Working With Discharge Planning:

Reducing Return ED Visits & Hospitalizations

Teri Round MS, BSN, RN, NE-BC
The University of Oklahoma Health Sciences Center
Fran & Earl Ziegler College of Nursing

Program Objectives

- Differences in Acute and LTC
- Transfer Form Use
- How to get the Most From Discharge Planners, Case Management, and Social Services
- Different Communication Approaches

What's the PROBLEM?

- The thirty-day hospital readmission rate from nursing homes in Oklahoma is 19.2% with the state goal set for 13.7%. No other long term care setting is farther from the goal than NHs/ skilled nursing facilities (SNF) (Medicare Part A FFS Claims Data, 2015)
- Older adults are vulnerable to injury from poorly implemented care transitions from one level to the other
- Between one fourth and one third of hospital readmissions pertaining to the chronically ill older adult are considered preventable and avoidable hospital readmission rates of the elderly in Long Term Care (LTC) are thought to be higher still (Naylor, 2009)

What Can We Improve?

- Gaps in communication between care givers
- Lack of sufficient knowledge of the Residents medications after discharge
- Recognition of early warning signs that their condition is worsening AND calling the physician when they return to the LTC facility
- Obtaining documentation of stay in acute care/ER: MAR, Labs, Discharge Summary, Discharge Paperwork
- Ensuring a verbal handoff and a written handoff

HOW CAN WE IMPROVE?

- Identify your preferred providers for acute care
- Understand their electronics and explain yours
- Be aware of each others processes
- The Physicians role
- Identifying what you need
- Work directly with preferred providers to provide education and communication to ensure safe transfers, transitions, and acute care stays
- Development of a Transfer Form

WHO DO YOU WORK WITH?
(on a regular basis?)

- ONE or MANY locations
- Identify in the facilities who to communicate with to improve patient safety
- What EHRs are used ?

Did you know if they are on EPIC you may have access to records on their EPIC Care Platform for other facilities?

Do you use Point and Click and have access to the Interact Module to improve transitions of care and communication between facilities?

Processing Processes

- While determining acceptance for all parts of the residents care, ensure your physician looks at their medications: ask for the MAR for this review
- Ensure residents are taken off “hospital orders” before release
- There is a misconception by some acute care providers that doctors see the residents immediately when the return to the LTC facility like they do in acute care
- Transportation is scheduled 24-48 hours ahead of time; they take the time they get-if the receiving facility sets is up then it is **their** time….

Processing Continued……

- **Determine what you need and how you get it:** every facility in this state may determine what they choose to send you…or not…
- Ask the Facility HOW to get your residents' information and a list of what you want: labs, MAR, discharge summary, other paperwork?
- Before discharge call the Unit and insist on a verbal handoff:

  ask for the inpatient nurse or charge nurse

COMMUNICATION ISSUES=POOR OUTCOMES

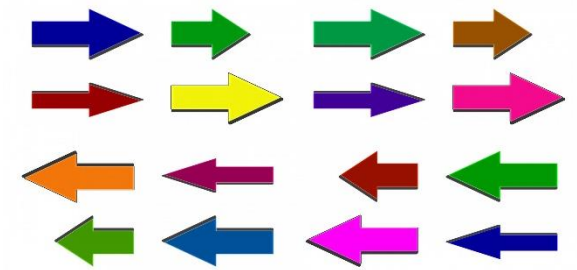
- Case Managers can receive **30-50 calls or more per day**
- Many Case Managers **have cell phones**
- Call the main number or Facility Operator for their number
- **Without texting PHI,** use texts to leave contact information and what you need; tell them if it is time sensitive
- Late in the day discharges may find some facilities using non-clinical people- **Always ask to speak to an RN if you need clinical help**

MAKE A FORM

- There is no statewide Transfer Form (EMTALA Form is not enough)
- **NO FORM?** Develop a **Transfer Form** with facilities that are referral centers to you and from you!

NURSING HOME → EMERGENCY ROOM

NURSING HOME → ACUTE CARE

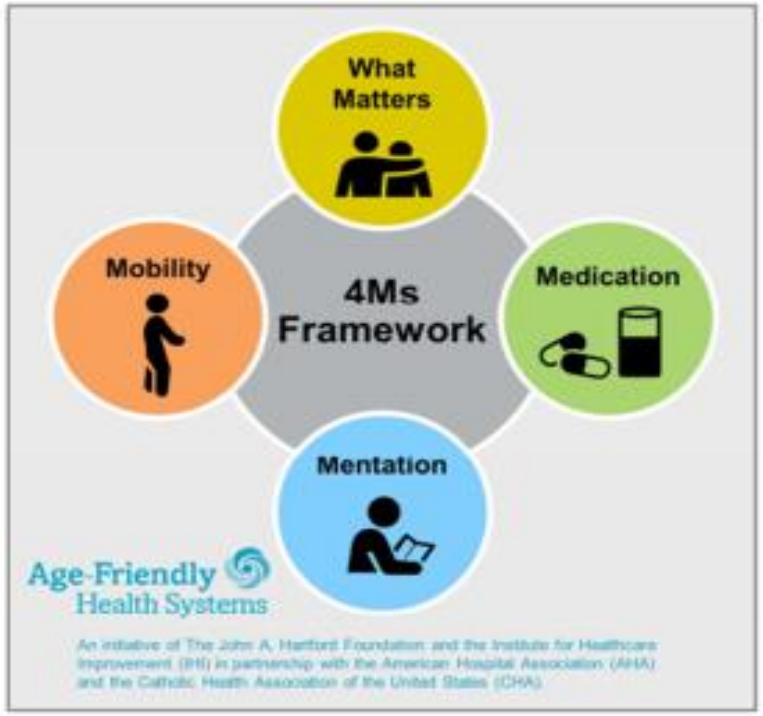


- There will be copies on the WEBSITE with this presentation of examples showing different forms

We Need to Change this:

"If there are problems or questions after the transfer, the DON calling the transferring facility helps"

Figure 1. 4Ms Framework of an Age-Friendly Health System



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

WHAT MATTERS

Do you ask your Residents “What Matters” when they return from another level of care?

Medications

Do you check the residents inpatient MARs and discontinue “hospital drugs” or those not tolerated well by the older adult?

MENTATION

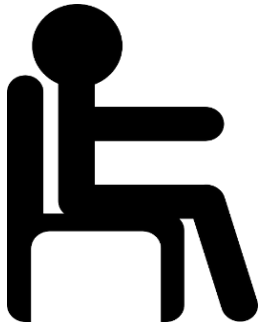
Do you assess the residents

mental status and watch for delirium

after an inpatient stay?

MOBILITY

Always assess mobility status after returning from a different level of care



QUESTIONS?

Thank You!

Teri Round
teri-round@ouhsc.edu