PointClickCare®

Successful Transitions of Care

Your guide to safe discharges and better outcomes

Introduction

Once your resident is well enough to leave your facility, your focus is ensuring a successful transfer and their continued wellness.

In this eBook you will learn how to:

- Enable your team to plan for a discharge with effective communication
- Maintain proper care delivery and treatment to lower the risk of unplanned readmissions
- Give practitioners secure access to resident information to make informed decisions
- Have a thorough strategy for Advanced Directives

Transitions of Care

Planned or Unplanned

Transitions of care can be planned or unplanned.

Unplanned transitions of care occur when an acute problem arises and there is either the determination that the facility is not the appropriate setting to address change in condition or the family requests the transfer to the hospital.

Planned transitions include payer changes and formal discharges to other settings, whether that be home, home with home care, to another SNF, or back to the hospital for a scheduled surgery.

Discharge Planning

The Beginning and the End of the Care Process

Discharge planning should start during admission and carry on throughout the stay. The discharge plan should clearly state what capabilities the resident needs to have on discharge. This means that your EHR needs to provide you with standardized discharge content for ease of use and to ensure a comprehensive plan is put together while at the same time allows personalization, to include those unique characteristics of the resident.

Understanding what is expected and what is achieved through the stay is also necessary for helping the resident and family with the appropriate next steps. Communicating about progress, declines, and plateaus helps families make the right decisions with their loved ones. Setting a realistic expectation is important to securing buy-in when the next setting isn't necessarily the preferred one. Some people may be able to go home because they have family to help and the home care resources in the area can support their staying in the community. However, not everyone can go home though. Some will need 24-hour care or supervision.

Communication between the team and the family about what is realistic needs to be part of the care strategy for that individual.

Secure Conversations™ sends encrypted Protected Health Information (PHI) from mobile devices and the EHR application itself, enabling your care team to perform more timely interventions to improve resident outcomes. Conversations are stored in the resident's record, ensuring all care team members have access to the information.

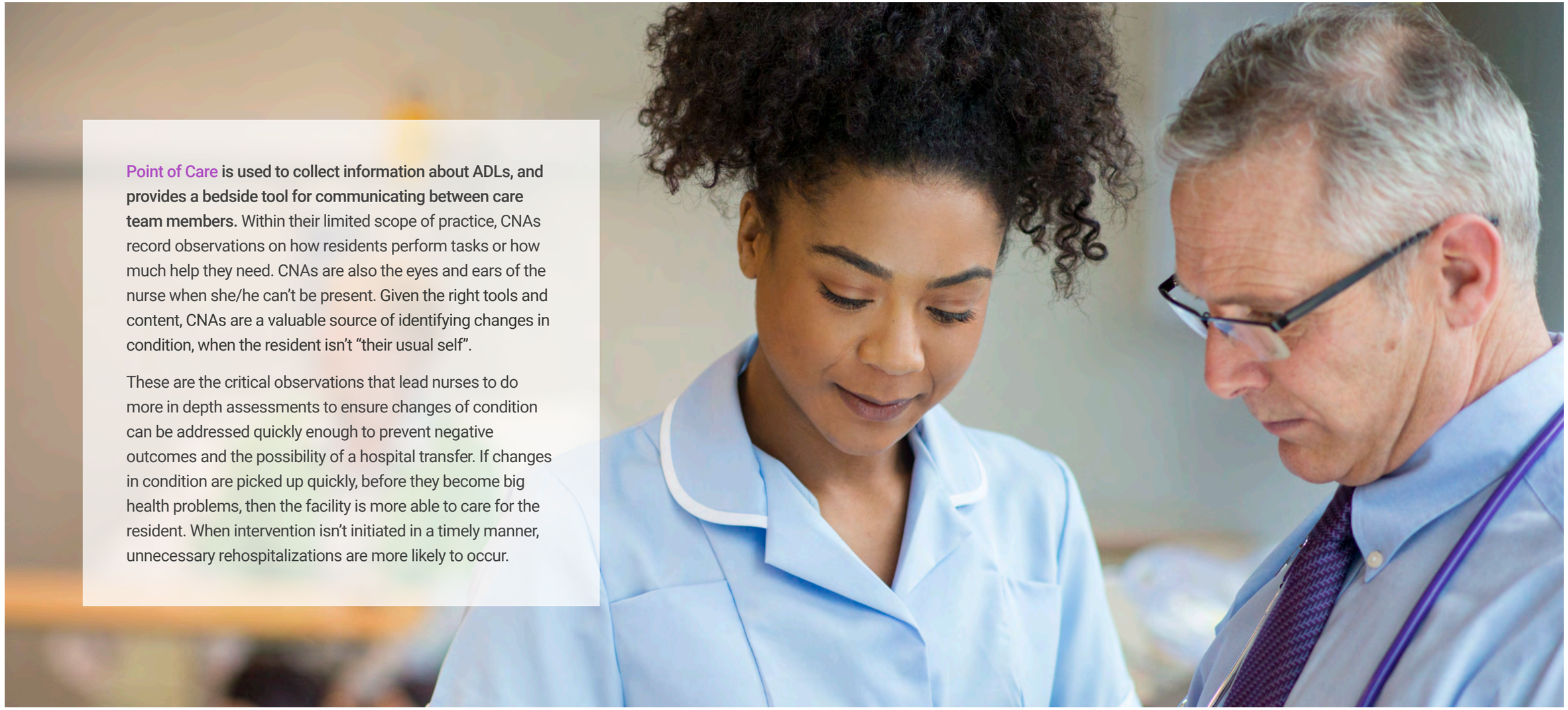
When Rehospitalizations Occur

Rehospitalizations are costly to your facility and your reputation, and they also negatively affect the resident's experience. Facilities should focus on getting the right person into the bed, but also once there, managing their care and treatment in a standardized, consistent approach using evidenced-based tools to prevent unnecessary, unplanned rehospitalizations.

In a study conducted by the University of Colorado, research showed that residents who are re-admitted to hospital are 2x more likely to die in the 30 days following hospital discharge, and 4x more likely to die within 100 days of hospital discharge as those who stayed in the SNF. [1] Residents who needed some form of invasive device, such as tube feeding, dialysis, or a catheter were at higher risk for rehospitalization. With the move to PDPM and the push towards taking on more clinically complex residents, that risk will increase. This means that you will need embedded tools that not only highlight risk, but also enhance the communication of changes in condition from bedside to physician.

Care Content by COMS allows you to leverage standardized, evidence-based care assessments that ensure all of your staff are using the same enhanced assessments. This improves your organization's care delivery while reducing the risk of readmissions.

1 Mortality risk doubles for SNF residents readmitted to hospital; McKnights, January 18, 2016



Point of Care **is used to collect information about ADLs, and provides a bedside tool for communicating between care team members.** Within their limited scope of practice, CNAs record observations on how residents perform tasks or how much help they need. CNAs are also the eyes and ears of the nurse when she/he can't be present. Given the right tools and content, CNAs are a valuable source of identifying changes in condition, when the resident isn't "their usual self".

These are the critical observations that lead nurses to do more in depth assessments to ensure changes of condition can be addressed quickly enough to prevent negative outcomes and the possibility of a hospital transfer. If changes in condition are picked up quickly, before they become big health problems, then the facility is more able to care for the resident. When intervention isn't initiated in a timely manner, unnecessary rehospitalizations are more likely to occur.

Communication needs don't stop with the CNA and nurse. Timely intervention is often dependent on connecting with the physician or the nurse practitioner to receive orders for additional tests or treatments. Communication with these integral members of the team is often difficult. They are often busy and in situations when calling back isn't possible given HIPAA concerns. When you do get them on the phone, they are hurried and may not give you the full picture. Nurses need secure communication texting tools that integrate with existing apps and allow doctors and nurse practitioners to write orders on the record from wherever they are. The right tools provide access to all relevant resident information to ensure well-informed decisions are made without relying on second hand communication of chart details.

Practitioner Engagement is a HIPPA compliant mobile communication solution that improves access to information, streamlines communications, and automates error-prone, time consuming, paper-based processes.

When the doctor has the right information, the care team can come together to make sure the resident gets the right treatment to prevent transferring to a hospital.

Sending the Right Information When the Transfer is Necessary

Once the determination is made that the resident needs to be transferred, you need to send the right documentation with them to ensure continuity of care is maintained.

Duplicate treatments can be ordered, and mistakes can easily be made if the most current information isn't available at the receiving facility.

With **Integrated Direct Messaging**, senior care providers have the power to conveniently connect electronically with hospitals and other care providers and exchange resident information securely from within the PointClickCare EHR platform.

Advanced Directives

Adhering to Client Wishes for End of Life Care

It may be odd to talk about advanced directives as part of a transition of care strategy rather than in the admission phase, but this is when they matter most.

Advanced Directives should be completed before a resident is admitted to any setting and should outline the end of life care and treatment they want to receive.

These are extremely important decisions that need to be made so that the resident doesn't suffer undue harm and pain. These decisions are best made when the resident is well and thinking of the long-term — not in an emergency. Part of that decision making should include determining whether hospitalization is something the resident wishes. This is an important aspect in considering actions with acute changes in condition.

Your EHR needs to make these a part of every care page in the system and automatically include this requirement in transfer documentation. They should be easily accessible and guide actions during end of life scenarios. They should also be included in documentation accompanying any transition of care that any resident requests. They are the guiding principles for end of life care in any setting.

Maintain Close Relationships With Hospital Partners

A study from Brown University showed that close partnerships with hospitals reduced the risk of rehospitalizations. In fact, a close relationship with the SNF has the greatest effect on reducing readmissions within a week of hospital discharge, supporting the need for better care coordination.[2] Technology can really help in this area. Systems that support remote case management and allow access to portals that give them all the clinical information needed — vitals, notes, changes in condition — can really improve relationships.

When hospitals can access the information on residents they have sent to you, anywhere, anytime, the case management support has a direct impact on readmissions.

This benefits both parties, improves the resident experience, and ensures the best care is being provided. These insights into care coordination are integral to managing readmissions, improving the patient experience, and maintaining preferred partner relationships.

Analytics is a cloud-based tool that provides you with real-time actionable data, guided workflows and goal setting capabilities, to truly allow you to make an impact on your operations and improve relationships with your partners.

2 Close, specific hospital-SNF partnerships drive down readmission rates, researchers find; McKnights, October 30, 2013

Conclusion

Transitions of care don't need to be complicated. Planning for your resident's discharge on Day 1 will help to guide care activities and measures of resident success throughout their stay. Your goal should be to get the resident to the next setting and have them settle and stay there. Successful discharges lead to better quality reporting outcomes and improved relationships with upstream providers.

Preventing unplanned transitions requires the right tools and processes, including:

- ☐ Standardized content
- ☐ Evidenced-based protocols
- ☐ Interdisciplinary communication tools
- ☐ Access to data to provide insights for both internal and external stakeholders

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