Transitions of Care Meeting Notes, September 3rd …

* Discussion of reasonable transition of patients related to bowel movements. An agreement to discuss cases individually and patient’s normal patterns however 72hours and discharge with bowel care is a reasonable request established and agreed upon by this team.
* Discussion of need for hospital to provide documentation and hand off one hour prior to transport. The hospital requests that if the RN calls to give report every effort is made to take that call then as often times they are told no one available and they will call back. When they do it’s full of questions and delays discharge as it’s generally close to transport time when the call is returned.
* Remember that if you have a change in your agencies contact information you are sending that information on a business letterhead to Hollie or Rochelle. There can’t be any “today send it to this fax”. All documents must be transmitted through EPIC.
* Alternative living facilities are asking for 24 hour notice to be able to perform their assessment of the patient. Hospital is asking that this does not exceed 24 hours as the current trend is greater than 72 hours.
* All attendings have been educated on the upcoming changes to admissions to SNF and eventually to Home Health. Further changes or concerns please contact Candy Sawyer who will address further needs of the hospital teams.
* Discussion of discharging patients with DNR status. Candy has reached out to hospitalists and Supportive Services teams. Supportive Services Dr. Steele advises that he uses the EPOLST process. Dr. Barry Smith the hospitalist Medical Director advises he is aware of the EPOLST but is unsure what percentage of his team uses. There appears to be a need for further education of the attendings. They all recognize that if they are discharging a patient with DNR status they must have a POLST as well.
* Discussion of barriers to discharge homeless patients requiring post acute care. Avamere states they are committed to assisting the hospital with taking a % of their current census IHN patients. Hospital is hoping to be discussing further plans to collaborate with post acute care providers to establish contracts to assist with these patients e.g. contracted SNF beds, contracted caregivers etc.
* Discussion of this team building a standardized hand off tool to be used by facilities and hospital teams alike. Candy will provide examples and next session we will attempt to create a first draft.