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Transitions of Care Checklist: SNF to Home Health Care

As networks continue to narrow it is vital to ensure smooth and safe transitions of care. Check out our top tips for Skilled Nursing and Home Health Care agencies.

Skilled Nursing Care Transition Checklist	Notes	Date Completed
SNF ensures a valid Face to Face (F2F) visit has been completed		
Provide HHA copies of discharge note and last note written by MD		
Provide patient/caregiver with Home Care agency's name and phone number for questions		
Discuss diagnosis specific red flags with patient/caregiver (e.g. CHF: shortness of breath, edema)		
Encourage patient to participate in care		
Encourage follow-up appointment with PCP after transition home		
SNF identify and set up delivery of DME and other essentials need		
SNF ensure patient has medications/prescriptions		

Home Care Transition Checklist	Notes	Date Completed
Perform a risk assessment to determine patient's risk for rehospitalization (OASIS M1033) **High Risk:** Has had two or more in-patient admissions in past year; patient failed teach back or caregiver has low level of confidence to carry out selfcare at home **Moderate Risk:** Has had one in-patient admission in past year; caregiver has moderate level of confidence to carry out self-care at home		
Ensure client's homebound status		
Determine client's language interpretation needs using assessment tools per agency protocol		
Conduct an early medication error risk assessment		
Identify who will serve as patient's primary physician for Home Care admission, especially if hospitalist made the referral, and contact that PCP regarding signing Home Care orders		
Verify F2F has been accurately completed		
Clarify whether SNF or Home Care staff will assume responsibility of overseeing making follow-up appointment with PCP		
Coordinate with SNF case manager/discharge planner on discharge date		
Communicate with Home Care office to ensure timely admission depending on risk level and/or agency policy		
Ensure timely DME delivery for care transition		

Learn More about how to Improve Transitions of Care CLICK HERE