Partners IN HOME CARE | BRINGING HEALTHCARE HOME

How To Make a Home Health Referral

What is Home Health Care?

Home Health Care is a wide range of healthcare services that can be given in the patient's home for an illness or injury. Home Health Care is often less expensive, more convenient, and just as effective as the care a patient would get in a hospital or skilled nursing facility (SNF) and can make hospital visits shorter and less frequent with home-based Skilled Nursing, Rehabilitation, and Chronic Disease Management.

Whether the patient is recovering from surgery or illness or living with a chronic disease like Diabetes or COPD, we work closely with their Physician to coordinate all aspects of their care to help them recover and regain independence.

We provide Skilled Need Services

Skilled Nursing

Medically necessary part-time or intermittent skilled nursing care; including post operative care, wound care, IV therapy, safety evaluations, medication reconciliation, catheter care & caregiver disease process education, catheter care & IV infusions

Physical Therapy

Treatment to address pain, injury, neurological impairments, or muscle and bone disorders that limit safe mobility.

Social Work

Social Workers enhance the coping skills of families & caregivers while promoting the social & emotional health of our patients. With access to a network of community resources they can assist in maintaining the patient's health and safety.

Occupational Therapy

Using adaptive equipment and home modifications, occupational therapy helps patients to regain their independence in bathing, grooming, and dressing, as well as housekeeping and meal preparation.

Speech Therapy

Therapy services for patients experiencing communication and/or swallowing disorders that accompany diseases such as stroke, MS, and traumatic brain injuries.

Certified Nursing Assistant

While receiving skilled need services, a CNA can assist in weekly bathing services & personal cares. (Please note this is NOT a daily service)

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Send a Complete Referral

Facesheet

Must include service address, insurance information, and primary contact for services.

Face-To-Face Note

Progress note, DC Summary or office visit note completed by the same provider signing Home Health Order

Home Health Order

Order to include qualifying diagnosis for home health services & specific services being ordered. Signed by the same provider that completes the Face-to-Face.

Other Documentation

History & Physical, Hospital Therapy Notes, Imaging, Labs & Vitals, Allergies, AVS or Discharge Medication List, POLST and/or Advanced Directives, POA records.

***Hospital Discharge Referrals – Documentation must state provider to follow care/Home Health post discharge.

Face-to-Face – Sending a Complete Note

Type of Note

Office visit note, hospital progress note or DC Summary. Note must include qualifying information.

Date of Encounter

Must occur 90 days prior or 30 days after Home Health start of care.

**Provider must agree to sign orders prior to Face-to-Face if occurring after start of care

Homebound Statement

Documented support from assessment showing patient is homebound and need for skilled home health services.

Patient Identifiers

Patient name & date of birth (any additional identifiers deemed necessary by provider/facility.

Visual Assessment

Narrative of visit/visual assessment. Including head-to-toe assessment, review of systems assessment, vital signs, etc. Including audio/visual telehealth visits.

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Qualifying Diagnosis

PDGM Diagnosis assessed during visit and documented in note.

Signatures & Dates

Note must be signed by the provider completing visual assessment; including credentials and date completed.

Homebound Statement Examples

- Pt requires rest periods after ambulating more than 30-50 feet due to weakness and tremors secondary to Parkinson's disease. Pt remains at high risk for falls
- Clinical findings that support homebound status is leaving home is medically contraindicated and needs assistance of another individual; ambulates limited distance of 50' with the assistance of a 4WW, unable to leave home unsupervised requires supervision/assistance of another person; currently walker dependent with painful ambulation.
- Pt is homebound d/t failed R THA dislocation and Covid 19. Pt requires assistance of c/g when leaving home to navigate FWW in and out of car.
- Patient is homebound due to Acute on chronic respiratory failure with hypoxia and hypercapnia; Unable to leave home unsupervised Poor endurance, SOB with minimal ambulation and needs assistance to leave the home

Qualifying Diagnosis

Primary Diagnosis

Often the primary diagnosis for home health orders are not the reason for hospital admission or office visits. Symptoms of illness are the reason patients seek help from hospital and providers; including things such as falls, weakness, superficial injuries, acute illness, etc.

When completing Face-to-Face encounter documentation, providers must assess symptoms and address underlying diagnosis causing symptoms and need for home health.

EXAMPLE: If the primary diagnosis for home health is diabetes but this was not the primary focus of the clinical encounter note, the face-to-face encounter would be accepted if some of the following were included in the face-to-face encounter note:

* The diagnosis and/or acceptable ICD-10 code for diabetes
* Inclusion of the patient's glucose level under the vital signs
* An assessment note specific to the patient's diabetic status under the review of systems assessment
* Current diabetic medication(s)
* An implementation/summary note specific to the patient's diabetic status
* Ongoing plan or changes to the treatment plan based on the patient's current clinical status

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Sending Referrals

Fax Referrals:

All referrals are processed at our Missoula Office.
Please fax to: **406-549-8970**

Intake Contact Information:

Nikki McGowan – Intake Specialist:
406-327-3625
McGowanN@partnersinhomecare.org
Quinlynn Wood – Intake Specialist:
406-327-3710
intake@partnersinhomecare.org
Brittney Talbott – Intake Specialist:
406-327-3747
intake@partnersinhomecare.org