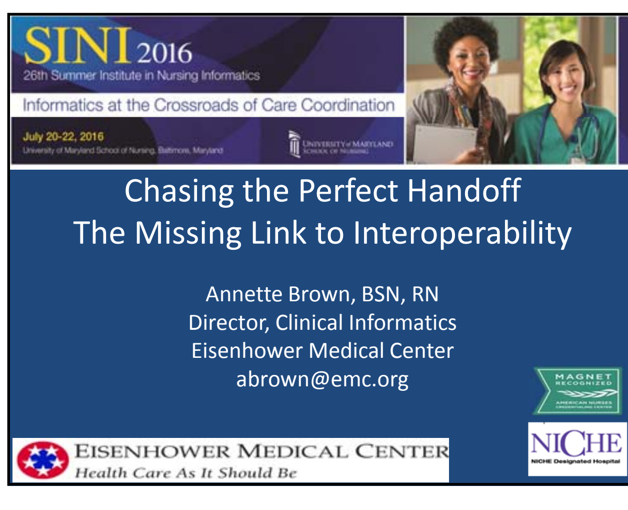


Organization

Not-for-profit, academic, community hospital

- 463 licensed beds with 71 clinics
- 3,500 employees; 496 affiliated physicians

2015 Awards & Recognition

- Most Wired Hospital since 2012
- Magnet Recognition® & NICHE Recognition®
- Leapfrog Hospital Safety Score A
- Ranked in Top 50 US Cardiovascular Hospitals *(Truven Health Analytics)*
- LGBT Healthcare Equality Leader since 2013 *(Healthcare Equality Index)*

Care Coordination Goals

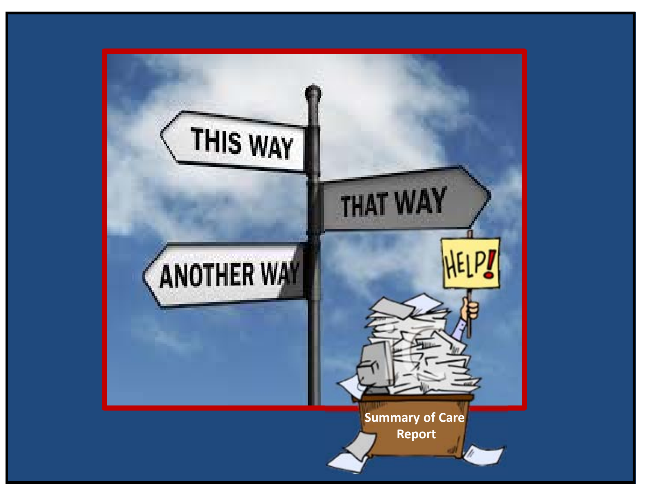
The National Quality Strategy aims to **promote effective communication and coordination of care** across the healthcare system by focusing on three goals:

- Improve the quality of care transitions and communications across care settings.
- Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
- Establish shared accountability and integration of communities and healthcare systems to improve quality of care and reduce health disparities.

National Quality Forum, 2012

Hospital to SNF Communication

- Major communication problem
  - Easily identified
  - More difficult to solve
- Eisenhower Medical Center (EMC) Family Medicine Residency Program highlighted multiple physician concerns regarding the quality, adequacy, and timeliness of EMC-SNF hand-off information.
  - Critical information insufficiently presented
  - Not always timely
  - Both major contributing factors to substandard hand-offs
- Need for in-depth gap analysis of hospital to post-acute care transitions identified by patient safety review.

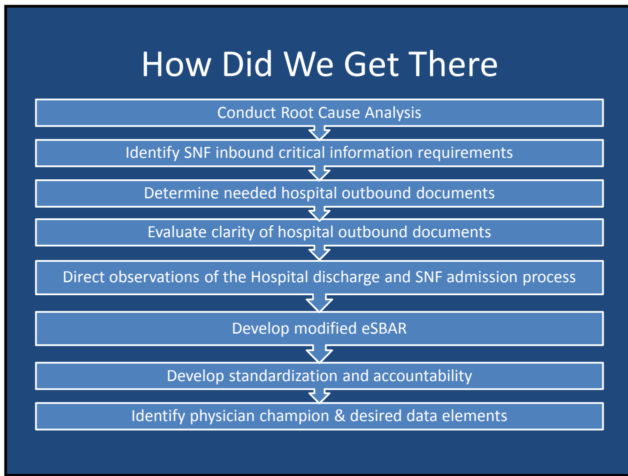


MU Stage 2 Summary of Care Report

- Too Lengthy
- Inefficient
- Interpretation Literacy Levels
- Incomplete Plan of Care & Progress to Goals
- Negative Impact to Clinical Workflow
- Clinicians Perceived Minimal Benefit to Care
- Technology Challenges
- Clinical Challenges
- Strategic Challenges

EMC-SNF Gap Analysis

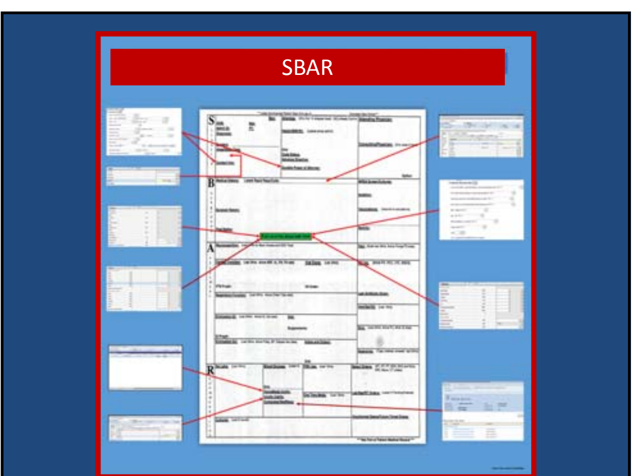
- History - Eisenhower Medical Center (EMC) and surrounding SNFs functioned as separate entities
- 2012 Center for Medicare and Medicaid Services (CMS) and Meaningful Use Stage 2 Requirements mandated electronic interoperability and "Summary of Care" (SoCR) report
- February 2014 - EMC formed a SNF Collaborative Committee
  - Aim: to align care providers in the EMC network
  - Goal: to deliver more integrated patient care to the community
- EMC educated SNF staff to the SoCR
  - Process
  - Key elements of the report
  - Establish SNF Internet Protocols Addresses (IPAs)

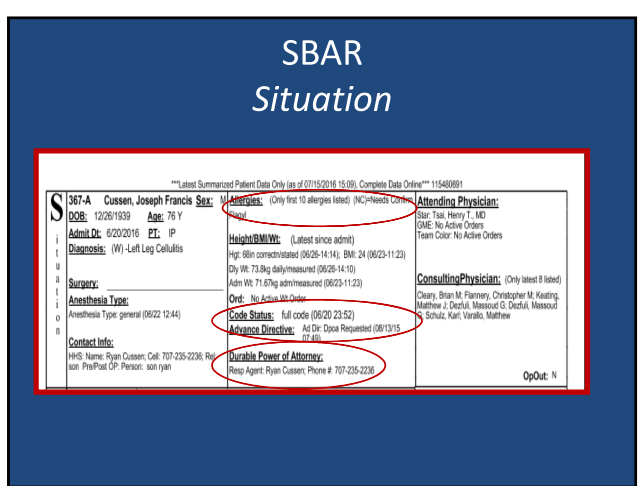


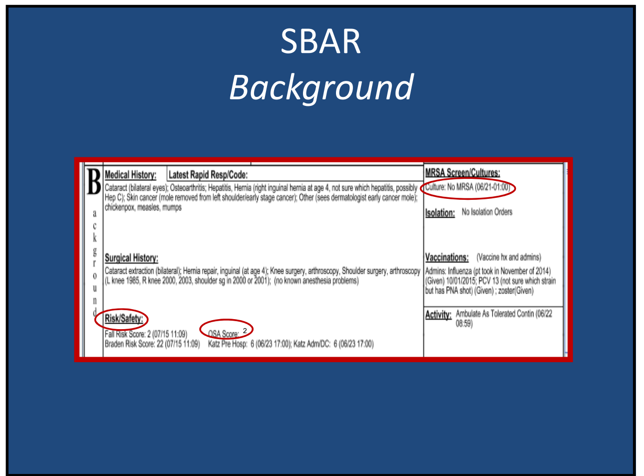
Accomplishments

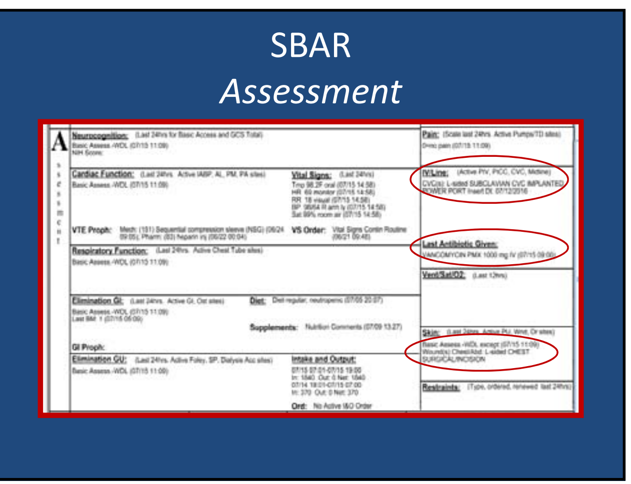
- IPAs
- eSBAR
- SNF Discharge Document Checklist
- Reconciliation of Medication Documents
- Training and Education
- Timeliness of Discharge Summary
- Enhanced SNF Discharge iForm
- Risk Stratification
- ABILITY|ILLUMINATE referral process "lights up the care transition process to make faster, easier, more informed connections among patients, acute and post-acute providers."
  - Similar to Extended Care Information Network (ECIN)

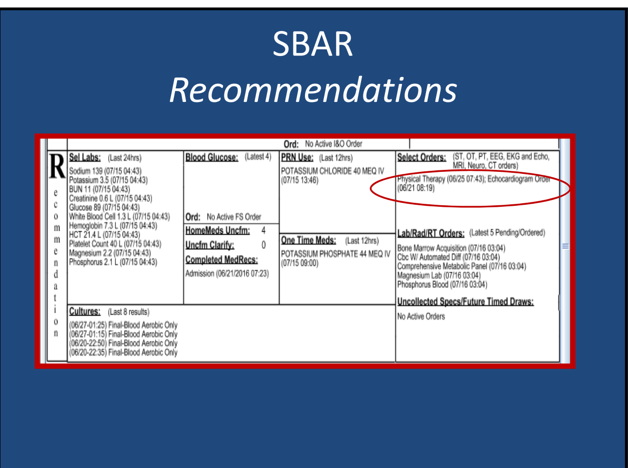
Ability Network.com , 2016

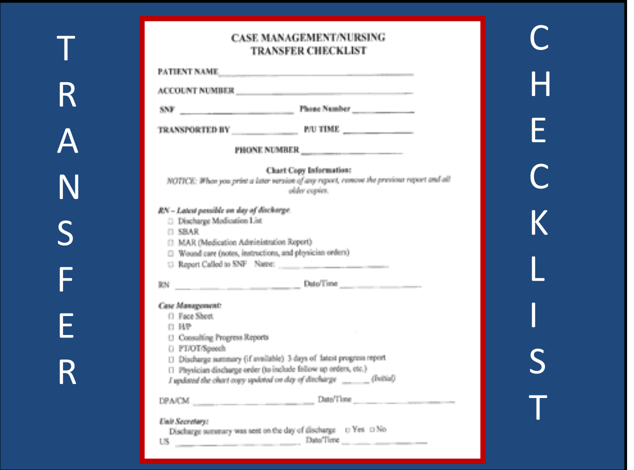












CASE MANAGEMENT/NURSING
TRANSFER CHECKLIST

PATIENT NAME ____________

ACCOUNT NUMBER ____________

SNF ____________ Phone Number ____________

TRANSPORTED BY ____________ P/U TIME ____________

PHONE NUMBER ____________

Chart Copy Information:

NOTICE: When you print a later version of any report, remove the previous report and all older copies.

RN – Latest possible on day of discharge
- ☐ Discharge Medication List
- ☐ SBAR
- ☐ MAR (Medication Administration Report)
- ☐ Wound care (notes, instructions, and physician orders)
- ☐ Report Called to SNF Name: ____________

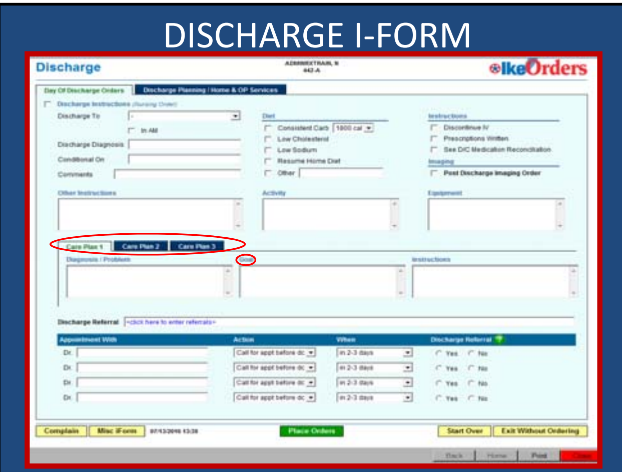
RN ____________ Date/Time ____________

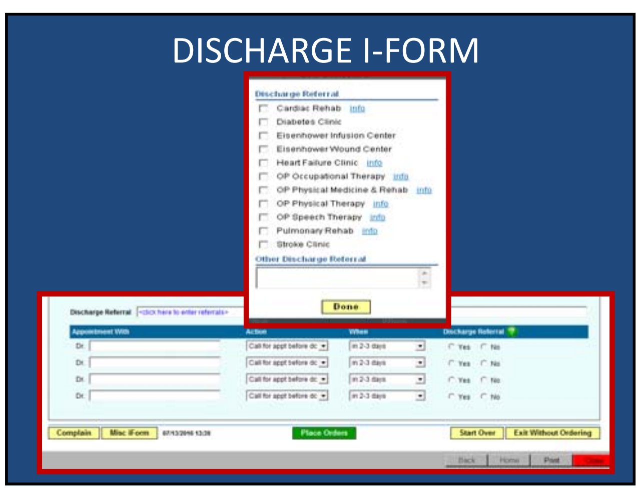
Case Management:
- ☐ Face Sheet
- ☐ H/P
- ☐ Consulting Progress Reports
- ☐ PT/OT/Speech
- ☐ Discharge summary (if available) 3 days of latest progress report
- ☐ Physician discharge order (to include follow up orders, etc.)

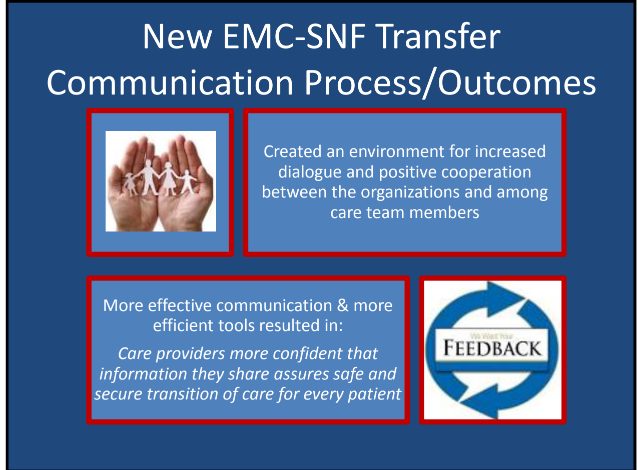
I updated the chart copy updated on day of discharge ______ *(Initial)*

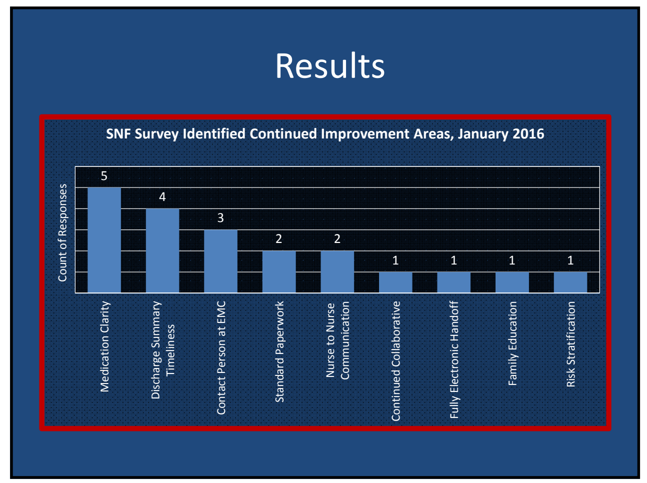
DPA/CM ____________ Date/Time ____________

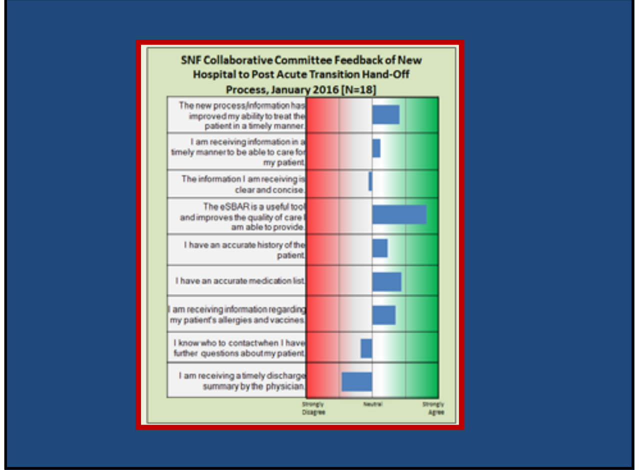
Unit Secretary:
Discharge summary was sent on the day of discharge ☐ Yes ☐ No
US ____________ Date/Time ____________

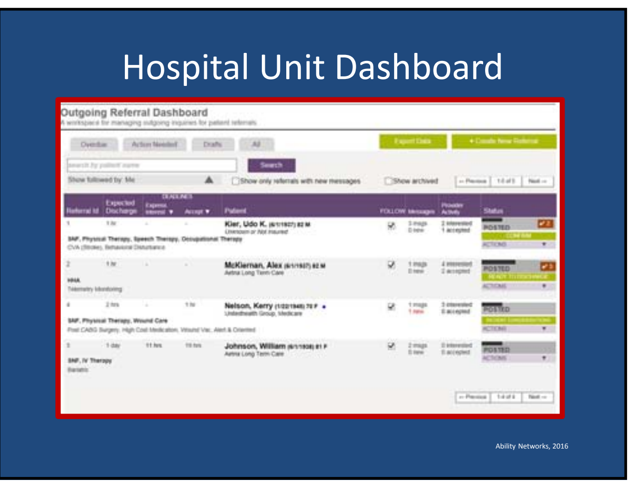

DISCHARGE I-FORM
Discharge
IkeOrders
Day Of Discharge Orders
Discharge Planning / Home & OP Services
Care Plan 1
Care Plan 2
Care Plan 3
Discharge Referral
Appointment With
Action
When
Discharge Referral
Complain
Misc iForm
Place Orders
Start Over
Exit Without Ordering


DISCHARGE I-FORM
Discharge Referral
Cardiac Rehab info
Diabetes Clinic
Eisenhower Infusion Center
Eisenhower Wound Center
Heart Failure Clinic info
OP Occupational Therapy info
OP Physical Medicine & Rehab info
OP Physical Therapy info
OP Speech Therapy info
Pulmonary Rehab info
Stroke Clinic
Other Discharge Referral
Done
Discharge Referral
Appointment With
Action
When
Discharge Referral
Complain
Misc iForm
Place Orders
Start Over
Exit Without Ordering


New EMC-SNF Transfer Communication Process/Outcomes
Created an environment for increased dialogue and positive cooperation between the organizations and among care team members
More effective communication & more efficient tools resulted in:
Care providers more confident that information they share assures safe and secure transition of care for every patient
FEEDBACK


Results
SNF Survey Identified Continued Improvement Areas, January 2016
Count of Responses
5
4
3
2
2
1
1
1
1
Medication Clarity
Discharge Summary Timeliness
Contact Person at EMC
Standard Paperwork
Nurse to Nurse Communication
Continued Collaborative
Fully Electronic Handoff
Family Education
Risk Stratification





Lessons Learned - 1

- Don't be afraid of change
- Identify a physician champion
- Relationship-based care / patient engagement
- Transition of care pharmacist & Behavioral Health support
- Engage leadership
- Develop relationships
- Schedule routine meetings
- Monitor & measure the process

Lessons Learned - 2

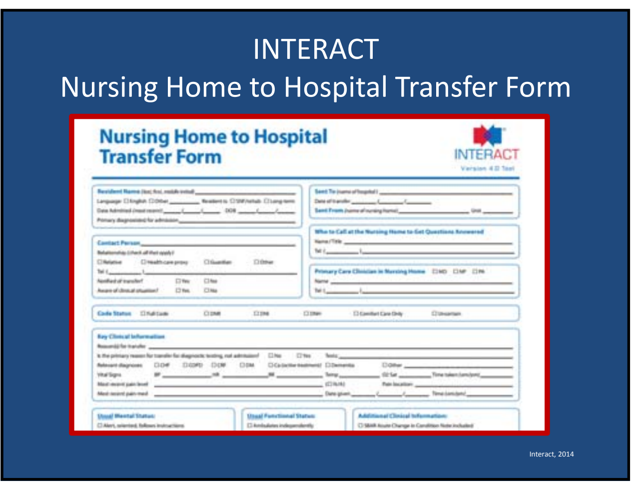
- Develop a SNF dashboard
- SNF designated case manager or color code SNF admissions
- Consider assigning a case manager with responsibility for SNF patients or color code SNF admissions
- To improve the transfers
  - Create a transfer process to include policy and procedure for transfer accountabilities
  - Determine the information to be sent for referral vs. discharge
  - Put in place the tools, forms, and education for safe transfers
  - Monitor and measure your process
  - Communicate, communicate, and communicate!

Summary

To close the loop for the Hospital and SNF relationship, SNFs will outbound patients to the hospital with a similar practice developed here with INTERACT (Interventions to Reduce Acute Care Transfers)

INTERACT "a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities."

INTERACT
Nursing Home to Hospital Transfer Form


Nursing Home to Hospital Transfer Form
INTERACT
Version 4.0 Tool

Interact, 2014

Potential Areas for Improvement

- Improve communications during transitions between providers, patients and caregivers
- Implement SNF electronic medical records that include standardized medication reconciliation and SBAR elements, assess interoperability of "Ability" & "Interact" tools
- Establish points of accountability for sending and receiving care, particularly for hospitalists and '*SNFists*'
- Increase the use of case management and professional care coordination
- Expand the role of the pharmacist in transitions of care
- Implement payment systems that align incentives and include performance measures to encourage better transitions of care

Six Communication Best Practices for Transitional Care Management

- Lay The Groundwork Prior To Discharge
- Provide Constant Contact
- Capture Patient Preferences
- Be Persistent
- Automate the Outreach
- Implement Smart Reminder Messaging

West Healthcare. 2016

Four High Impact Areas

- Linkages and Synchronization
- Individuals' Progression Toward Goals
- Comprehensive Assessment
- Shared Accountability

Acknowledgements

EMC expresses it's appreciation to individuals and organizations that share their insights with us.

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The Fountains at the Carlotta
Indio Nursing and Rehab
HCR Manor Care
Monterey Palms
Premier Health Care
Rancho Mirage Health Care

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West Healthcare. (2016). *Six Communication Best Practices for Transitional Care Management*. https://www.west.com/wp/content/uploads/2016/04

That's Enough

Thanks for listening!