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Readmission Improvement Resource Guide

Pennsylvania Hospital Engagement Network

ACHIEVING more TOGETHER

Pennsylvania Hospital Engagement Network

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Using This Guide

The following information has been compiled to provide you appropriate resources among the vast amount of information that is available on readmission improvements. This Resource Guide has been created with the intent of consolidating nationally recognized readmission strategies, resources and toolkits that utilize evidence-based best practices and support the work of transitions of care in health care facilities throughout the United States. We recognize that there is no one way for readmission improvements but that each facility is unique within culture and patient populations.

The Guide is organized into categories that address different opportunities for readmission improvements. These categories include national models of improvement, state readmission campaigns, transitions of care, assessment tools and recent journal articles pertinent to this topic. Each resource contains a brief description of the resource and a hyperlink to the material. In addition included are three case studies from Pennsylvania hospitals who have agreed to share their success stories in implementing readmission and transition of care interventions.

The PA-Hospital Engagement Network (HEN) believes that using these resources will help to support your efforts in the area of readmissions and transitions of care. We encourage health care facilities to dig further into the resource links, as there are many helpful documents and sources available.

We would appreciate if after reviewing and using this Guide, you consider sharing your successes with us. Please contact us with any suggestions for updating and revising the Guide.

As always, we thank you for all of your efforts in developing and sustaining a culture of patient safety and for keeping the patient at the center of all of your readmission improvement strategies.

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Project Managers – Readmissions
Pennsylvania Hospital Engagement Network

NATIONALLY-RECOGNIZED MODELS

Identifying Your Model

- There are many recognized models which have been found to aid in the reduction of readmissions.
- They provide pathways and guidelines for strategic action that lead to better patient outcomes when used correctly.
- It is important that your facility choose the right model that fits your facility, goals and available resources.
- Understanding the needs of your organization and the themes from the different models will assist in choosing a model that works with your organization.
- Many organizations have developed a composite model which uses various parts from each model.
- You will notice that many of the themes remain the same in all models.
- Summary information is below on these models, as well as a link to find out more.

Title	***Source***	***Description***
Project RED (Re-Engineered Discharge) (Boston University)	http://www.bu.edu/fammed/projectred/	**P**roject **R**e-**E**ngineered **D**ischarge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components, and has been proven to reduce re-hospitalizations and increase patient satisfaction.
Care Transitions Program® (University of Colorado)	http://www.caretransitions.org/ Eric.Coleman@ucdenver.edu	During a 4-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach® and learn self-management skills to ensure their needs are met during the transition from hospital to home.
Project BOOST (Society of Hospital Medicine)	http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27659	"**B**etter **O**utcomes for **O**lder Adults through **S**afe **T**ransitions,"(BOOST) a national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home.

Title	Source	Description
TCM Overview (Transitional Care Model) Mary D. Naylor, PhD., RN, FAAN, University of Pennsylvania School of Nursing	http://www.transitionalcare.info/	The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCM is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists, and other members of the health care team in the implementation of tested protocols with a unique focus on increasing patients' and caregivers' ability to manage their care.
An Early Look at a Four-State Initiative to Reduce Avoidable Hospital Readmissions-STAAR (Institute for Healthcare Improvement [IHI])	http://www.ihi.org/knowledge/Pages/Publications/AnEarlyLookFourStateInitiativetoReduceAvoidableReadmissions.aspx	State Action on Avoidable Rehospitalizations (STAAR) aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing State-level leadership to improve care transitions. It includes enhanced assessment of post-discharge needs, enhanced teaching and learning, enhanced communication at discharge, and timely post-acute follow-up.

NATIONAL/STATE CAMPAIGNS and TOOLKITS

- Various states and national associations have established campaigns and toolkits to assist in readmission work.
- Below is a summary of a selected group of these campaigns and toolkits, as well the link to access these tools.

Title	***Source***	***Description***
RARE: Reducing Avoidable Readmissions Safely (Minnesota Hospital Association's Patient Safety Initiative)	http://www.mnhospitals.org/patient-safety/collaboratives/reducing-avoidable-readmissions-effectively-rare	The Reducing Avoidable Readmissions Effectively (RARE) Campaign started by engaging hospitals and care providers across the continuum of care to prevent 4,000 avoidable hospital readmissions within 30 days of discharge across Minnesota between July 1, 2011, and December 31, 2012. Doing so helped alleviate the burden these readmissions place on patients and their families and will allow them the comfort and well-being of staying in their own beds. The project continues and both the program and the success can be found on the RARE website.
Quality Improvement Organizations (Colorado Foundation for Medical Care)	http://www.cfmc.org/integratingcare/toolkit.htm	A toolkit designed by the National Coordinating Center (NCC) for the Integrating Care for Populations and Communities Aim (ICPCA), which helps Medicare Quality Improvement Organizations (QIOs) to promote seamless transitions between health care settings.
Washington State Hospital Association	https://www.wsha.org	This comprehensive toolkit includes flowcharts and forms for triaging high, moderate, low risk patients, information on follow-up patient appointments and copy of transfer form to name a few.
HQI toolkit (Hospital Quality Institute California)	http://www.hqinstitute.org/hqi-toolkit/eliminating-readmissions	The HQI toolkit will assist hospitals in measuring readmissions, identify and engage key stakeholders providing harm elimination tools that work and learning through the successes of other hospitals. The toolkit is divided into five sections: 1. What to Measure 2. Key Improvement Team Members 3. Tools that Work 4. Success Stories from hospitals that used the tools in the toolkit 5. Additional Resources with other websites
Hospital Guide to Reducing Medicaid Readmissions (Agency for Healthcare Research and Quality – AHRQ)	http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html	AHRQ built a guidebook and toolkit to assist hospitals in the reduction of Medicaid readmissions. This tool includes areas such as: • Data Analysis tool • Readmission review tool • Data Analysis Synthesis tool

TRANSITIONS OF CARE

PA-HEN: Building Community Transition Teams through Regional Events

Purpose of regional events:

- Regional meetings were designed to provide direction and education in building Community Transition Teams. Community transition teams are joint ventures between acute care facilities and relevant transition partners. These partners may vary depending on location and population. In an effort to start new teams or build on established teams, the PA-HEN project manager set up regional meetings with acute care facilities and skilled nursing facilities.
- Transition teams have been shown to assist with decreasing readmission rates and improving transitions of care.

The following descriptions were gathered from regional events conducted over the last two years which were identified as cornerstones to improving transitions of care.

Developing Relationships and the value of Transition Teams

Patients with chronic illness often require care from a variety of experts in multiple settings. During times when patients are most vulnerable and their informal caregivers are often overwhelmed, systems can fail patients by not ensuring that: (1) the important elements of the care plan developed in one setting are transferred to the next setting; and (2) the critical steps that need to take place before and after transfer are executed.

The Partnership for Patients program identifies the goals of creating community based transition teams:

1. To improve transitions of beneficiaries from the inpatient hospital.
2. To improve quality of care.
3. To reduce readmissions for high risk Medicare beneficiaries.
4. To document measurable savings to the Medicare Program.

Best Practice Themes for Transition Teams:

Membership

- Members are often designated related to the culture of a specific community and the resources that are available.
- Acute Care Hospitals and the Skilled Nursing Facilities they refer to, and admit from should be the first step in the development of the transition team.
- It is recognized that there are sometimes competitive factors that weigh in, but as some facilities have identified, this must be looked past to develop practices to improve transitions for the patients served, as well as improving the safety of transitions for the patient and organization.

- As teams evolve the involvement of home health agencies and county resources can begin to be rolled into the teams.

Recruitment

- Determination of the different stakeholders for your facility is critical – Where do the referrals and admissions originate?
- Keep the lines of communication open, it may mean going to visit their facility first and inviting them to yours in an individual capacity before it becomes a group session.
- Knowing the right contacts at a facility is critical; however it also takes time to develop the relationships.

1:1 Meetings (one on one vs. High volume relationships)

- A majority of facilities at regional meetings have identified the value of 1:1 meetings with the major facilities they work with. This allows an opportunity to meet them on their own ground and develop an understanding of their challenges.
- There was a lot of discussion regarding the fact that regulations are different and even though we are not expected to know the regulations specific to an area we are not responsible for, we need to respect the limitations that are imposed. Knowledge is power.

External Pharmacies

- Another point of success for some regions has been the development of relationships and agreements with community pharmacies. In addition to sitting on the teams, they have also worked out agreements to work through the most frequently seen barriers for specific areas. (For example the impact of late discharges)

Partnerships

- Partnerships may take many different paths. In your community, there is likely to be more than one possible health care/community partner that may be interested in implementing a care transitions program.
- The Aging Network has collaborated with a variety of different organizations to improve care transitions, including physician practices, hospitals, quality improvement organizations, home health agencies. The Aging Network website offers valuable information on forming partnerships and collaboration with entities within your community that will help improve transitions of patient care.

Enhancing Communication

End of life decisions (POLST, Advanced Directives)

- Across all regional meetings concerns regarding communication of advanced directives and patient's wishes were evident.

- Advance directives are legal documents that allow the patient to spell out their decisions about end-of-life care in advance of an emergent need.
- Advance Directives allow the individual a means to communicate their wishes to family, friends, and health care professionals and to avoid confusion later on.

POLST (Physician Orders for Life Sustaining Treatment)

- POLST is a national project.
- It is an approach to end-of-life planning based on conversations between patients, loved ones, and medical providers.
- POLST is designed to ensure that seriously ill patients can choose the treatments they want and that their wishes are honored by all medical providers.
- Link to the POLST website is listed below.

Standardizing hand offs and transfer forms

- Many states have identified through their collaborative transition teams the value of the transfer form and have initiated standardized transfer forms throughout the state.
- Appendix A has links to samples of the universal transfer forms used in various states throughout the United States.

- Wendling (2009) cited the value of the electronic medical record "A standardized electronic form detailing essential patient information improved communication about transfers from a skilled nursing facility."
    - The researchers said that use of the form significantly decreased paperwork from 24 pages of information transferred per patient to 5.5 pages.
    - When the electronic form was not used, the ED received either no paperwork or used the old system of photocopying the patient's entire chart and sending it to the ED with the patient. "Implementing an Internet-based system for communication between skilled nursing facilities and EDs is feasible and significantly improves communication and the efficiency of information transfer," he said.

- Through the Regional meetings there had been a theme related to the need for a standardized process for transfer communication between facilities.
- As facilities are at different stages and phases of Electronic Medical Record (EMR) implementation, there may be value as a collaborative to develop a Universal transfer form for the state of PA, since this is a global concern.
- Many states have already completed this process and links to samples from other states can be found in Appendix A.
- The allowance of access to Electronic records for continuity of care must be considered, there have been identified obstacles, but this is an important element for the continuity of care for the patients, as well as facilitation of all the information for the care givers.

Title	Source	Description
State Action on Avoidable Rehospitalizations STAAR Initiative (Institute for Healthcare Improvement)	http://www.ihi.org/search/pages/results.aspx?sq=1&k=staar%20how%20to%20guides	This site gives access to numerous tools from the STARR program. The STAAR Initiative aims to reduce rehospitalizations by working across organizational boundaries to improve the delivery of effective care at a regional scale. The site includes the four How-to Guide books for improving transitions. These four guides include transitions from the hospital to either the community, home health, skilled nursing facilities or clinical office practices.
10 Facts Physicians Need to Know About Coaches (Quality Insights of Pennsylvania)	http://www.caretransitions.org/documents/Physicians_Need_to_Know_About_Coaches.pdf	Quality Insights of Pennsylvania (QIP) offers an informative poster for physicians related to what care transition coaches can provide.
Medicare Demonstrations: Details for Community-Based Care Transition Program (U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services)	http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313	The Community-Based Care Transitions Program (CCTP) goals are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measurable savings to the Medicare program. The demonstration is conducted under the authority of Section 3026 of the Affordable Care Act of 2010.
Aligning Forces (Robert Wood Johnson Foundation)	http://forces4quality.org www.aligning4healthpa.org	Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform. AF4Q asks the people who get care, give care and pay for care to work together toward common, fundamental objectives to lead to better care. There are 16 geographically, demographically and economically diverse communities participating in AF4Q together covering 12.5 percent of the US population. An AF4Q is active in York and Adams Counties, PA.
Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (AHRQ)	www.ahrq.gov/qual/match/match.pdf	While your facility may already have a medication reconciliation process in place, this toolkit will help you evaluate the effectiveness of the existing process, as well as identify and respond to any gaps. It promotes a successful approach to medication management and reconciliation that emphasizes standardization of the process for doctors, nurses, and pharmacists within the facility to document and confirm a patient's home medications list upon admission. It also emphasizes the need to clearly define roles and responsibilities of clinical staff.

Title	***Source***	***Description***
Transition Home Program Reduces Readmissions for Health Failure Patients (US Department of Health & Human Services, Agency for Healthcare Research and Quality)	http://innovations.ahrq.gov/content.aspx?id=2206	The Transition Home for Patients with Heart Failure program at St. Luke's Hospital in Cedar Rapids, IA, incorporates a number of components to ensure patients a safe transition to home or another health care setting. These components include enhanced assessment of post-discharge needs at admission, thorough patient and caregiver education ("teach-backs"), patient-centered communication with subsequent caregivers at handoffs, and a standardized process for post-acute care follow-up (home visit, post-discharge phone calls, and outpatient classes). The program reduced the 30-day readmission rate for heart failure patients from 14 percent to 6 percent.
Hospital to Home (H2H): Excellence in Transitions (American College of Cardiology and the Institute for Healthcare Improvement)	http://www.ihi.org/resources/Pages/OtherWebsites/HospitalToHome.aspx	Joint initiative of the American College of Cardiology and the Institute for Health care Improvement to develop a national improvement initiative. The aim of the initiative is to reduce unnecessary readmissions and improve care transitions for cardiovascular patients. The initiative has a goal to reduce all-cause readmission rates among patients discharged with HF and AMI.
Transitions of Care: The need for a more effective continuing patient care. (The Joint Commission)	http://www.jointcommission.org/hot_topics_toc/	Planned communication that defines the problems related to transitions of care as well as Evidenced-Based transitions of care models and programs. The defined problem and EB practice for this paper is: Ineffective transitions of care.
Transitions of Care: The need for collaboration across entire continuum. (The Joint Commission)	http://www.jointcommission.org/hot_topic_toc/	This communication is the second in a series related to care across the continuum. It discusses developing ways to assure safety transitions of care through collaboration among providers all along the care continuum.
Care Transitions in Action: From Hospital to Home in Two Communities (U.S. Department of Health & Human Services, Administration on Aging)	http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/AoA_ACA_CT_slides_033011.pdf	Social worker-based hospital-to-home care transitions program.
Transitions Coach (AHRQ)	http://www.innovations.ahrq.gov/content.aspx?id+1833	A Transitions Coach* encourages patients who are transferring from either a hospital or a short-term skilled nursing facility stay at home to assert a more active role in their self-care.

Title	***Source***	***Description***
Need to know about Coaches (Quality Insights of Pennsylvania)	http://www.caretransitions.org/documents/Physicains	Quality Insights of Pennsylvania also offers information for physicians about what care transition coaches can provide.
POLST-Physician Orders for Life Sustaining Treatment	http://www.polst.org	POLST is a national project with an approach to end-of-life planning based on conversations between patients, loved ones and medical providers. It is designed to ensure that seriously ill patients can choose the treatments they want and that their wishes are honored by all medical providers. Transitions teams can advocate for consistent use of advanced directives and/or POLST.
POLST – Aging Institute Collation for Quality at the End of Life (CQEL)	http://www.upmc.com/Services/AgingInstitute/partnerships-and-collaborations/Pages/polst.aspx	Various resources including teaching opportunities and videos to assist with understanding of POLST and advance care planning discussions.
TeachBack	Teach Back Module	This is a self-learning module for teach back and related competencies for staff education.
Health Literacy Kit (AMA)	http://www.ama-assn.org	The Health Literacy kit helps inform physicians, health care professionals and patient advocates about health literacy. The kit includes an instructional video and in-depth manual for clinicians. The kit can be purchased through the AMA bookstore.

ASSESSMENT TOOLS and Health Information Systems (HIS)

Assessment tools are being designed to assist continuum teams in identifying those patients most at risk for readmission prior to discharge or readmission. Health Information Systems are being researched to assist with transmission of vital statistics to allow for smooth transitions from one level to another level of care.

Title	***Source***	***Description***
INTERACT: Interventions to Reduce Acute Care Transfers	http://www.interact2.net/	The overall goal of the INTERACT program is to reduce the frequency of transfers to the acute hospital, using three basic types of tools: (1) communication tools, (2) care paths or clinical tools, and (3) advance care planning tools.
LACE (Ottawa Hospital Research Institute, Institute for Clinical Evaluation Sciences, University of Toronto, University of Ottawa and University of Calgary)	http://www.cmaj.ca/content/182/6/551 (original study) http://www.iha.org/pdfs_documents/news_events/Breakout%20Session%202B%20-%20Richard%20Fraioli,%20John%20Muir.pdf (PDF explaining use of LACE)	The LACE index was developed to help quantify the risk of early death or unplanned readmission after discharge from hospital to the community and can be useful in focusing post-discharge support on patients at highest risk of poor outcomes. Key factors associated with these events are length of stay ("L"), acuity of admission ("A"), patient comorbidity ("C") and number of visits to the emergency room ("E"). Called the LACE index for easy recall, the index has a potential score of 0 to 19. While easy to use, the system will be difficult to memorize and will need a computational aid.
Statistical Tool Helps Cut Heart Failure Readmissions	http://sciencebusiness.technewslit.com/?p=13140	The Intermountain Heart Institute in Murray, UT, developed a statistical index that evaluates a cardiac patient's condition and calculates the risk of readmission within 30 days. The index gives physicians an effective, real-time tool to help ensure patients are in a healthy position for discharge.
HealthCare Partners: Medical Group and Affiliated Physicians	http://www.healthcarepartners.com/	Uses risk assessment to stratify patients and match to four levels of programs; special programs for frail patients.
Transforming Care at the Bedside (IHI)	http://www.ihi.org/IHI/programs	Admission assessment for post-discharge needs; teaching and learning; early post-acute care follow-up; patient and family-centered handoff communication.

Title	***Source***	***Description***
Readmission Checklist	Reducing Readmissions Top Ten Checklist	This checklist provides the top ten evidenced based practices as related to reducing readmissions.
Delivering big-picture insights across the care continuum. (Daniel Newman)	http://www.hiewatch.com/perspective/delivering-big-picture-insights-across-care-continuum	Article designed to discuss the importance of using electronic health sharing to improve care across the care-continuum.

PERTINENT JOURNAL ARTICLES

GENERAL

Readmission Penalties: RNs to the Rescue

Financial incentives offered by reducing readmissions could offset the cost of hiring more nurses. Investing in nurse staffing benefits all patients because not only would there be gains in readmission reductions, but also in hospital-acquired infections and fewer complications. Nurses will have to provide more of these services, so we need to make sure the workforce is keeping pace with the demands of care. Access to the article.

Simple Rules That Reduce Hospital Readmission

To overcome system failures, health care organizations must implement a few simple rules of complex adaptive systems. Kaiser Permanente Southern California's program to reduce hospital readmissions is an example of a program design that meets the principles of complex adaptive systems and enumerates five rules, which must be followed if a health system is to create value for their stakeholders. Access to the article.

Sustaining Change Checklist

This checklist identifies factors that play an important role in helping teams sustain the changes of their performance improvement projects. The more factors you include in your project plan, the more likely it will be that your team will be able to sustain its change over time. Use these questions to spark discussion.
Access to the article.

Reducing Hospital Readmissions through Stakeholder Collaboration

The Northeast Business Group on Health convened stakeholders to discuss opportunities and challenges in implementing readmission avoidance programs and the roles that the various stakeholders—health plans, hospitals, suppliers, employers and patients – play in the success of these programs. This work and its findings are included in this solutions centers project.
Access to the article.

Predictors of Excess Heart Failure Readmissions: Implications for Nursing Practice

In this study of California, Massachusetts, and New York hospitals, 6 factors predicted 27.6% of readmissions for patients with heart failure (HF). We found that higher admissions per bed, teaching hospitals, and poor nurse-patient communication increased HF readmissions. Conversely, the HF readmissions were lower when nurse staffing was greater, more patients reported receiving discharge information, and among hospitals in California. The implications for nursing practice in the delivery of care to patients with HF are discussed. Access to the article.

ASSESSMENTS

Why Cedars-Sinai Screens All Inpatient Adults for Depression

Risk factors that can adversely affect a patient's recovery or trigger a hospital readmission include behavioral issues. The chair of the Cedars-Sinai Department of Psychiatry discusses how screening for depression will become more widespread as hospitals adopt value-based reimbursement models. Access to the article.

END OF LIFE – PALLIATIVE CARE

How Hospital Palliative Care Programs Drive Value

Turner West, director of Education and Community Programs at Lexington, KY-based Hospice of the Bluegrass, discusses how palliative care can drive value at hospitals in areas such as readmissions, mortality, and patient satisfaction. Access to this article.

Palliative Care Should Start With the Diagnosis

It's clear that costs associated with end-of-life care are significant—estimates suggest approximately one out of every four Medicare dollars is spent on services for beneficiaries in their last year of life. But the real focus should be on early empowerment of patients and their families with information on their options. If this is done well, the rest will follow.
Access to this article.

Improving Your AIM: Better care for the most seriously ill patients boosts quality and reduces costs

Better advanced illness management, palliative care and end-of-life care boost quality and reduce health care costs. As hospitals grapple with health reform initiatives and new reimbursement models, a quiet revolution in advanced illness management has taken root within their walls.
Access to this article.

MEDICATION MANAGEMENT

Avoidable Readmissions and ambulatory pharmacies

Ambulatory pharmacies can help improve outcomes and patient satisfaction, increase revenue, and decrease readmissions. They extend the hospital's reach into the community and extend the continuum of care. Hospital-based ambulatory pharmacies have taken hold and are gaining momentum. A recent survey found that 34% of hospitals already operate an ambulatory pharmacy and 48% of larger urban hospitals do so. More than half of hospitals with an ambulatory pharmacy (58%) plan to expand their ambulatory pharmacy offerings.
Access to the article.

Extending the Role of the Pharmacist in Preventing Hospital Readmissions

Duke Clinical Research Institute presentation on how the community pharmacist might become more engaged in improving the transition from hospital to home and in reducing risks. Access to the article.

Multidisciplinary Medication Reconciliation process

Hennepin County Medical Center implemented a multidisciplinary medication reconciliation process for patients discharged to skilled nursing facilities, with the goal of ensuring that multiple reviews occur in a timely manner. As part of each discharge order, the physician writes medication orders and performs the initial medication reconciliation within 4 hours of a nursing home bed becoming available. A clinical coordinator and pharmacist then review the order, with the pharmacist meeting with the physician if needed to resolve discrepancies. As a final check, the bedside nurse reviews the orders and communicates pertinent information to the nursing home. The program virtually eliminated medication errors and reduced readmissions by nearly one-half, leading to significant cost savings.
Access to the innovation summary.

Low-risk patients three times less likely to be admitted to hospital in medication therapy management (MTM) study of home-health patients

Low-risk Medicare patients entering home health care who received medication therapy management by phone were three times less likely to be hospitalized within the next two months, while those at greater risk saw no benefit, according to a study led by Purdue University. The study helped determine which patients benefit most from medication therapy management by phone and a way to identify them through a standardized risk score. Access to the article.

PATIENT AND FAMILY ENGAGEMENT

PA-HEN/HAP Patient and Family Centered Care Guidebook

This guidebook explains how to incorporate patient and family centered care as a key element in improving quality, safety, perception of care and care outcomes. It includes best practices and case studies from both the national level and in Pennsylvania hospitals.

Tool integrates family caregivers into the hospital discharge plan

The Project RED (Re-Engineered Discharge) toolkit has added a tool to help hospitals integrate family caregivers into the discharge plan so they can be partners in improving transitions and reducing readmissions. The new toolkit chapter structures the process of working with family caregivers into five steps: identifying the family caregiver; assessing the family caregiver's needs; integrating the family caregiver's needs into the after-hospital care plan; sharing family caregiver information with the next setting of care; and providing telephone reinforcement of the discharge plan. Developed by researchers at Boston University Medical Center, the toolkit includes a set of 12 actions hospitals can implement to ensure effective transition at discharge. The new chapter was developed in collaboration with the United Hospital Fund. The project is supported by grants from the Agency for Healthcare Research and Quality and the National Heart, Lung and Blood Institute.

Patient and Family Engagement: Readmission Prevention Planning

Access to the article.

Reduce Readmissions by Activating Patients to Do 'Self-Care'

The push is on to target patients who need help with self-care, which is key to lowering hospital readmission rates. A tool to measure "patient activation" offers health care providers a way to look beyond the bedside to assist patients.
Access to the article.

TRANSITION OF CARE

Hospital Admits, LOS Cut with Home Care

An advanced illness management program for home-bound patients successfully reduced hospital admissions and lengths of stay, even though illnesses increased**.**
Access to the article.

Extra doctor visit may help prevent rehospitalization of kidney failure patients

Among kidney failure patients on dialysis who were treated in the hospital, one additional doctor visit in the month following hospital discharge was estimated to reduce the probability of 30-day hospital **readmission** by 3.5 percent. Seeing kidney failure patients one additional time in the month following discharge could save $240 million in health care costs each year. Access to the article.

Could food bags help reduce hospital readmissions?

Elderly hospital patients who have no one to care for them are being given food bags containing basic provisions to help them cope after they have been discharged. Staff at Chesterfield Royal hope that the scheme will help cut down the number of people who end up back on the wards within weeks of leaving.
Access to the video.

Home-Based, Low-Cost Strategies for Improving Adherence and Preventing Readmissions among Heart Failure Patients

Patients spend far more time in the home than with their health care providers, making the home an ideal and perhaps essential place to improve adherence and outcomes. Two studies presented at the American Medical Association Scientific Sessions focused on home-based strategies for care improvements in heart failure (HF). Access to the article.

N.Y. Hospitals, Nursing Facilities Utilize Innovative Strategies to Reduce Readmissions

New York hospitals and long-term care facilities are finding innovative ways to reduce hospital readmissions from nursing homes. Access to the article.

AHRQ Review of Readmissions Interventions Finds Mixed Results

An AHRQ review finds that telephone support interventions such as telemonitoring and providing education only do not appear to reduce all-cause readmissions. However, home-visits and multicomponent interventions may be effective in preventing readmissions after heart failure. The results of the review were publish in the Annals of Internal Medicine on May 27. Access to the article.

Access to the full AHRQ evidence report.

The Shift from Hand-Off to Hand-Over: How University of Iowa is Lowering Readmissions

Access to the article.

Care Transitions program best in country at reducing hospital readmissions

For the most recent reporting quarter, the Community-based Care Transitions Program (CCTP) in southwestern Ohio has been selected as the country`s top performer in helping hospitalized seniors avoid readmission to the hospital after they return home. Patients who participate in the region`s care transitions program are less likely to be readmitted to the hospital during the most recent reporting quarter than patients participating in similar programs elsewhere. Access to the article.

Alameda County pilot program decreases hospital readmission for HIV/AIDS patients

Pilot program tasked with providing higher-quality care to HIV and AIDS patients in Alameda County has reduced hospital readmission rates at one hospital in Oakland. The program — patient-centered medical homes, or PCMH — is not a physical space but a health care system that aims to reorganize primary care within a model that centers on individual needs. The new system has been piloted at five Bay Area medical centers, including LifeLong Medical Care in Berkeley. Access to the article.

Reducing Readmissions through Better Care Transitions

With the financial consequences associated with hospital readmissions gradually mounting, providers are focusing on improving transitions from inpatient to outpatient status. Access to the article.

Building Dynamic Post-Acute Partnerships to Reduce Readmissions

The secret is out: post-acute partnerships are an invaluable part of any hospital's readmission reduction strategy.

Access to the article.

Follow-up program at UNC Hospitals clinic reduces readmissions by 65 percent

Study evaluated a new program created by the Internal Medicine Clinic at UNC Hospitals for patients that have recently been discharged from the hospital. The program includes identification of patients that have been discharged, a process for contacting patients after hospital discharge, and standardization of the hospital follow-up appointment content. The hospital follow-up appointments are with a clinical pharmacist practitioner and a physician.

Access to the article.

Diabetics + patient navigators improved blood glucose control by 32% in Cleveland Clinic pilot

Diabetes patients at one of the Cleveland Clinic's health centers improved their blood glucose control by 32 percent and cut their no-show appointment rate in half after working with patient navigators for a year.

Access to the article.

Partnership for Patients improvement in 6 states

This is an article about the success of the Partnership for Patients in 6 states. Access to this article.

Medical Respite Helps the Homeless

Studies have found that homeless patients discharged to a medical respite program experienced 50% fewer hospital re-admissions at 90 days and 12 months than patients discharged to their own care. The demonstrated savings for hospitals across the United States that partner with medical respite programs is in the millions of dollars. Grant funded to support a medical respite program to serve homeless people too ill or frail to recover from illness or injury on the streets, but not sick enough to be hospitalized. Designed to be short-term and recuperative, respite allows for the continuation of hospital recommendations and recovery in a safe environment.
Access to this article.

Hospital Admits, LOS Cut with Home Care

An advanced illness management program for home-bound patients successfully reduced hospital admissions and lengths of stay, even though illnesses increased**.**
Access to the article.

Transfer forms:

Dalawari P., Duggan J., Vangimalla V., Paniagua M., & Armbrecht E.S., (2011). Patient transfer forms enhance key information between nursing homes and emergency department. Geriatric Nursing 32(4):370-375.

Wendling,P. (2009). Electronic transfer form improves patient handoffs. American College of Emergency Physicians.

Risk Assessment:

Access to Risk Prediction Models for Hospital Readmission: A Systematic Review.

Access to articles related to Risk Assessment Guides

Other Websites:

Access to JAMA website and articles.

PENNSYLVANIA CASE STUDIES

A Pennsylvania Promising Practice

Cole Memorial Hospital

Bonnie Kratzer, RN Director of Care Transitions

Project Description – Cole Memorial Hospital set out to build a team that would enhance care transitions and reduce or eliminate unplanned 30 day readmissions. This improved care transition would not only decrease readmissions but increase care coordination, quality of patient care transitions, patient education and patient satisfaction. The team would also allow for improved collaboration with other entities in the local region involved in patient care and experience.

Key Strategies –

- In mid-2011, the hospital embarked on a plan to meet with community partners, approaching transitions in a more global fashion. Those invited included:
    - Cole Memorial Hospital CEO and CNE
    - Care Managers
    - Pharmacists
    - Office of Aging
    - Home Health
    - Hospice
    - Physician Office Practices
    - DME Companies
    - Long Term Care Facilities in the Service Area
    - Inpatient Behavioral Health
    - Personal Care Home Administrators
    - Cole Memorial Hospital Directors and Managers
- Kick off meeting was held July 2011
    - Meet and greet included 30 members
    - Brief overview of transitions
    - Speaker from a hospital with a successful community hospital transition team
    - Meeting feedback of interest and next steps
- Second Care Transitions Meeting held August 2011
    - Meet and greet
    - Brainstorming session …. What are our most important issues?
    - Created minutes and sent out information for their input on the three top issues.
    - Created listserve and distributed to all members
- Top 3 Areas at the start of the project
    - Patient Transfer form
    - Medication awareness/compliance
    - Chronic care issues

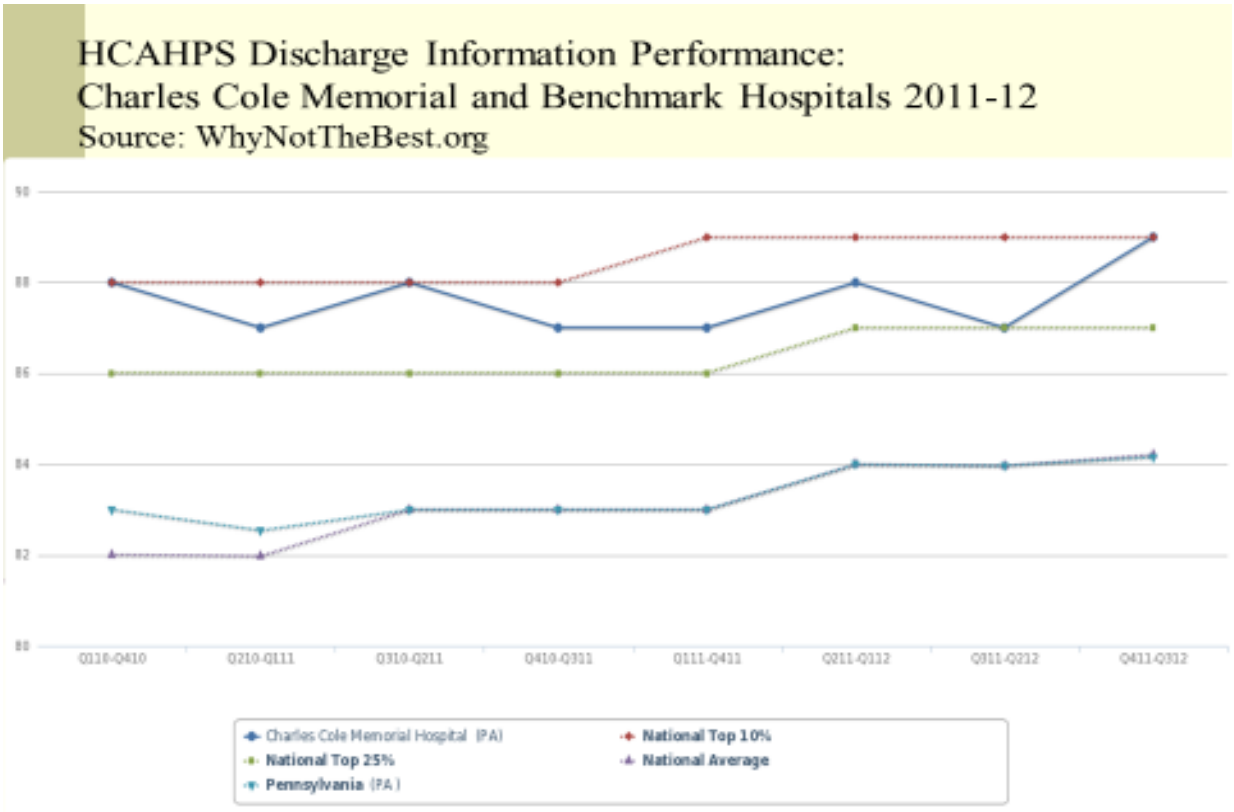
- Meetings continue monthly
- Members are asked to share their stories at meetings – one per month with 10 minutes to explain their facility and services
- Data is shared via email
- Feedback is elicited after each meeting
- Report out findings at each meeting
- Continue to encourage brainstorming and sharing
- **Team members have evolved over time as different areas of concern are 'uncovered'**

Accomplishments –

- Transfer completed and all entities on team are using form (see Appendix A)
- Quality tracking
- New system for completion of Medication Reconciliation within Cole Memorial Hospital
- Development of Care Plans for selected chronic conditions
- Awarded HAP Achievement Award for reduction of rehospitalizations
- Invited to speak in Seattle, Washington for the Partnership for Patients National Content Developer
- Use of 'Direct Connect' as a secure email system
- Achievement of a grant with the help of the Area Agency for Aging to supply medical calendars and medication boxes
- New bus routes to assist with transportation of seniors
- Subcommittee for POLST implementation
- Universal education for all providers
- Invited to assist other hospitals in setting up transition teams.
- Created a 2 minute video for the Robert Wood Johnson foundation on care transitions.
- Increased collaboration and interaction with team members throughout the region.
- Decreased readmission rates and increased HCAHPS scores (see below).

Outcomes –

- **Reduced readmission rates by 15.2% on self-reported data since start of transition team**
- **Readmission rate is 35% lower than PA-HEN 2011 baseline**
- **Improved HCAHPS scores**



Lessons Learned –

1. Outcomes are much improved working together on a project.
2. "JUST DO IT" - Jump into transitions no matter how large or small a hospital you are. You are bound to make an improvement in safety for your patient.
3. Working TOGETHER is much easier than working alone!
4. The community of caregivers is one team for the patient not separate teams.

Appendix B – Universal Transfer Form

A Pennsylvania Promising Practice

UPMC St. Margaret

Rod Rutkowski, MSW, LSW, Director of Social Work

Project Description – After study of the service area for St. Margaret it was determined that there were several factors that reflected a need to have better coordinated care with local skilled nursing facilities. These included that there are 30 skilled nursing facilities in our service area, we utilize 85 different skilled nursing facilities for continued care and on a yearly basis, the hospital averages over 2,400 skilled nursing facility transfers or approximately 19% of total discharges. Review of these numbers showed that we needed to develop collaboration to improve transitions of care for our patients. These collaborations can have major effects on such areas as medication errors, quality of care, patient satisfaction, and unplanned hospital readmissions. Beginning in 2005, UPMC St. Margaret focused on an initiative with three community Skilled Nursing Facilities designed to enhance relationships and improve communication and sharing of clinical information.

Key Strategies –

- The process of transferring patients from UPMC St. Margaret to the Skilled Nursing Facility.
- The process of transferring patients from the Skilled Nursing Facility to UPMC St. Margaret and Emergency Department.
- Enhancing the relationship and communication between UPMC St. Margaret and the Skilled Nursing Facility.

Steps taken for action-

- Met with key members of the hospital staff who were involved with discharge planning process.
- Evaluated the workflow to transfer a patient.
- Identified areas of concern and opportunities for improvement with the process
- Met with the Administrators, Directors of Nursing, and Admission Coordinators from the Skilled Nursing Facilities.
- Identified areas of concern and opportunities for improvement with the process in addition to their relationship with UPMC St. Margaret.

What we learned from the hospital staff –

- Transfer forms for clinical information existed for over 20 years without any revisions.
- These forms were developed with no input from the Skilled Nursing Facilities.
- Information on advance care planning was not being communicated to the Skilled Nursing Facilities.
- There was no standardized process for communication between the hospital and Skilled Nursing Facilities.
- Limited knowledge of what clinical information was needed by the receiving facility to provide continued care.
- Inconsistent information was received in the Emergency Department for patients transferring from Skilled Nursing Facilities with basic information often missing.

- Misunderstanding of the scope of Skilled Nursing Facility services and the care that can be provided in that setting.
- "Us versus Them" culture existed with both facilities operating in a silo" with limited interaction.

What we learned from the Skilled Nursing Facility Staff –

- There was an impression that the hospital had all the control in the discharge planning process.
- "Us versus them" culture existed with both facilities operating in a "silo" with limited interaction.
- Lack of direct communication with the hospital staff.
- The Skilled Nursing Facilities did not always receive the clinical information needed to provide care in a timely manner.
- Difficulty obtaining answers to questions related to patient care once the patient arrived in the facility.

Steps taken after gap analysis –

- Within the hospital, a Care Transitions Committee was formed with representation from the medical and health professional staff to address the identified issues and develop strategies for process improvement.
    - This committee also included representation from the Skilled Nursing Facilities.
- Within the Skilled Nursing Facilities, a Care Transitions Committee was formed to address the identified issues and develop strategies for process improvement.
    - These committees also included representation from the hospital's Care Management Department.
- The initial focus of the Care Transitions Committees was to ensure that the next level of care received the clinical information needed to meet the needs of the patient.
- Through the collaborative efforts, three areas of focus were identified:
    - Information needed to decide if the referred patient met criteria for Skilled Nursing Facility admission.
    - Information that should be sent on transfer with the patient to ensure a safe and smooth transition.
    - Medications and equipment needed upon arrival at the Skilled Nursing Facility.

Successes:

- **Transfer forms and orders**
    - Revised transfer forms for physician orders and medication reconciliation.
    - Revisions were made based on feedback received from the Skilled Nursing Facilities on the clinical information needed to best provide care.
    - A Clinical Summary along with a "lean medical record" are now electronically sent to the facility at the time of transfer.
    - The medication orders and Schedule II prescriptions are faxed to the Skilled Nursing Facility on the morning of transfer to ensure that medications will be available for the patient upon arrival.
    - Contact numbers for nursing and the hospital staff are included in the Clinical Summary.
    - Worked with Skilled Nursing Facilities to develop a standardized transfer form and procedure for patients being sent to the emergency Department.

    - This form incorporated clinical information that the Emergency Department staff felt was needed to best provide care.
    - Transfer form now includes telephone numbers to contact at the Skilled Nursing Facilities for additional questions.
- **Nurse to Nurse Verbal Report**
    - Developed a standardized procedure and form to ensure direct communication between nurses at the hospital and the Skilled Nursing Facility.
    - This form is generated electronically from the hospital's electronic health record.
    - During the report, nurses are able to ask questions related to the patient's care and to clarify orders.
    - Telephone numbers are provided for both the Hospital and Skilled Nursing Facility should additional questions occur following the transfer of the patient.
    - Established a process in which the Skilled Nursing Facility nurse calls verbal report to the triage nurse in the Emergency Department for patients being sent for treatment.
- **Electronic Health Record**
    - Established access to the Hospital's Electronic Health Record at local Skilled Nursing Facilities for patients transitioning to that facility.
    - Trained the Skilled Nursing Facility staff on how to access clinical information in the Health Record.
    - Worked with one Skilled Nursing Facility to establish access to their electronic records by the Emergency Department.
- **POLST**
    - Created a policy and procedure at UPMC St. Margaret in which the POLST (Physician Orders for Life Sustaining Treatment) is completed for patients transferring to all Skilled Nursing Facilities.
    - This process ensures that the patient's preferences for end of life care are respected.
    - Provided education on the POLST to the Skilled Nursing Facilities.
    - Assisted the Skilled Nursing Facilities in establishing policies and procedures for the use of the POLST in their facilities.
    - Continued to provide ongoing education and training on the POLST at the Skilled Nursing Facilities.
- **Key Contacts**
    - Established a key contact person at the Hospital and at the Skilled Nursing Facilities.
    - This provides a point person at each facility to immediately address issues and concerns as they arise.
    - Contact has been maintained in person, by telephone or via email.
    - Meetings have also been set up (monthly or quarterly) with the key contacts to discuss transfers, services provided and to review readmission data.
- **Care Transition Meetings**
    - Monthly meetings held at the Hospital.
    - Interest in the meetings continues to grow.
    - Currently there are over 30 Skilled Nursing Facilities represented at the meetings.
- **Skilled Nursing Facility Visits**
    - Regular visits are made to the local Skilled Nursing Facilities by Hospital Administration and Care Management.

- Meet with the Management Team at the Skilled Nursing Facility in addition to key members of their clinical staff.
- Tour the Facilities and review services provided.
- Discuss the transition of patients and obtain feedback on “how we are doing.”
- Understand issues that impact the delivery of care and how the Hospital can help with these issues.
- Review the Skilled Nursing Facilities Process Improvement Initiatives.

- **Skilled Nursing Facility Breakfast**
  - Ninth annual breakfast held in March 2013 with over 100 people in attendance.
  - Opportunity for the Hospital to thank the staff at the Skilled Nursing Facilities for their work and effort to provide quality care for the patients.
  - Networking opportunity for the Skilled Nursing Facility staff to meet and interact with the Administrative and Care Management staff at the Hospital.
  - The program format includes welcoming remarks by the President of the Hospital, introduction of the Administrative and Care Management staff, a short presentation focusing on hospital and Skilled Nursing Facility collaboration and door prizes.
- **Hospital Social Workers Orienting at Skilled Nursing Facility**
  - All newly hired Social Workers spend a full day of orientation at our Health System’s Skilled Nursing Facility.
  - Orientation includes tour of facility, meeting with the Administrator and Admission Coordinator, reviewing the role of the Skilled Nursing Facility Case Manager and Social Worker, attending patient care conferences.
  - Experience the admission process on the day of transfer from the perspective of the patient.
  - Learn how the discharge planning process at the hospital impacts the care of the patient upon entering a facility.
  - Discuss potential barriers to smooth transition.
- **Speaker’s Bureau**
  - **Educational presentations that are offered to facilities by hospital staff.**
  - **All programs are free of charge with Nursing CEU’s provided.**
  - **Topics include:**
    - Advance Care Planning
    - POLST
    - Management of COPD and CHF
    - Care of the Patient with Dementia
    - Infection Control
    - Geriatric Fractures
  - **Coordinating Transition Together Program**
    - Continuing Education Program held the last three years for Skilled Nursing Facility staff.
    - Offers 5 CEU’s for Nursing Home Administrators, Nurses and Social Workers.
    - Registration has reached 150, with over 35 different Skilled Nursing Facilities represented.
    - Speakers are physicians and health care professionals working in the Acute Care Hospital or Skilled Nursing Facility.
    - Topics presented have been identified based on input received from the Skilled Nursing Facilities.

- Presentations focus on quality care and prevention of unplanned readmissions.

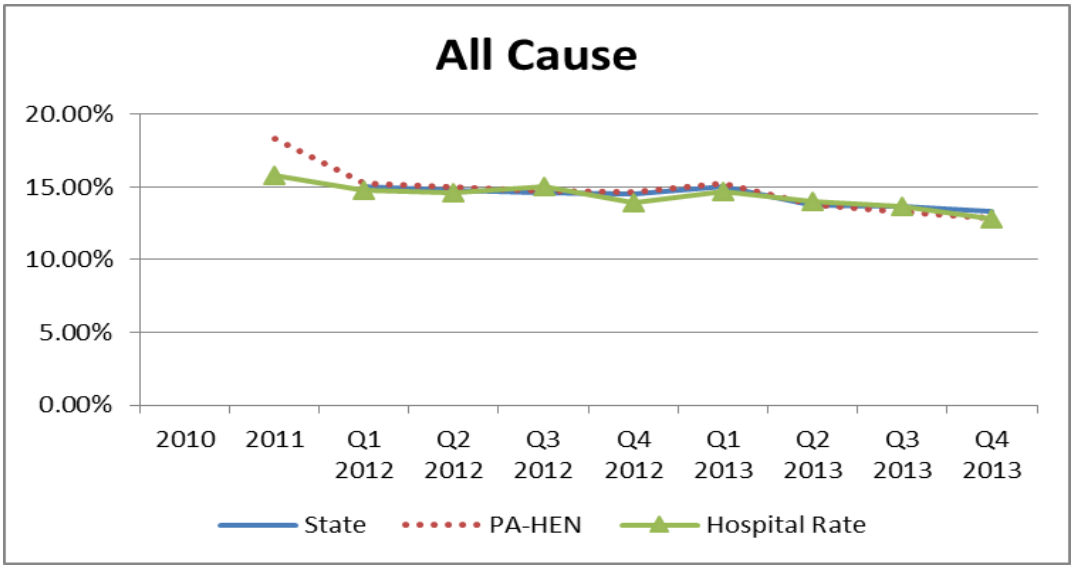
- **INTERACT**
  - Committee established with five Skilled Nursing Facilities
  - Goals of the Committee are to identify strategies to reduce unplanned readmissions by implementing communication tools, advance care planning and care paths.
  - Discuss strategies and experiences with the implementation of communication tools such as Stop 'N' Watch and SBAR.
  - Discuss issues associated with the use of the POLST
  - Care plans reviewed and developed for CHF and UTI.
  - Developed a Quality Improvement Tool for clinical chart reviews to identify factors that led to readmissions.
  - Both the Hospital and Skilled Nursing Facilities use this tool to complete a chart audit for all readmissions.
  - Audits are then reviewed between the Hospital and Skilled Nursing Facility to discuss if the admission could have been prevented.
  - Discuss additional strategies on how the hospital and skilled nursing facilities can work together to prevent future readmissions and improve the care for the patient.

Goals of the Care Transition Meetings

- Provide updates on hospital programs and services.
- Address issues that are impacting the care and transition of patients.
- Complete an annual survey on the Skilled Nursing Facilities satisfaction with the Hospital discharge planning process.
- Obtain feedback from the Skilled Nursing Facilities on issues impacting care and work to identify opportunities to effectively address these concerns and issues.
- Discuss ways in which the Hospital and Skilled Nursing Facilities can collaboratively work together on education and training.

Outcomes –

- **Readmission reduction of 30% from PA-HEN wide 2011 baseline**



Lessons Learned –

- Administrative support is crucial to the success of Care Transitions.
- It takes time to build and maintain collaborative relationships with skilled nursing facilities.
- Establishing a key contact person at the hospital and the skilled nursing facility is essential for effective communication and for building positive relationships.
- There is often a high turnover rate of key staff members of the skilled nursing facilities. Therefore, ongoing education of staff on the program is essential.
- A successful Care Transitions program can be implemented by incorporating responsibilities into the daily work of the staff.

A Pennsylvania Promising Practice

Nazareth Hospital

Elaina Kim Watts RN, BSN, MHA, CCM, Director Case Management

Project Description – In response to a Hospital & Health System Association of Pennsylvania readmission reduction initiative, the NorthEast Cross Continuum Team (NECCT) was formed in July 2013. The initial goal was the development of a partnership between Nazareth Hospital, and several area care providers. The cross continuum team is a multi-stakeholder team with representatives from eight skilled care facilities as well as other community resource providers.

NECCT Partnership Members:

- Deer Meadows Nursing Home and Retirement Community
- Elkin's Crest Health and Rehabilitation Extendicare
- Immaculate Mary Nursing Home
- Manor Care Huntingdon Valley
- Mercy Home Health Care and Mercy Life
- Nazareth Hospital
- Pauls' Run Liberty Lutheran
- Saint John Neumann Nursing Home
- Wesley Enhanced Living Pennypack Park

Mission

- The NorthEast Cross Continuum team's mission is to "Provide quality health care options across the continuum that prevent avoidable readmissions and maximize patient wellness".

Key Strategies –

- Our first year goal was the enhancement of coordination and communication between our hospital and local care facilities, to reduce unnecessary readmissions of patients to the acute care setting.
- A Patient ED Transfer Envelope was developed by the team (attached) in cooperation with the director of Emergency Medicine to streamline information provided to the ED physicians and ensure care capabilities were known for patient return.

Outcomes –

- Avoidable admissions or readmissions are from short-term-stay skilled nursing facilities or long-term care facilities, from assisted living residences or rehabilitation facilities have decreased.

- Readmission reduction in 2014 has varied but ranges from between 30% - 50% reduction.

Lessons Learned –

- Face-to-face meetings improve collaboration and team work both at the meetings and beyond.
- Readmission reduction takes the ‘whole’ team to be involved.
- Start with small aims and celebrate all accomplishments.

Appendix C

- Acute Care Transition Form

Appendix A

Universal Transfer Forms
Samples

A. New Jersey
   http://www.state.nj.us/health/ems/documents/univ_patient_transfer_form_qa.pdf
B. Minnesota
   http://www.mnhospitals.org/Portals/0/Documents/ptsafety/stoc/patient-transfer-form-baudette.doc
C. Florida
   http://www.agingresources.org/wp-content/uploads/2012/01/3008-form.pdf
D. Iowa
   http://www.idph.state.ia.us/ems/common/pdf/transfer_rpt.pdf

Appendix B

PATIENT TRANSFER RECORD

Page 1 of 2

Transfer Date: _____ **Transferring From:** _____ **Transferring To:** _____

Name:_____ Age:_____ Attending Physician:_____	
Current Diagnosis or Signs/Symptoms:_____	
Allergies:_____	
Reason for Transfer:_____	
Current Level of Care: ❑ Skilled Nursing ❑ From Home ❑ From Home with Home Health ❑ Personal Care / Assisted Living ❑ Critical ❑ Acute ❑ Tertiary ❑ ED ❑ MedSurg ❑ ICU ❑ IBH	
Family or S/O Notified:	❑ Yes ❑ No Name:_____ Relationship:_____ Phone Number:_____
Code Status:	❑ DNR ❑ DNI ❑ Full Code ❑ Other_____ ❑ Unknown
Isolation Precautions:	❑ Yes ❑ No ❑ Current ❑ Hx of Site:_____ ❑ MRSA ❑ VRE ❑ C-Diff ❑ Other:_____ ❑ Unknown ❑ MDRO Type of precautions: ❑ Contact ❑ Airborne ❑ Droplet ❑ Protective
Vital Signs:	Time:_____ Last Blood Glucose_____(if patient is diabetic) B/P:_____ P:_____ R:_____ T:_____ Pulse Ox:_____ Height_____Weight:_____ Oxygen __liters via_____ Current Pain Level & Location_____ Time Last Pain Med Given_____Alternatives to pain medication_____
At Risk Alerts:	❑ Fall ❑ Harm to Self ❑ Harm to Others ❑ Seizure ❑ Elopement ❑ Aspiration ❑ Restraints ❑ Impaired Safety Awareness ❑ Skin Breakdown – Braden Score:_____ ❑ Restricted Limb_____ ❑ Pacemaker ❑ Other:_____ ❑ Unknown
Mental Status:	Baseline:_____ Current:_____ Time of Onset:_____ ❑ Alert Oriented to (❑ Person ❑ Place ❑ Time) ❑ Confused ❑ Forgetful ❑ Wanders ❑ Depressed ❑ Agitated ❑ Dementia ❑ Delirium ❑ Semi-comatose ❑ Comatose ❑ Other: _____ ❑ Unknown
Vision:	❑ Good ❑ Poor ❑ Blind ❑ Adequate with corrective lenses ❑ Cataracts ❑ Glaucoma ❑ Other _____ ❑ Unknown
Hearing:	❑ Good ❑ Poor in right ❑ Poor in Left ❑ Deaf ❑ Adequate with hearing aid ❑ Other _____ ❑ Hearing Aides: ❑ Remain at facility ❑ Unknown
Communication:	❑ Clear ❑ Slurred ❑ Difficulty ❑ Aphasic ❑ Trach ❑ Barriers to Learning_____ ❑ Speaks English ❑ Reads English Other:_____ ❑ Speaks ❑ Reads ❑ Need Interpreter ❑ Sign Language
Activity Level:	❑ Ambulatory alone ❑ Assist w/one ❑ Assist w/ two ❑ Bedrest ❑ Wheelchair ❑ Walker ❑ Cane ❑ Gerichair ❑ Crutches ❑ Unknown ❑Other:_____ ❑ Amputation: ❑ Right ❑ Left ❑ Prosthesis type: _____ ❑ Sent with resident ❑ Remain at facility
IV Access:	❑ Central Line ❑ PICC ❑ Mediport ❑ Other:_____❑ Insertion Date_____ Dressing Change Date_____

Form # 700126-11/23/11
Revised: 1/10/12
Patient Sticker

COLE Memorial

PTTRANS

Diet:	Type of Diet: ❑ Regular ❑ Mechanical Soft ❑ Pureed ❑ Other:_____ Diet Restrictions: ❑ Cardiac ❑ Renal ❑ Diabetic ❑ Other_____ Aspiration Precautions: ❑ Thin Liquids ❑ Thickened Liquids ❑ Consistency_____ ❑ NPO Feeding Requirement: ❑ Independent ❑ Needs assistance ❑ Dependent ❑ G Tube ❑ NG Tube ❑ TPN Appetite: ❑ Good ❑ Fair ❑ Poor
Elimination:	Bowel: ❑ Continent ❑ Incontinent ❑ Ostomy Last BM: _____ ❑ Regular ❑ Constipation ❑ Loose stools ❑ Diarrhea ❑ Frequent laxatives ❑ Enemas ❑ Suppositories ❑ Unknown Bladder: ❑ Continent ❑ Incontinent ❑ Urostomy ❑ Unknown ❑ Catheter type:_____ Size:_____ Date inserted:_____ Needs Assistance for: ❑ Bowel ❑ Bladder ❑ Unknown
Hygiene:	Grooming: ❑ Independent ❑ Needs assistance of _____ ❑ Total Care ❑ Unknown ❑ Bed bath ❑ Tub bath ❑ Shower ❑ Whirlpool ❑ Other:_____ Oral Care: ❑ Own teeth ❑ Dentures ❑ Edentulous ❑ Needs assistance ❑ Total Care ❑ Unknown
Sleep Pattern:	❑ Sleeps at night ❑Naps during day ❑ Sleeps poorly, awakens frequently ❑ Unknown ❑ Requires HS meds for sleep (specify) _____ ❑Sleep Location_____
Skin Condition:	❑ Intact ❑ Good turgor ❑ Dry ❑ Fragile ❑ Reddened areas ❑ Skin tears ❑ Abrasions ❑ Bruises ❑ Sutures/Staples ❑ Unknown ❑ Pressure Ulcer: ❑ Stage I ❑ Stage II ❑ Stage III ❑ Stage IV ❑ SDTI ❑ Unstageable Location:_____
Treatments received in last 14 days:	❑ Chemotherapy ❑ Dialysis ❑ IV medication ❑ Oxygen ❑ Transfusions ❑ Radiation ❑ Ventilator ❑ Tracheotomy Care ❑ Suctioning ❑ Wound Vac ❑ Unknown
Items sent with Patient:	❑ Glasses ❑ Hearing Aid ❑ Cane ❑ Crutches ❑ Walker ❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Prosthesis: ❑ Right ❑ Left ❑ Other:_____
Copies of Forms in Packet:	❑ Advance Directive/POLST ❑ Copy of Bed Hold Form ❑ Last H & P ❑ Wound Sheet (if applicable) ❑ Face Sheet ❑ Current MARs ❑ AED Report ❑ Diagnosis List ❑ Current Treatment Sheets ❑ Physician Orders ❑ Recent Labs ❑ EKGs ❑ Radiology Reports ❑ Procedure Reports ❑ Discharge Summary ❑ Face to Face ❑ Other_____ ❑ Prescriptions for Nursing Home ❑ Immunization Records Influenza given:_____ Pneumovax given:_____ TST (PPD) given:_____ Result:_____
Situation/ Background & Special Considerations:	
Next Appointment with PCP	**Provider**_____ **Date**_____ **Time**_____

Unit:_____ Phone Number:_____ Fax Number:_____

Transferring Nurse:_____ Alternate Nurse Contact:_____

Report Called To:_____ Time:_____

Transported By:_____ Time of Departure:_____

For further information, please call. Copy of this form faxed to provider Date:_____Time:_____

PTTRANS

COLE Memorial

Appendix C

FACILITY NAME:
ADDRESS:
TELEPHONE NUMBER:

ACUTE CARE TRANSFER FORM

Resident	**Information**	**Comments**
Name		
Next of Kin		
Telephone Number		
POA		
Telephone Number		
Current Code Status		
Attending Physician and Telephone Number		
Primary Physician and Telephone Number		
PROBLEMS		
Symptoms		
Interventions		
Intervention Outcome		
Pertinent History (as relates to the current situation)		
Facility Capabilities (as relates to the current situation)		
IV Fluids Limits		
IV Medications Exceptions		
Oxygen Therapy Limits		
Physical Therapy Limits		
Other		