

PATIENT NAME: _____

DOB: _____



Ventura County Hospital to Home Health Alliance Liaison Protocol for Patient and Family Interviews

Pneumonia Vaccine: _____ Flu: _____ Pets: _____ Isolation: _____

Confirmation of Address: _____

A. Introduction to Home Health Services

- Hospital name: _____
- Today's Date: _____
- What matters most to the patient?** _____
- Discuss the following points with the patient:
 - Services provided and not provided by the home health agency (HHA)
 - Expectations the patient and family have of HHA services
 - Level of care provided by HHA
 - Number of visits and type of visits anticipated

B. Activity Assessment (circle Yes or No):*

- Is the patient homebound? Y N Why? _____
- Patient and caregiver primary language(s)? _____
- Caregiver status:
 - Is the caregiver present while this assessment is being conducted? Y N
 - Are the care needs understood by the patient and/or caregiver? Y N
 - Does the patient serve as a caregiver to someone? Y N
 - Is this caregiver capable of performing the necessary elements of care? Y N
 - What is the availability of the caregiver's time? _____
 - Caregiver Name: _____ Phone: _____
- Transportation: Are there any concerns regarding the patient's ability to travel to doctor appointments? Y N
- Medication Management: Focus on medication education between hospital discharge and the first home visit.
 - Who will pick up new medications? _____
 - From which pharmacy? _____
 - Are there concerns about the patient's ability to pay for medications? Y N
 - Are there co-pay issues? (Check with case management on insurance form) Y N

C. Functional Assessment

- Is durable medical equipment (DME) needed? Y N
- Are DME items already in the home? Y N
- Type of DME already in the home: _____

D. Review of Services Ordered by the Hospital

- Are the right services ordered for the patient? Y N
- Are palliative care/social work services part of the care of plan? Y N
- Primary care physician name: _____

Hospitalizations in past 12 months: _____

ER visits in past 12 months: _____

Last MD visit: _____

Scheduled new MD visit: _____

MD to follow: _____

LIAISON NAME: _____