

Hospital Transition Overview

Comment [DC1]: Please see comments about this approach to care transitions document, compiled by West County (referred to as “the agency”)

Goal:

- To proactively assist patients in successfully transitioning from Emergency room or inpatient admission to home.
- Timely management of information about WCHC patients who have been seen at any inpatient facility.
- Palm Drive Hospital, Sutter Medical Center, and Santa Rosa Memorial Hospital.
- Reduce the number of patients seeking medical care at an Emergency room for care best provided in the ambulatory primary care setting.
- Minimize hospital inpatient admissions with timely access to effective primary care.
- Minimize hospital re-admission through proactive RN Care Management with outreach to hospital discharge staff, effective communication of relevant Health Information, and use of the Coleman model upon discharge.

Agency Hospital Management Team:

- Veronica Jordan, Clinical Lead
- Katy Jenkins, RN Care Manager Lead
- Marakesh Lewis, Health Information Lead
- Marlo Carreno, Health Information Support

Comment [DC2]: West County has a management team dedicated to care transitions from the ER and hospitals. There are representatives of the major staff roles involved with care transitions and complex care management: provider, RN, and Health IT.

Proactive Hospital Communication and Collaboration:

- Hospital Management team to work collaboratively with Palm Drive, Sutter Medical Center, and Santa Rosa Memorial Hospital at scheduled hospital transition meetings.
- Goal:
 - Management of information of WCHC seen admitted to ER or Inpatient within 24 hours.
 - Collaboration with hospital staff to have access to important clinical information about WCHC patients at the time of service.
 - Reduce barriers to communication between WCHC staff, ER staff, Hospital staff or Hospitalist physicians.
 - Establish ongoing relationship with hospital staff to improve care long term.

Comment [DC3]: The agency has a commitment to working with all of the local hospitals where their patients are seen.

Health Information Exchange

- eCW Access
 - Access to eCW as resource provider for Resident Physicians .
 - Manage future access to eCW for all hospitals using eCW E-Health Exchange when available.
- Notification of ER or Inpatient admission

Comment [DC4]: Building relationships is an important component for primary care practices in managing patient care transitions.

Comment [DC5]: Identification of patients being admitted to the ER or hospital is essential for helping reduce readmissions.

- Sutter Medical Center:
 1. All patients admitted to the hospital (ER or Inpatient) are asked who to identify their primary care provider (or primary clinic if the patient is unsure of the provider).
 2. Daily census is generated and faxed to 824-9335.
 3. Marakesh (or Marlo if Marakesh is unavailable) will generate a TE and send to patient's Care Team RN to manage further. Effort will be made to minimize duplication of notification if Care Team RN already aware through document or previous TE.
- Palm Drive Hospital:
 1. Katy to meet with Discharge Nurse at PDH daily to discuss patients in the hospital – focusing on potential needs for successful hospital transition.
 2. Katy to communicate with patient's Care Team RN through TE or by phone to manage hospital transition.
 3. Care Team RN to schedule a WebEx meeting with patient and hospital staff prior to discharge to discuss hospitalization, coordinate needed assistance, and set up transition visit.
- Santa Rosa Memorial Hospital:
 1. All patients admitted to the hospital (ER or Inpatient) are asked who to identify their primary care provider (or primary clinic if the patient is unsure of the provider).
 2. Daily Census is generated and sent via encrypted e-mail to Marakesh and Marlo.
 3. Marakesh (or Marlo if Marakesh is unavailable) will generate a TE and send to patient's Care Team RN to manage further. Effort will be made to minimize duplication of notification if Care Team RN already aware through document or previous TE.

Comment [DC6]: There are detailed backup plans to ensure coordination of care.

RN Care Management

- ER admissions:
 - Review reason for admission,
 - Triage potential need for close follow up including phone call or office visit as needed
 - Assist patients in using outpatient services for conditions that could have been served in the office
 - Initiate Care Team Discussion about patients with frequent ER admissions.
- Hospital admissions:
 - In hospital visit via WebEx or phone call if possible before discharge to understand reason for admission, determine potential risk factors for successful transition (insurance risk, medication complexity or barriers, high risk diagnosis, barriers to primary care access, lack of home support, pain, immobility, etc.)

Comment [DC7]: See the clinical protocol and tools that RN Care Managers use to manage patient care transitions in Steps 5-7 of the Team Guide module on Complex Care Management.

- Transition visit (timeframe expectation: within 48 hours of discharge if possible).
 - *Note: Visit can be at home or in office but home visit is preferable to understand potential barriers or risk factors that would be more readily apparent when interacting in the home environment.*
 - Initial Transition Care Visit to be guided by intake bubble sheet and follow the Coleman Model “Four Pillars” assessment.
- Follow up visit by phone or in office and closely managed for the first 30 days after discharge.
- Communication with Care Team and other health partners (home health, specialty care, care givers, etc.) as indicated to coordinate and optimize care transition.