

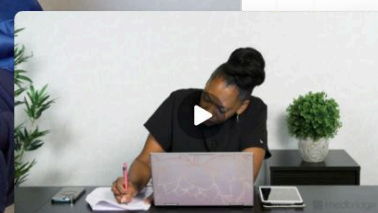
GUIDE

Stronger Together: How Interdisciplinary Care Reduces Home Health Rehospitalizations

By Cindy Krafft, PT, MS, HCS-O; Sherry Teague, MESS, ATC, PTA, HCS-D, HCS-O; and Kim Tate, RN, BSN



Skill
Complete!



Home Health Excellence: Best
Practices for Home Visits

Presented by Kim Tate and Natalie Venable

Overview

Home health care is complex. Every patient brings unique needs and goals, and it takes a team to help them achieve success. Nurses, physical therapists, occupational therapists, speech pathologists, social workers, aides, and others all play a role, but without strong collaboration, care can feel fragmented and incomplete—for clinicians and for patients.

Team-based care strengthens patient education, improves outcomes, and reduces hospitalizations. It also builds mutual trust and reduces burnout, making care more sustainable on every level. And while interdisciplinary collaboration might seem easier said than done, the good news is that it's entirely achievable with the right strategies.

In this guide, co-written by Kim Tate, RN, BSN; Cindy Krafft, PT, MS, HCS-O; and Sherry Teague, MESS, ATC, PTA, HCS-D, HCS-O, we'll cover:

- Why clinicians so often work in silos—and how that can compromise patient care.
- Actionable, achievable strategies and tools for creating a culture of collaboration.
- Real-world examples of interdisciplinary care in action.

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Team-based care in action: A real-world example



When clinicians collaborate, everyone benefits—patients, agencies, and the entire care team. Let's take a look at one example from our own experience.

Recently, a home health team was supporting a patient with advanced multiple sclerosis whose legs often contracted into a scissor position. For the nursing staff, even routine catheter changes became extremely challenging—often requiring one to two hours just to stretch the patient's legs enough to perform the procedure. This time-consuming process also made it difficult to maintain a sterile field or provide proper hygiene, increasing the patient's risk for infection.

Recognizing the strain on both the patient and the nursing staff, the team added therapy services back in for a full certification period. Physical therapists began working with the patient two to three times per week, focusing on gentle stretching and maintaining flexibility.

The impact was significant:

- The patient didn't develop UTIs during the entire 60-day period. Because early signs of infection could be spotted and addressed quickly, the patient could be treated at home before symptoms became troublesome.

- Right away, nurses no longer needed to spend extended time stretching the patient.

- Catheter changes quickly became normal, taking only the typical 45 minutes.

Eventually, the team was able to titrate down therapy to just two visits per month, establishing a maintenance therapy plan that kept the patient comfortable and stable while significantly reducing staff time and improving care quality.

Takeaway: Interdisciplinary collaboration can often be the key to solving complex care challenges. By recognizing the problem and proactively engaging therapy to help solve it, this team created a more patient-centered approach that benefited everyone involved.

Connecting around a common goal: The patient's well-being



Working in silos might seem efficient in the moment, especially when schedules are tight and caseloads are heavy, but it often leads to missed opportunities, duplicated efforts, and confusing or inconsistent messaging for patients. Across your organization, this can translate into lower patient satisfaction, reduced adherence, and increased risk of rehospitalization.

By contrast, when clinicians share goals, communicate proactively, and approach care as a team effort, the result is:

- ✓ Fewer rehospitalizations
- ✓ More consistent patient education
- ✓ Standardized protocols
- ✓ Improved adherence to care plans
- ✓ Higher job satisfaction for staff
- ✓ Patient-centered care
- ✓ Better patient outcomes

Clinicians might sometimes feel like ships in the night, seeing the same patient days apart with no interaction in between. But even a quick text or heads-up from another clinician on a HIPAA-safe platform—about a wound, a blood pressure reading, or a change in mobility—can shift the entire care plan for that visit. Being sure to document that status in the patient's EMR is also essential for keeping everyone in the loop.

When care team members see themselves as part of one coordinated plan rather than parallel providers, they're able to support each other's visits—for example, with reinforcement of medication adherence during a balance training session, or gait safety checks during wound care. This also gives patients a more cohesive experience of care.

At the end of the day, clinicians want the same thing: what's best for the patient. But they're often trained to approach it from different angles. When clinicians are able to talk to each other more effectively, they can see how those angles fit together. That shared intention of patient-centered care connects the team, and when it guides the work, everything else becomes easier—from communication to care coordination and documentation.

Team-Based Care Reduces Hospital Time and Improves Lives

A 2025 meta-analysis revealed that interdisciplinary collaboration in home health settings led to a significant reduction in hospitalization days for patients with chronic conditions. The study also found notable improvements in self-management, quality of life, and patient satisfaction.¹

Who's on the team and what they bring



Home health care is a team effort. Each discipline brings specific expertise to the table, but it's the collaboration between team members that makes patient care truly effective. When clinicians understand and respect each other's roles, communication improves—and so do patient outcomes.

Let's take a look at the core team members and what they contribute:

Nurses

Nurses often serve as the first point of contact for identifying changes in a patient's condition. They're in a great position to spot clinical trends but might need support from therapy to maintain function and prevent decline. Key contributions include:

- Medication management
- Wound care and infection prevention
- Acute, chronic, and post-surgical disease monitoring
- Patient and caregiver education

Physical therapists (PTs)

PTs are able to identify key functional goals early on. Key contributions include:

- Mobility assessments and fall risk prevention strategies
- Gait, strength, endurance, and balance training to restore or maintain independence
- Pain management strategies that support function and safety
- Patient and caregiver education in safe mobility techniques

Occupational therapists (OTs)

OTs may recommend environmental changes or tools that make the difference between a patient being able to remain safely at home or not. Key contributions include:

- Support for activities of daily living (ADLs)
- Home safety evaluations and recommendations
- Adaptive equipment training

Speech-language pathologists (SLPs)

While not always involved in every case, SLPs play a vital role in supporting patients who are recovering from neurological events or who face barriers to eating, speaking, or understanding.

Key contributions include:

- Training patients in compensatory strategies for communication, cognition, and safe swallowing
- Functional assessments in the above

Medical social workers

Social workers address the social, emotional, and practical barriers that affect a patient's ability to recover or manage illness at home. Key contributions include:

- Psychosocial assessments
- Care coordination and planning throughout the episode of care
- Emotional support and counseling

Home health aides (HHAs)

Aides are often the most frequent visitors in a patient's home. Their observations, when effectively communicated, can provide important day-to-day context that informs care planning across disciplines. Key contributions include:

- Personal care and hygiene
- Bathing, dressing, and grooming assistance
- Observation and reporting of changes in patient condition

Primary care providers

PCPs serve as the central medical decision-makers and often rely on home health feedback to adjust medications, address symptoms, or reassess goals.

Case managers

Some agencies employ dedicated case managers, who help coordinate care across disciplines, ensure proper utilization of services, and support smooth transitions of care. In other cases, field clinicians take on the role of case manager.

When each member of the team is aware of what others bring—and feels empowered to reach out or collaborate—it leads to fewer gaps, better care, and more rewarding experiences for both patients and clinicians.

Common barriers to interdisciplinary care



Even when everyone agrees that collaboration is important, there are real-world obstacles that get in the way. Some are logistical, while others stem from professional norms, habits, or misunderstandings about what other disciplines do. Here are some of the most common ones we see:

Communication Breakdown

Care might feel fragmented because team members don't always know when others are visiting, what was addressed, or what the latest patient status is. For example, a nurse might arrive at a visit unaware that a therapist had already worked on the same problem a day or two earlier, leading to duplicated efforts or conflicting approaches.

Parallel Plans, Not Shared Ones

Therapists might be working on gait retraining, while nurses are focused on wound care—and both may be unaware of how the other's plan could support or hinder progress. Without shared communication or clear interdisciplinary goals, these plans stay siloed.

Lack of Visit Awareness

Schedules don't always align, and without tools like shared calendars, many clinicians don't know which other team members are seeing the patient—or when.

Discipline-Specific Language

Each discipline has its own documentation style, clinical language, and assumptions. This can make it hard for clinicians to extract actionable insights from each other's notes. Therapists might have their own lingo, while nurses have theirs, and sometimes those don't translate well unless there's intentional effort to bridge the gap.

Unclear Expectations or Roles

Especially for newer clinicians, it's not always clear who should be doing what. For example, aides might observe important changes in a patient's mobility or mental status but may not know how or if they should share that with the broader team.

Talking the same language: Best practices for better collaboration



Clear communication is the foundation of interdisciplinary care. But in home health, it's easy for discipline-specific jargon, assumptions, or even documentation habits to create barriers. When clinicians don't share a common language or understanding of each other's roles, misalignment and missed opportunities can follow. By becoming more intentional about how we communicate—both verbally and in writing—we can strengthen collaboration, reduce confusion, and ensure patients receive seamless, high-quality care.

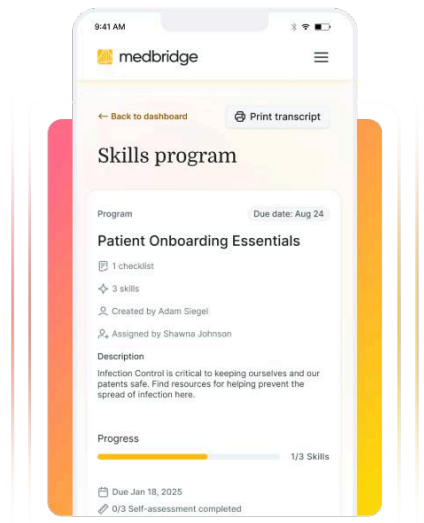
Core Communication Strategies

- **Break down cultural silos:** Every discipline has its own language and lens, but shared goals benefit from a common vocabulary.
- **Align on goals:** Goals should be patient-centered, clear, and reinforced by the whole team.
- **Strengthen handoffs:** Whether through verbal updates or notes in the EMR, sharing observations can prevent critical details from slipping through the cracks.
- **Standardize language and tools:** Shared terms and templates help reduce confusion.
- **Make time to connect:** Even just a quick call or text message on a HIPAA-safe platform can prevent costly misunderstandings.

When the whole team uses the same language and defines terms the same way, patients get clearer guidance and teams make better decisions.

Tools, Pathways, and Documentation that Standardize Care

- **Implement [onboarding and ongoing education](#) that strengthens collaboration:** Introduce interdisciplinary expectations early in training to establish norms, and then reinforce them through continuing education.
- **Create feedback loops:** Incorporate short real-life case reviews and virtual or in-person huddles to help teams learn from each other and stay connected.
- **Use structured tools:** Employ shared calendars, handoff templates, and communication checklists to improve team alignment.
- **Use [interdisciplinary pathways](#):** Implement shared frameworks for fall risk, wounds, or chronic conditions to help clarify each role and reduce overlap.
- **Make documentation notes with the full team in mind:** Ensure that notes in the EMR speak to and inform all disciplines.



Supporting a Culture of Collaboration

Leaders can model collaboration and encourage connection with practices like regular team huddles and monitor progress on an ongoing basis. If collaboration isn't supported at the organizational level, it can be hard to sustain. Everyone needs time, tools, and encouragement to succeed at improving interdisciplinary care.

On the following page, you'll find a handout with quick collaboration tips that you can print as a convenient reference for your care team.

Multidisciplinary Care Cuts Readmissions: One Nurse's Story

In [this 2023 commentary](#), get another nurse's take on how a multidisciplinary approach consistently improves long-term patient outcomes and significantly lowers rehospitalization rates.²

Clinician handout

Quick take: Stronger care through teamwork

- ✓ **Think beyond your scope.**

Ask: What would other members of the care team want to know about this patient?

- ✓ **Use quick touchpoints.**

Share short HIPAA-safe texts, calls, or notes about patient concerns—and document in the EMR.

- ✓ **Check documentation for cues.**

Skim recent notes from other disciplines. Even a single comment can flag an emerging issue.

- ✓ **Reinforce each other's goals.**

Therapists can remind patients about medications or wound care; nurses can reinforce safety and mobility strategies.

- ✓ **Build relationships.**

Collaboration is easier when you know who you're working with. Learn your teammates' names and strengths.

- ✓ **Schedule in-person sessions.**

Perform joint visits (per agency policy) and hold case meetings.

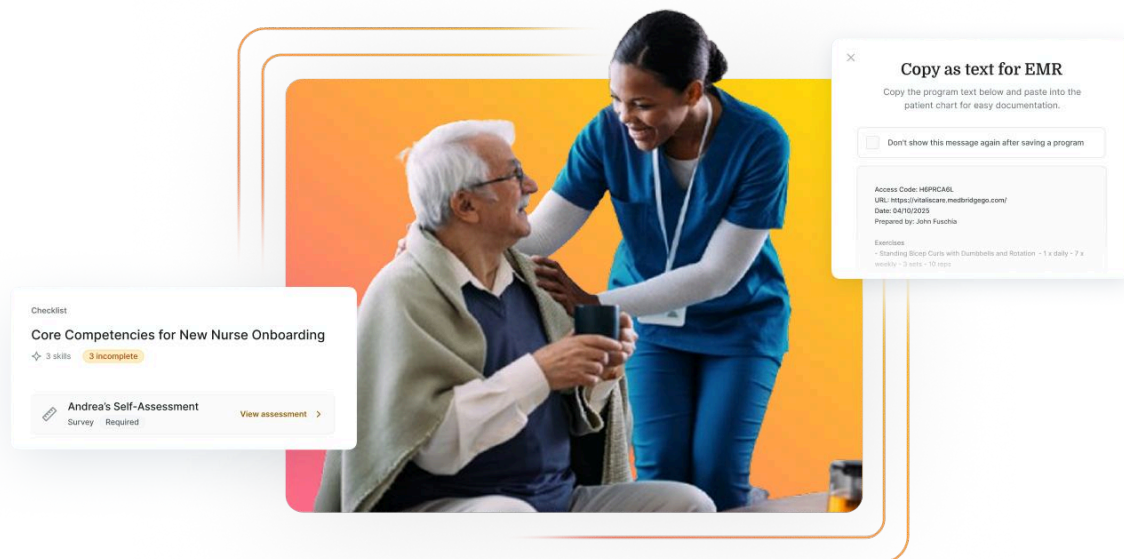
- ✓ **Keep each patient's big picture in mind.**

The result is better outcomes and a better experience—for patients, clinicians, and agencies.

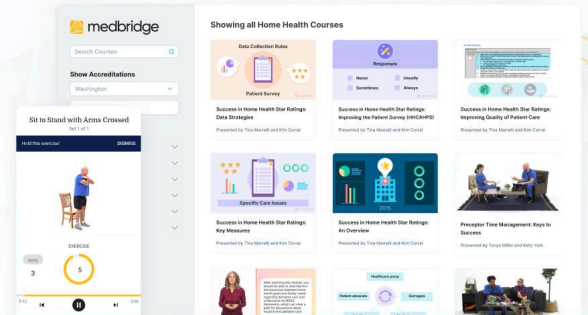
Moving forward

Improving interdisciplinary care in home health doesn't need to involve a huge overhaul—or be overly complicated or time consuming. It can start with small, intentional shifts. For example, a brief note in the EMR, a heads-up to another clinician about a patient concern, or simply aligning an in-home visit with another team member's goals can go a long way. These small acts build trust, prevent duplicated work, and ultimately support better patient outcomes.

Leadership plays a key role in reinforcing this mindset. When interdisciplinary collaboration is woven into onboarding, encouraged by managers, and supported through regular practices like team huddles, it can become a natural part of the workflow. Ultimately, the most effective care happens when everyone feels connected by a shared purpose: doing what's best for the patient.



How Medbridge helps



Educational and Training Resources

- **Interdisciplinary onboarding:** Our [Home Health Excellence Series](#) was developed for PTs, OTs, SLPs, and nurses so that everyone receives the same information spanning topics from care planning to documentation.
- **Disease-specific programs:** Medbridge has [courses and programs](#) verified by the Community Health Accreditation Partner (CHAP) that focus on specific diseases like heart failure, dementia, diabetes, and stroke. These courses are designed to be multidisciplinary, providing nurses and therapists with evidence-based training to enhance disease management and standardize care.
- **Team-focused education:** Medbridge offers courses specifically on [interdisciplinary teamwork and collaboration](#), which cover topics such as:
 - The foundational principles of home healthcare and the importance of [interdisciplinary collaboration](#).
 - Effective communication strategies for team members to ensure cohesive care delivery and improve patient outcomes.
 - The roles and responsibilities of different clinicians—such as nurses, therapists, and social workers—and their contributions to patient-centered care.
 - Strategies for an organization to improve the [coordination of care and services](#).

Operational and Patient Care Tools

- **Home Exercise Program (HEP):** Medbridge offers a [customizable home exercise program](#) that can be delivered to patients via print, a patient portal, or a mobile app. This allows clinicians from different disciplines to provide consistent, evidence-based care and education to patients between visits.
- **Competency management:** Medbridge provides tools for [digital skills checklists](#), training videos, and reporting dashboards. This helps agencies prepare new hires for the field faster by focusing on identified skill gaps and streamlining the onboarding process for therapists, nurses, and home health aides.
- **Point-of-care resources:** The Medbridge platform includes over 200 [point-of-care skills resources](#) for nurses, therapists, and home health aides. These resources provide quick access to step-by-step instructions and video tutorials, supporting excellence at the point of care.

References

1. <https://doi.org/10.1186/s12875-025-02814-0>
2. https://journals.lww.com/homehealthcarenurseonline/citation/2023/05000/the_benefits_of_the_multidisciplinary_approach_in.13.aspx

About medbridge

Combining powerful digital patient care tools with the highest quality education, Medbridge is committed to making healthcare better for both providers and patients. Organizations across the care continuum use Medbridge to provide an enriched, digitally enabled experience that engages patients while streamlining and simplifying care. Designed with over a decade of insight from more than 350,000 clinicians and 25 million patients, Medbridge has helped thousands of organizations realize better patient outcomes. [Learn more.](#)

See how Medbridge can help your organization.

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