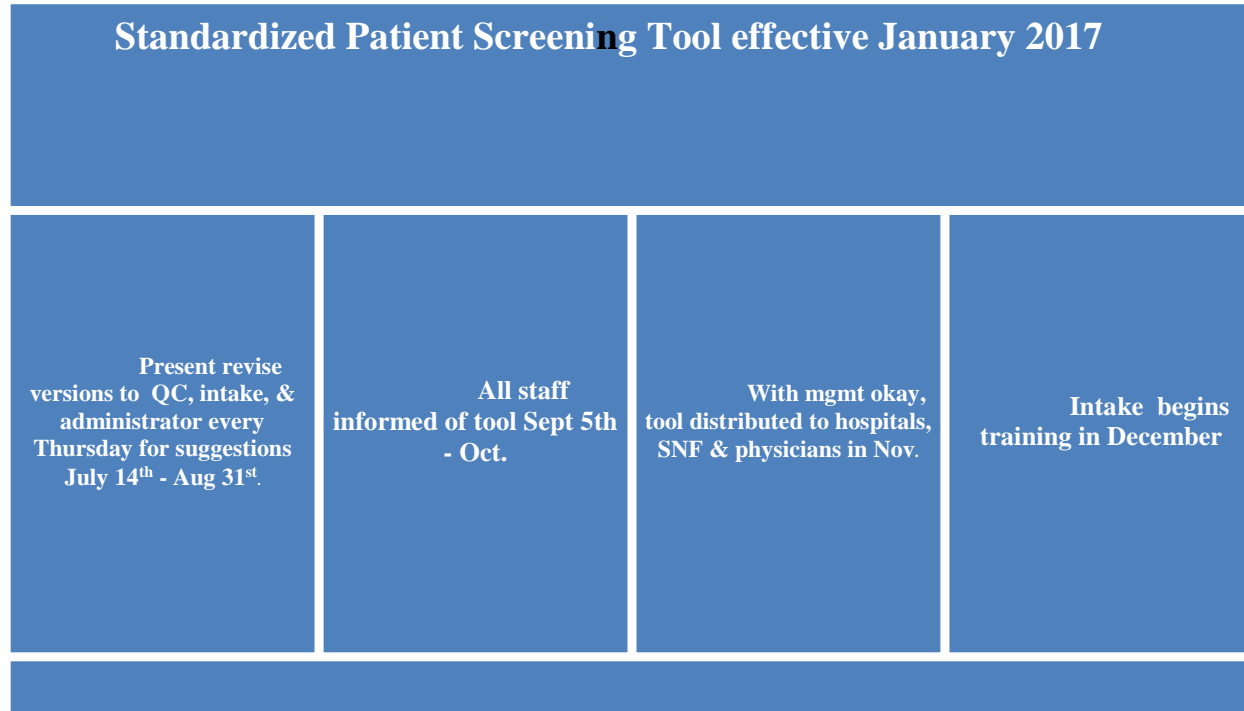
Appendix D

Peter Senge's 'Ladder of inference'



Appendix E

Timeline for "Patient Screening Tool



Appendix F

Cost analysis in regard to LUPA

This project has no financial expenses attached to its development for the agency and in term of staff training. However, the agency has much to gain from its implementation. First, it will augment the agency reputation within the community. Patients will return to the agency if further services are needed and will refer their friends and loved ones to the agency as well. Second, it will increase the agency financial revenues. Physicians and other referrals sources will continue to choose the agency in lieu of other agencies within the community because of patients' outcomes.

Most importantly, this tool could prevent the agency from serious financial deficits related to preventable LUPA. From the numbers reviewed, it was determined that LUPA rate for the organization as a whole was 12% in comparison to Marin county's average LUPA rate of 10% in 2015. In 2015, this agency alone had 9.86 % LUPA (Agency Patient-Related Characteristics Report, HCHB 2015) and thus faced tremendous financial difficulty.

Appendix G

Stakeholder analysis

Everyone within this home health agency regardless of his/her position: field clinicians such as: physical therapist, occupational therapy, nurse, speech therapy, home health aide, medical social worker and office staff such as: administrator, supervisor, intake and clerical staff is an important stakeholder whose input is beneficial for the success of this project. Internal participant effort is not enough to maintain the implementation of this project. Direct collaboration with external stakeholders such as referring hospitals, SNF, and physicians' is necessary to smoothen the transition period and promote safe transitioning and admission of well-informed patients to home health care.

Appendix H

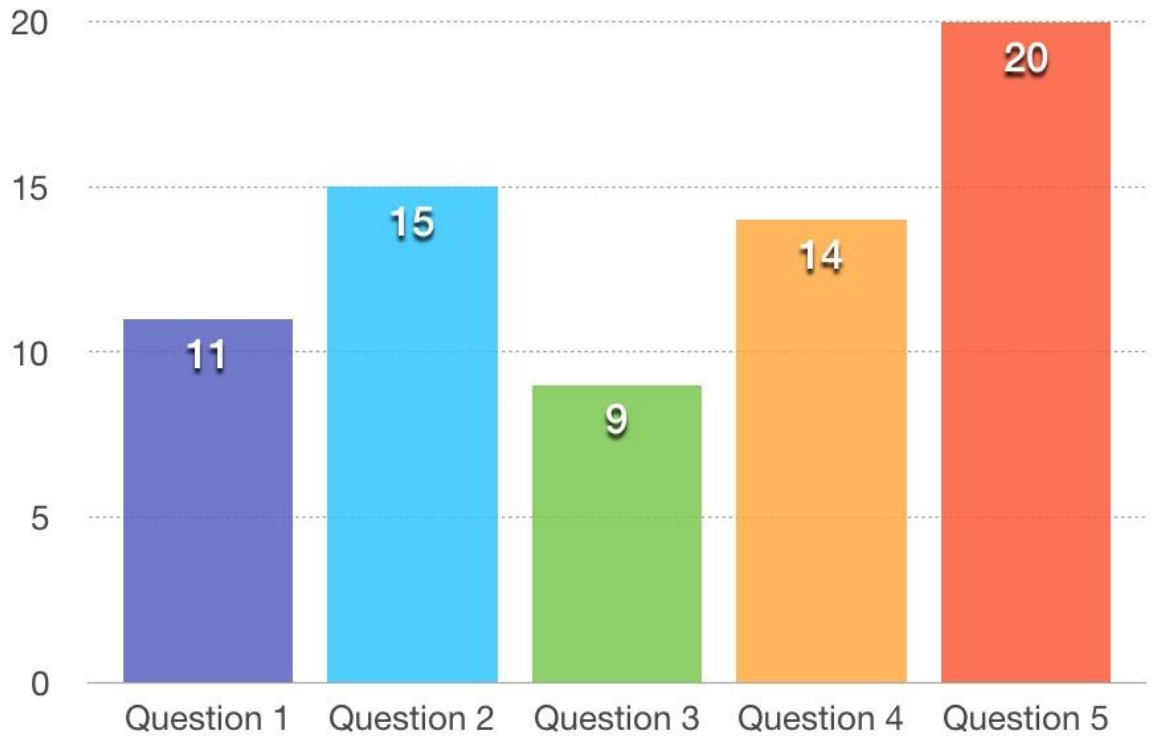
Fictitious table of hypothetical patient survey result

Home health patient survey results

PARTICIPANT	YES	NO
Question 1	11	9
Question 2	15	5
Question 3	9	11
Question 4	14	6
Question 5	20	0

Appendix I

Fictitious Run chart of hypothetical patient survey result



These fictitious survey results and graph are provided as a sample of how data would be analyzed and shared related to techniques by which outcome results will be shared with stakeholders.

Appendix J

Patient survey: Satisfaction with Home Health Intake and Admission Process

1. Did our intake staff explain our services to you as well as the services ordered?	Yes	No
2. Did our intake staff explain your medical coverage and billing fees to you?	Yes	No
3. Were you informed about start of care (SOC) requirement (med review, physical & environmental	Yes	No
4. Were most of your questions answered during your conversation with our intake staff?	Yes	No
5. Did our clinicians explain your treatment plan with friendly terms?	Yes	No
6. When you were getting discharge from the hospital or when you physician referred you to our services, how much information about Home Health care were you given?		
7. Please explain your experiences with our staff during your intake screening and your admission visit		
8. Please give us some advises on how we can improve our intake and admission process		

Appendix K

Clinician Survey: Satisfaction with Home Health Intake and Admission Process

9. Was the patient well informed about Home Health care and the services ordered?	Yes	No
10. Was the patient well informed about his/ her medical coverages and billing?	Yes	No
11. Was the patient well informed about admission requirement (med review, physical & environmental	Yes	No
12. Were you able to answer most of the patient questions answered during the admission visit?	Yes	No
13. Was the patient treatment plan explained with friendly terms	Yes	No
14. Do you fell the patient had enough information about our services from the referring sources, Hospitals or Physician office?		
15. Does well informed patient enhance your admission experience?		
16. Please give us some advises on how we can improve our intake and admission process		

Appendix L

Patient Screening Tool

Patient Details	
Last Name	First Name
Referring Facility	Physician To Sign F2F
Admitting Dx	PMH
<p><u>Intake</u> Staff call patient. Introduce self and confirm you are speaking with patient or caregiver (write caregiver name). Explain reason of call. Explain Home Health services and ordered services</p>	
<p><u>Assessment</u> Assess mental status Assess respiratory system (oxygen in home?) Assess pain level</p>	<p>Explain Home Bound status Explain driving policy Determine if patient lives alone and how he/she gets around</p>
<p><u>Determine Level Of Functioning</u> How much can patient do independently Does patient use assistive devices (cane, wheelchair, walker) Assistance with dressing Assistance with bathing and toileting Fall in past 6 months or recent fall</p>	

Assess Medications

Do you need assistance with taking your medications?

Who help you with your medications?

Any unused medications in medicine cabinet?

Are you taking other medicines (over the counter) beside your prescription medication? (If yes, please leave them out for our clinicians to review)

Our staff will review your medications, please leave everything on your table with the hospital discharge papers.

Wound Assessment

Do you have a drain (tubing inserted to your surgical incision)?

Can you do your wound care independently?

How much teaching you think you might need to do your wound care independently?

Any caregiver we can teach the wound care to assist you?

Were you given additional supplies for your wound care

Any new skin tear or cuts we need to know about?

Our clinicians will do a head-to-toe assessment to determine any skin issues

DME Equipment

Were you sent home with the wound vac machine? (if yes, what kind is it)

Were you sent home with the feeding machine?

Were you sent home with an IV pump?

Where you given additional supplies for your machine? (If not, can you please let us know what type you are currently using?)

Other Questions?

Staff Safety

Can you please secure your dog in another room when our clinicians visit?

Can you please not smoke during our clinicians visit?

Can you please safely place all weapons away during our clinicians visit?

Any question we can assist you with?

Thank you for your time and patience. Our clinician (RN, PT) will come tomorrow for your admission to our home health agency.