# Home Care Referral Guide

## Situation

<table>
<thead>
<tr>
<th>Situation</th>
<th>Refer to home care for:</th>
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<tbody>
<tr>
<td>Wounds and skin ulcers, ostomy care</td>
<td>Wound care, CWOCN wound care consultation available, photos to document healing, pre-op, post-ostomy teaching and care</td>
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<tr>
<td>New diagnosis, symptom change or exacerbation including CHF program, diabetic care, etc</td>
<td>Physical assessment (pulse oximetry with MD order) patient teaching, prevention of complications, glucose assessment, labs and follow up</td>
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<tr>
<td>Treatment plan changes - patient cannot come back to office easily</td>
<td>Assessment of response to treatment plan, patient teaching, monitor compliance</td>
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<tr>
<td>Medications-new, changed or compliance problems</td>
<td>Assess medication and OTC use, assess compliance, develop schedules, calendars, assess and teach/effects/side effects (medication management)</td>
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<tr>
<td>Recent fall at home - fall prevention</td>
<td>Home safety assessment, physical therapy, home exercise program, home modifications, fall prevention program</td>
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<tr>
<td>Frail elder - family says “we don’t know what to do for our parent anymore.”</td>
<td>Nurse assessment of home environment, functional status, mental status and reporting, help with finding community support services - geriatric care management, senior services</td>
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<tr>
<td>Patient has been diagnosed with life-threatening and progressive illness</td>
<td>Palliative care or hospice services depending on patient status</td>
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<tr>
<td>A condition that requires home medical procedures such as catheterization and injections, infusion therapy, enteral therapy</td>
<td>Nurse performs procedures and teaches patient or family how to perform, assesses effectiveness of physician plan of care</td>
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**Medicare will pay for home care only if:**
- The patient is essentially homebound (can only leave home occasionally with “considerable and taxing effort”)
- A physician certifies the plan of care
- A skilled service (nursing, physical therapy, speech language pathology) is needed

**Note:** Home health aide services will be covered by Medicare **ONLY** if a skilled service is being provided.

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**For Questions or Referrals Call 508-957-7476 or 800-675-2203**
### What Home Care Clinical Staff Can Do

#### Assessment
- Ability to perform activities of daily living
- Home safety evaluation
- Physical assessment
- Vital signs
- Pulse oximetry
- Home blood sugars
- Mental status
- Compliance with treatment plan
- Nutritional status
- Weight changes
- Wound healing
- Social support systems and coping
- Medication assessment

#### Services
- Injections
- Catheterization
- Wound care - Ostomy care
- Medication reconciliation
- Develop medication calendar
- Pain management
- Gait training
- Endurance improvement
- Strengthening exercises
- Home modifications
- Recommend assistive and adaptive devices
- Arrange for support services and entitlement programs
- Help with bathing, dressing, toileting, exercises, ambulation (home health aides)
- Speech language pathologist, physical therapy, occupational therapy, medical social worker
- Hospice
- Palliative care/symptom management

### Patient Teaching
- How to comply with medical treatment plan
- When to call the doctor
- Special diets
- Diabetic teaching
- Self-administration of meds
- Medication dosage effect, dosage, side effects, interactions
- Disease process, reportable signs and symptoms
- How to prevent complications
- How to perform medical procedures at home
- Emergency protocol - when to call 911
- Home safety procedures

### Services through Private Pay
- Home health aides
- Medication pre-fill
- Homemaking services
- Care for the Caregiver
- Companion services
- Mother’s Little Helper
- Pre-op/post-op assistance

Private Pay Referrals call 800-696-4047.

### Questions? Call the VNA of Cape Cod at 508-957-7400 or 800-631-3900