QuickSafety
An advisory on safety & quality issues

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Improving access to home care

Issue:
Many patients who are discharged from the hospital benefit from home health care services, but some patients who need and are eligible for these services are not receiving them. The reasons for this gap in care are multifactorial, some related to patient or family refusals for home health care services, while others are related to health care providers and organizations not following through on referrals.

Studies have shown that patients who receive home health care after being discharged from the hospital are less likely to be readmitted, and other studies show patients who receive home health care report better quality of life. A recent analysis of 26 international randomized controlled trials concluded that "a home visit within three days of discharge by a nurse can address specific health care needs related to symptoms that patients experience. In addition, if the nurse performs a medication reconciliation, the number of adverse drug events can be reduced."[1]

Among the most commonly cited reasons that patients/families refuse home health care services are: invasion of privacy; don't feel help is needed; do not know about services; and cost (co-pay in private insurance).[2] Participants of an expert roundtable sponsored by the United Hospital Fund (UHF) and the Alliance for Home Health Quality and Innovation (AHHQI) noted that information that patients receive from providers about home health care may be incomplete, confusing or treated as just another item on a checklist.[2]

Health care providers and organizations have a role to play in providing information so patients can make more realistic and well-informed decisions about their care after being discharged from the hospital. In addition, health care providers should be able to talk to patients about their specific care challenges, and offer insight into how home health care services could help.

One common misunderstanding that explains why many patients don't receive referrals for home health care services stems from the mistaken belief that these referrals can only be made in the hospital and come from hospital discharge planners and/or social workers. It is not widely known that physicians in the community and in the emergency department (ED) also can make referrals. Referrals to home health care do not require a hospital stay of any length. In addition, referrals from community physicians are covered by Medicare, as long as the physician documents a face-to-face encounter with the patient or certifies that a non-physician practitioner, such as a nurse or physician assistant, conducted the interview. (The certification must include a plan of care for each 60-day covered home health care episode.)[2]

Safety Actions to Consider:
Health care organizations can assist in promoting home health care services for patients in a variety of ways. The list below is identified in the UHF/AHHQI report: [2]

- Improve discharge planning by providing complete and up-to-date information about available home care services to providers, especially physicians. This information will enable providers to talk knowledgeably about home health with their patients.
- Develop training sessions for physicians, nurses, and discharge planners to ensure that they understand home health care and why it may be appropriate for patients.
- Develop scripts for professionals to guide their discussions about home health care.
- Develop and test models for technology-based decision support for patients and caregivers.

(Cont.)

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- Develop collaborative relationships between EDs and home health agencies, so that appropriate patients can be referred to home health care even if they are not admitted to the hospital.
- Develop or revise policies that address access to home health care services and collaboration with home health care agencies.

In addition, in the Agency for Healthcare Research and Quality's *Hospital Guide to Reducing Medicaid Readmissions Toolbox*, providers are reminded to:[3]

- Arrange for post-hospital services prior to discharge, and effectively communicate with providers who are receiving care of the patient.
- Know the capabilities of post-acute and community-based providers.

Resources:

1. Verhaegh KJ, et al. Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. *Health Affairs*; 2014;33(9):1531-39.
2. Levine C and Lee T. I can take care of myself!: Patients' refusals of home health care services. United Hospital Fund and Alliance for Home Health Quality and Innovation. 2017.
3. Agency for Healthcare Research and Quality. Hospital Guide to Reducing Medicaid Readmissions Toolbox. August 2014.
4. United Hospital Fund. Next Step in Care. Home Care: A Family Caregiver's Guide. 2014.
5. Labson MC. Innovative and Successful Approaches to Improving Care Transitions from Hospital to Home. Home Health Care Now; 2015;33(2):88-95.

Note: This is not an all-inclusive list.

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