Transitions of Care Meeting Notes, July 2nd:

Topics Covered:

• AVA/1:1 transition

o No Haldol prior to transition

o No set hours e.g. 24, 48, 72 hours

o Needs to be patient specific e.g. pulling at lines/drains and patient

won’t be transitioning with lines/drains

• Insulin Orders

o Standard orders for all facilities

• Changes to Home Health orders after discharge from hospital

o Signature offered their document to be built for a standard paper

form document

o Many PCP’s don’t like to give verbal orders

o Agencies ask that there is no specific names of equipment or supplies

used on orders but that there is more generic wording to allow the

agency to use an equivalent that they offer otherwise the patient

may be completely without the equipment

o When ordering infusions, it is important to be as specific as possible

e.g. flushes, frequency and make them complete

o Don’t promise the frequency or type of care being offered with the

Home Health agency. Please defer to the agency to explain services

at start of care/intake

o In January 2020 the same changes affecting SNF’s will impact

admissions to HH

§ They can’t admit patients for falls, you must explain, document

thoroughly the severity of illness that is creating the patient to

fall, weakness and failure to thrive are the same

o Important to understand about HH orders after d/c:

§ All agencies must contact the PCP to get approval to follow

§ Many times, the patient doesn’t understand what HH is and

expects that they will be there every day, they are in home

care givers, or really don’t want HH after all

§ HH agencies struggle with PCP’s who haven’t seen the patient

in over 6 months and now they are asking them to follow HH

orders, or they haven’t started care so they won’t follow

§ No PA or NP signatures on HH orders

• October changes to SNF admissions PDPM Changes

§ Discharge Summary same day or next day at latest

§ Moving away from therapy driven admissions

§ Must be clear about severity of illness, can no longer accept

weakness or falls there must be clear/adequate

documentation of the severity of illness CAUSING the falls

§ Discharge medication agreement is that the hospital will be

responsible for including diagnosis for the following

medications and all others will be obtained from PCP

• New medications

• Narcotics

• Psychotropics

• Facilities are struggling with nurse to nurse hand off

o Getting new information from the direct care nurse on day of

discharge that was never documented in the chart

o Inconsistent information given on day of discharge

§ This group will be working to create a standard tool to be used

by the hospitals and facilities to ensure all the required

information is being shared at time of hand off

• Emergency room staff calling facilities after normal business hours e.g.

2200 demanding that they come get the patient

o Not a clear understanding from the hospital teams of levels of care

o Not a clear understanding of the process of return to the facilities

o There needs to be an early communication to the facility of plan to

return to allow staff to prepare for return with a respectful amount

of notice

Corvallis Manor was our sponsor for this meeting. Offered information about the

types of care offered at their many locations.

They are a VA approved provider and are opening two homes south: Highland

House is a 17 bed VA facility in Grants Pass that is now open and there will be a

22-bed facility that is currently under construction.

Open House: July 23rd 12-5 2201 NW Highland Ave Grants Pass OR 97526

Next Meeting Topics/Candy Follow Up:

I have reached out to Dawn Castleman about the struggles that Signature is

having with In-Basket. They are aware and currently working on a resolution

I have reached out to Tyler Mann to include name of agency, start of care in the

discharge summary that is sent to PCP. This will aide in the hand off to the PCP

who will be required to follow the HH orders. Hoping to eliminate delays with this

inclusion of information.

I am working with Amy Hoffman from Corvallis Manor to get a copy of the Asante

system hand off tool that is being used to hand off to facilities in that area. We

will bring back to next meeting.

Invites sent to Angela Weld and Neftali Pizano from the Clinics for all Care

Coordinators and Jessica Morgan from Albany Emergency Department

I am providing education to all the CM’s in the valley, I have requested meetings

with all the attending teams at GSRMC and I will continue to reach out to leaders

at the other two campus’.