**Hospital/Home Care Assessment**

The hospital/home care assessment is designed for hospitals and home health care organizations to assess current transition practices implemented during transitions in care.

**How to Use the Assessment:**

These assessment instruments were designed for each organization to complete independently and review collaboratively. The gaps identified in the current practices of hospitals and home health organizations can be used to inform priority areas for improvement, setting goals, and developing work plans. Hospitals and home health care organizations can modify these tools to meet their needs and goals. The assessments can also be used as a baseline to determine progress over time.

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**GOAL 1: Build and strengthen relationships across care settings**

1. Approximately how often does a team from [hospital name] meet with a team from [home health care organization name] (in person and/or over the phone)?

* Once a week or more
* Every other week
* Once a month
* Every other month
* Once a quarter or less
* Do not meet

1. Which of the following had you already implemented with [home health care organization name]? *Please select all that apply.*

* Hospital staff visit(s) to select homes of home health care recipients to better understand the capabilities and processes provided by the home health care organization
* Home health care staff visit(s) to the ED to better understand its workflow
* Review of data or cases to identify root causes of readmissions
* Review of data or cases to identify root causes of emergency department (ED) visits
* None of the above

[ASK Q3 IF “Hospital staff visit(s) to…” IS SELECTED IN Q2]

1. Which hospital staff member(s) visit the homes of home health care recipients to better understand the capabilities and processes provided by [home health care organization name]? *Please select all that apply.*

* Case Manager
* Discharge Planner
* Hospital Liaison
* Other (please specify)

1. Please indicate the expected impact that implementing or improving the following processes with [home health care organization name] will have in building and strengthening your relationships with [home health care organization name].

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No impact | Slight impact | Moderate impact | Major impact |
| Hospital and home health care team meetings (in person and/or over the phone) |  |  |  |  |
| Hospital staff visit(s) to select homes of home health care recipients to better understand the capabilities and processes provided by the home health care organization |  |  |  |  |
| Home health care staff visit(s) to the ED to better understand their workflow |  |  |  |  |
| Review of data or cases to identify root causes of readmissions |  |  |  |  |
| Review of data or cases to identify root causes of emergency department (ED) visits |  |  |  |  |

**GOAL 2: Develop standardized processes for communication and information transfer between providers**

1. Which of the following processes are already in place. *Please select all that apply.*

* Creating and maintaining hospital and home health care team lists with current contact information
* Reviewing patient information and transfer/communication forms shared between facilities to ensure essential, actionable information is included
* Ensuring the provision of a 3-day supply of medications for the home
* None of the above

1. Please indicate when, if at all, you have implemented the following processes with [home health care organization name] when [home health care organization name] is involved. *Please select all that apply.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | At time of inpatient discharge to home health care | At time of ED discharge to home health care | At time of transfer from home health care to the ED | Have not implemented this process at any time |
| Use of a standardized transfer tool (e.g., INTERACT) |  |  |  |  |
| “Warm” handoff (person-to-person communication, over the phone or in person) |  |  |  |  |
| Medication reconciliation process between care settings |  |  |  |  |

*Home Health Care Referral to ED*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No impact | Slight impact | Moderate impact | Major impact |
| Use of a standardized transfer tool (e.g., INTERACT) at time of transfer from home health care to the ED |  |  |  |  |
| “Warm” person-to-person handoffs at time of transfer from home health care to the ED |  |  |  |  |
| Medication reconciliation process between care settings at time of patient transfer from home health care to the ED |  |  |  |  |

*Inpatient to Home Health Care*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No impact | Slight impact | Moderate impact | Major impact |
| Use of a standardized transfer tool (e.g., INTERACT) at time of inpatient discharge to home health care |  |  |  |  |
| “Warm” handoff at time of inpatientdischarge to home health care |  |  |  |  |
| Medication reconciliation process at time of inpatient discharge to home health care |  |  |  |  |

*ED to Home Health Care*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No impact | Slight impact | Moderate impact | Major impact |
| Use of a standardized transfer tool (e.g., INTERACT) at time of discharge from the ED to home health care |  |  |  |  |
| “Warm” handoffs at time of discharge from the ED to home health care |  |  |  |  |
| Medication reconciliation process at time of discharge from the ED to home health care |  |  |  |  |

1. If a patient receiving home health care returns to the ED without the involvement of the home health care organization, when is the home health care organization routinely notified of the patient’s visit to the ED?

* Upon the patient’s arrival in the ED
* Upon the patient’s admission to the hospital, if the patient is admitted
* Upon the patient’s discharge from the hospital, if the patient was admitted
* The home health care organization is not routinely notified
* Other (please specify)

*Communication, Information Transfer, and Quality Improvement Tools*

1. Has [hospital name] or [home health care organization name] adopted any INTERACT tools to improve communication and information transfer?

* Yes
* No

[IF “Yes” IS SELECTED IN Q9, CONTINUE TO Q10. OTHERWISE, SKIP TO Q15.]

NOTE: Q10–Q12 are only displayed to the respondents from home health care organizations.

1. Which of the following INTERACT tools are used by [home health care organization name]? *Please select all that apply.*

* SBAR (Situation, Background, Assessment, Recommendation)
* Stop and Watch Early Warning Tool
* Home Health to Hospital Transfer Form
* Home Health Capabilities List
* Acute Care Transfer Log
* Quality Improvement Tool for Review of Acute Care Transfers
* None of the above

1. How often does [home health care organization name] receive the INTERACT Hospital to Home Health Transfer Form when a patient is discharged from [hospital name]?

* Never
* Rarely
* Sometimes
* Often
* Always

[ASK Q12 IF “Rarely” – “Always” WAS SELECTED IN Q11. OTHERWISE, SKIP TO Q13]

1. When [hospital name] sends the INTERACT Hospital to Home Health Transfer Form to [home health care organization], how often does it contain sufficient information to address patient needs?

* Never
* Rarely
* Sometimes
* Often
* Always

1. Does [hospital name] use the INTERACT Hospital to Home Health Transfer Form?

* Yes
* No

NOTE: Q13–Q14 are only displayed to the respondents from hospitals:

1. How often does [hospital name] receive the following INTERACT tools when a patient is sent to the ED by [home health care organization]?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No impact | Slight impact | Moderate impact | Major impact |
| SBAR (Situation, Background, Assessment, Recommendation) |  |  |  |  |
| Home Health to Hospital Transfer Form |  |  |  |  |
| Home Health Capabilities List |  |  |  |  |

1. Has [hospital name] adopted any tools, other than the INTERACT tools, to improve communication and information transfer with [home health care organization name]? *Please select all that apply.*

* Medication Reconciliation Tools
* MOLST or other Palliative Care Tools
* Standardized Communication Tools
* Case Review Tools
* Tools to incorporate the patient, family/caregivers into the care coordination process
* Other (please specify)

*Pre-authorization for Home Health Care*

1. On average, when does the pre-authorization process for home health care services begin?

* On the day of discharge
* 1 day prior to discharge
* 2 days prior to discharge
* 3 days prior to discharge
* More than 3 days prior to discharge

1. How often are there delays in the pre-authorization process for...

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely | Sometimes | Often | Always |
| Home health care services (i.e., Nursing, PT, OT, SLP, other services) |  |  |  |  |  |
| Home health personal care services (i.e., Home Health Aide) |  |  |  |  |  |
| Home health care supplies and/or durable medical equipment |  |  |  |  |  |

*Plan of Care*

1. Does [home health care organization name] have access to [hospital name]’s electronic medical record to inform the plan of care in the home?

* Yes
* No

1. What other tools/mechanisms are available to [home health care organization name] to inform the plan of care in the home?

*Challenges in Home Health Care*

NOTE: Q20 – Q21 are only displayed to the respondents from home health care organizations:

1. Please rate how challenging it is to provide home health care services from each of the following disciplines in a timely manner?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not at all challenging | Somewhat challenging | Challenging | Very challenging | Extremely challenging |
| Nurse |  |  |  |  |  |
| Physical Therapist |  |  |  |  |  |
| Occupational Therapist |  |  |  |  |  |
| Speech/Language Pathologist |  |  |  |  |  |
| Respiratory Therapist |  |  |  |  |  |
| Home Health Aide |  |  |  |  |  |

1. Please rate how challenging it is to acquire the following supplies used for home health care related needs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not at all challenging | Somewhat challenging | Challenging | Very challenging | Extremely challenging |
| Medication Supply |  |  |  |  |  |
| Durable Medical Equipment |  |  |  |  |  |
| Ancillary Supplies (e.g., Spirometers, O2, Nasal Cannulas, Nebulizers) |  |  |  |  |  |

**GOAL 3: Incorporate patients, family members and caregivers in the transition process**

1. Please select whether the following activities routinely occur with patients, family members, or caregivers at [hospital name]. *Please select all that apply.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Patients | Family Members | Caregivers | Does not typically occur |
| Discussion of patient’s goals of care |  |  |  |  |
| Discussion of patient’s anticipated outcomes upon **discharge to home health care** |  |  |  |  |
| Discussion of advance care planning needs of patients upon **discharge to home health care** |  |  |  |  |
| Discussion of patient’s anticipated outcomes upon transfer **to the ED** |  |  |  |  |
| Continually inform and include in discussions about care of the patient |  |  |  |  |
| Ask about understanding or perceptions of the reasons why a patient was transferred and/or readmitted |  |  |  |  |

1. Please rate the effectiveness of the following processes in preparing and educating patients/family members/caregivers about the services being provided by [home health care organization name] in the home.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Not at all effective | Somewhat effective | Effective | Very effective | Extremely effective | N/A or do not use |
| Clinical tasks training (e.g., Teach-back Technique) |  |  |  |  |  |  |
| Telehealth |  |  |  |  |  |  |
| Audiovisual Aids |  |  |  |  |  |  |
| Educational Brochures |  |  |  |  |  |  |

1. Please describe any other processes that have been effective in educating patients/family members/caregivers about the services being provided by [home health care organization name] in the home.

*Transfer and Readmission Tracking*

1. Does [hospital name] track transfer or readmission rates between [Q1] and any home health organizations?

* Yes
* No

[IF Q25 is “Yes,” ASK Q26. OTHERWISE, SKIP TO Q27.]

1. Please select the ways in which [hospital name] tracks transfer and/or readmission rates between [hospital name] and home health care organizations. *Please select all that apply.*

|  |  |  |
| --- | --- | --- |
|  | Rate between [hospital name] and [home health care organization name] | Overall rate between [hospital] and multiple home health care organizations |
| Readmission rate |  |  |
| Transfer rate (including patients that returned to the ED but were not admitted) |  |  |

**Additional Information**

1. What other challenges have you encountered in working with [home health care organization name] to reduce avoidable admissions/readmissions?