

### Rush University Medical Center's Home Health Handoff Form



#### HOME HEALTH SERVICES HAND OFF COMMUNICATION – QUALITY FORM

Patient Name: \_\_\_\_\_

Home Health Agency Referred to: \_\_\_\_\_ Liaison Name and Contact: \_\_\_\_\_

Rush Physician Assigned to follow \_\_\_\_\_ Rush Case Manager \_\_\_\_\_

**Please Call Rush Case Management with all referrals at:**  
312-942-4343 and fax quality form to 312-942-7185

We realize that hand off communication is essential to assure quality coordination of care and want to work with you to strive toward **perfection**. Rush Case Managers are interested in receiving information to confirm:

	<u>HOSPITAL HAND-OFF</u>	<u>HOME CARE VISIT/SERVICES</u>
<b>P <u>Plan of Care:</u></b> Yes ___ No ___	Home Health Care orders provided Health literacy issues identified if present	- Plan reviewed with pt/family - Schedule left with pt/family - Emergency contact info provided - Teaching initiated for at risk dx. - Health literacy plan initiated prn
<b>E <u>Equipment/Supplies:</u></b> Yes ___ No ___	Provided as ordered within expected timeframe	- Drsg and/or supplies provided at initial visit - Teaching initiated
<b>R <u>Reconciliation of medications:</u></b> Yes ___ No ___	Patient prescriptions provided to patient, listed on Home Health orders, without medication error	- Meds reconciled      - At risk meds identified - Teaching initiated - Missing meds obtained and reported to MD & CM
<b>F <u>Follow-up physician:</u></b> Yes ___ No ___	Physician contact identified	- Confirm pt's MD follow-up appt & plan to attend
<b>E <u>Expectations met:</u></b> Yes ___ No ___	Patient/family informed and satisfied with plan	- Appt scheduling call to pt/family: barriers identified and reported
<b>C <u>Coordination of Care:</u></b> Yes ___ If No ___ check below:	<input type="checkbox"/> Patient/family refused care <input type="checkbox"/> Unable to locate patient <input type="checkbox"/> Patient not discharged from hospital <input type="checkbox"/> Patient re-hospitalized before first visit	- RN visit 24 hours after d/c, notify CM if delay - Pt/Support adequate?      - SW services offered - CM contacted with pt c/o's - Statement of fees provided and billing questions addressed
	<input type="checkbox"/> Care exceeds capacity <input type="checkbox"/> Unsafe environment <input type="checkbox"/> Another agency providing services <input type="checkbox"/> Insurance out of network	<input type="checkbox"/> Family refuses out of network co-pay <input type="checkbox"/> No skilled need <input type="checkbox"/> Cancelled by referral source <input type="checkbox"/> Referred to another agency
<b>T <u>Therapy:</u></b> Yes ___ No ___	Provided as ordered including PT/OT/ST within 24 hours, 1 hour duration for Ortho, Neuro, and/or Cardiac patients or (as specified)	- Multidisciplinary conference planned within 72 hours

Cognitive Function Clock Drawing Test Score \_\_\_\_\_

Source: Rush University Medical Center, Chicago, IL; Post-Acute Care Collaborative interviews and analysis.