Regional Care Transitions Model for Engagement of Integrated Care Networks

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Suffolk Care Collaborative

Background

The SCC's Care Transitions Program is focused on monitoring the Project's (2.b.iv and 2.b.ix) success and operationalizing quality improvement initiatives to impact performance outcomes. To support these efforts, Regional Care Transitions Workgroups (Workgroups) have been established to support learning collaboratives between hospitals and community partners to discuss strategies for effective care transitions.

Purpose Statement

To enhance the care transitions process and reduce unnecessary hospital admissions and emergency department (ED) visits throughout Suffolk County by recognizing areas of opportunity and regional trends, enhancing collaboration amongst stakeholders and promoting identification of best practices between acute care and community providers.

Program Goals

Regional Care Transitions Workgroups' goals include:

- Expand network engagement and development
- Drive performance improvement and quality assurance activities
- Identify and implement initiatives to improve care transitions between hospital partners and community providers

Workgroups provide a forum for facilitated discussions informed by data. Workgroups focus on identifying regional trends and initiatives, enhancing communication and collaboration amongst stakeholders and promoting identification of best practices between acute care, community and long-term care providers. Through this collaborative effort, the SCC plans to enhance the care transition process for Suffolk County patients and reduce unnecessary ED visits and hospital admissions.

Key Stakeholders

- Hospital representatives include Directors (or designee) of Emergency Department, Care Management, Social Work, Nursing, Palliative Care and Hospitalists.
- SNF representatives include the Administrator, the Director of Nursing and the Medical Director (or designee).

Program Regions

Workgroups were organized into geographic regions by hospital and skilled nursing facilities (SNFs) within the hospital's primary and secondary service areas.

Initiatives

SNF to ED Communication:

SNFs identified a need for improved communication to hospital when sending a patient for diagnostic testing or other procedure not available within their facility.

→ Nine hospitals and several SNF partners met to identify strategies to improve communication between facilities.

→ SNF to ED communication form was created to assist ED providers in decision making when a SNF resident presents.

Key Elements:

- Provider to Provider contact information to discuss patient
- Primary Reason for Transfer to the Hospital
- Allergies & Isolation Precautions

SNF/ED COMMUNICATION FORM

STOP AND READ THIS

FACILITY CONTACT INFORMATION

Facility Name:

Name of Person Completing Form (Print): Type of Stay at Facility: ☐ SAR ☐ LTC ☐ Palliative ☐ Hospice ☐ Dialysis

Who can the Hospital ED Physician call to discuss this patient (*include Name and Phone Number*):

☐ Medical Director/PMD _____ ☐ Discharging Physician _____

☐ NP/PA _____ ☐ Other: _____

PATIENT INFORMATION

Patient Name: DOB: ☐ Male ☐ Female Preferred Language:

Patient's Emergency Contact (Name & Phone Number): Health Care Proxy: ☐ Yes ☐ No

Code Status: ☐ Full Code ☐ DNR ☐ DNI MOLST Form Sent w/ Pt: ☐ Yes ☐ No DNR Form Sent w/ Pt: ☐ Yes ☐ No

Reason for Hospital Transfer:

Evaluation & Treatment of:

Family-Driven Transfer: ☐ Yes ☐ No

Other Pertinent information (include relevant past medical history):

Devices Sent w/ Patient: ☐ Hearing Aides ☐ Dentures ☐ Other: _____

VITAL SIGNS AND DIAGNOSTICS AT TRANSFER

HT: WT: BP: TEMP:

PULSE PULSE OX: RESP: O2 Dependent:

PAIN : ☐ YES ☐ NO RATING 1-10: ___ SITE(S) OF PAIN: LAST BLOOD SUGAR (if relevant):

Allergies:

Isolation Precautions: ☐ None ☐ Contact ☐ Droplet ☐ Airborne ☐ MRSA ☐ VRE ☐ C-Diff ☐ Other: _____

Reason for Isolation: _____

BASELINE MENTAL STATUS

☐ Alert ☐ Oriented ☐ Disoriented ☐ Dementia ☐ Lethargic ☐ Comatose ☐ Agitated

☐ Depressed ☐ Calm ☐ Anxious ☐ Combative ☐ Other: _____

BASELINE ADLS

☐ Ambulates independently ☐ Ambulates with assistance ☐ Fall-risk ☐ Wanders ☐ Other: _____

☐ Incontinent to Urine ☐ Incontinent to Stool ☐ Poor Speech ☐ Poor Hearing ☐ Other: _____

ATTACHMENTS

The following must be attached: Facesheet MAR POS (Doctors Orders) Signed DNR MOLST Advance Directives

Additional Attachments: ☐ Treatments ☐ X-rays ☐ EKGS ☐ Surgical Reports ☐ Most Recent Labs

☐ Skin Guide ☐ Immunization Records ☐ Other: _____

SPECIAL CONDITIONS

Skin Wounds: ☐ Yes ☐ No Foley Catheter: ☐ Yes ☐ No Chronic: ☐ Yes ☐ No Date of Insertion: _____

IV Access: ☐ PICC ☐ Port ☐ G-Tube ☐ Other _____ Manufacturer of Defibrillator: _____

RECENT HOSPITAL ADMISSION

Was the patient admitted to the hospital in the past 30 days? ☐ Yes ☐ No If yes, date & primary reason:

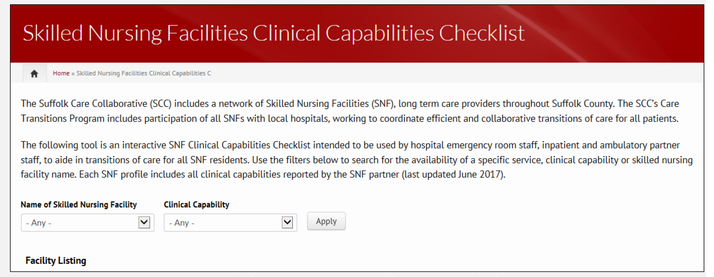
Initiatives Continued

SNF Clinical Capabilities:

Need Identified
- Lack of knowledge of SNF capabilities within hospital.

Solution
- Creation of an interactive tool supporting transitions of care for all SNF residents.
- Each SNF profile includes all clinical capabilities available within the facility.

Examples
- Discharge planning can utilize tool to search for specific service patient may need post-discharge.
- ED staff member can utilize to assist in determining safety of treating and releasing patient back to facility.



Skilled Nursing Facilities Clinical Capabilities Checklist

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The Suffolk Care Collaborative (SCC) includes a network of Skilled Nursing Facilities (SNF), long term care providers throughout Suffolk County. The SCC's Care Transitions Program includes participation of all SNFs with local hospitals, working to coordinate efficient and collaborative transitions of care for all patients.

The following tool is an interactive SNF Clinical Capabilities Checklist intended to be used by hospital emergency room staff, inpatient and ambulatory partner staff, to aide in transitions of care for all SNF residents. Use the filters below to search for the availability of a specific service, clinical capability or skilled nursing facility name. Each SNF profile includes all clinical capabilities reported by the SNF partner (last updated June 2017).

Name of Skilled Nursing Facility - Any - Clinical Capability - Any - Apply

Facility Listing

https://suffolkcare.org/interact/skilled-nursing-facilities

Growth & Expansion

SCC is exploring opportunities to evolve the regional care transitions workgroups to include other community partners, including home care, primary care and behavioral health partners. By adding these key stakeholders, a greater impact can be made to improve performance outcomes. Our goal is to positively affect both potentially preventable visits and potentially preventable readmissions.

Acknowledgements

Participating facilities include 7 Hospitals & 34 Skilled Nursing Facilities to date.

Contact Information

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