**Group 1:**

**Represented: Namaste, Goldleaf, Life Care, SCL HH, CLC**

***Accuracy of Referrals and Communications around referrals***

**Issues**

* Orders from discharging providers not complete.
* Orders coming with the admit instead of before the admit so meds can be obtained.
* Clinical information to the receiving case manager timely.
* Partners on the continuum of care brought in the day before discharge and then being canceled once patient returns home.
* Patients do not understand the change in the level of services at the next level of care, SNF/Rehab, Hospice, Home Care. Have expectations that the level is equal to the hospital.

**Best Practices**

* Bring in the partners in the continuum of care sooner in their care vs days before discharge so they can help prepare for discharge down the line.
* Adopt the LACE tool and use with home services providers (Hospice/Home Health) to give additional information of the risk of bounce back to the hospital.
* Set up transport time close to the time that the patient is due for pain medication, so they arrive the SNF/Rehab with decreased pain.
* Give the whole package, History and Discharge Summary to the Case Managers before admission so they can be more familiar with patient before admission.
* When the admission nurse or case manager gathers information on the new admit, do it on a form that can be shared with the direct care nurse so they get more information about the patient and not have to comb the chart.

**Group 2:**

**Represented: Team Select, TeamHealth, Julia Temple, Orchard Park, Tellegin**

***Assigned Challenges/Best Practices: Engagement (patient and MD); Staffing***

***Engagement MD Best Practices:***

* PCP buy in – reach out to the patients PCP before DC to inform them of the patients status, DC instructions and inform of a need for a follow up appointment; send the hospital information/DC ppw to the PCP
* Preferred list – making the preferred list more manageable in size
* Engage facilities across the organization in participation in case studies/QAPI meetings
* Use HIPAA compliant text messaging to keep MD’s engaged (this has been well received thus far)
* NP’s functioning in both palliative and hospice side – working with attending physicians within the community

***Engagement Patient Best Practices:***

* Having patients more involved in their care planning
* Engagement patient caregivers, family, MPOA and/or guardians in the care planning for the patient if the patient is unable to participate themselves
* Provide a copy of the care plan to the patients, families, caregivers, etc
* Meet with patient before DC and engage them in the decision making process with regards to next steps
* Educate patients on expectations with regards to next level of care recommendations in an effort to assist the patient in making the most appropriate choice for them
* Follow up with patient within 3-7 business days

***Staffing:***

* Strong leadership that is both supportive and willing to roll up their sleeves and get their hands dirty
* Employee incentives (i.e. – gift cards, etc)
* Compliment forms to be completed by patients; employees who are identified through these compliment forms earn an incentive
* Recruiting the ***RIGHT*** people and ***RETAINING*** those people
* Educational incentives (i.e. – tuition reimbursement)
* Employee focused events (i.e. – employee appreciation, etc.)

**Group 3:**

**Represented: Sky Ridge, CLC/Someren Glen, Team Select, Suncrest, Teamhealth**

* Carol: Hospitals are trying to be proactive in educating patients and families about Medicare rules and discharge policies. SkyRidge tries to have discharges set by 11 or 12, which can prove to be a challenge for physicians. The physician often gives the discharge order but does not complete DC paper work until 4:30 or 5:00.
* Hospice: They focus on doing a  thorough but quick assessment as soon as they receive the referral so they can line up all of the appropriate services.
* Nursing Home Best Practice: If most admissions arrive late in the day stagger nursing shifts to accommodate the later times.
* Best Practice: SkyRidge has a nurse in the ER from 11:00 am to 7:00 pm to evaluate if a patient can go directly to a nursing home rather than admit to the hospital.
* Best Practice: Team Health (TH) Doc tries to see the patient in the hospital and then follows them when they discharge to SNF. TH also calls the nursing home to alert them that they will be following in the nursing home. All too often patients are assigned to another doc upon admit to the SNF.
* Best Practice: Use CORHIO to get as much history as possible on new patients at every level of care.
* Team Health has narrowed the providers they work with in an attempt to streamline communication.

**Group 4:**

***Windcrest, Comforcare, SCL HH,* Littleton Care & Rehab, Health South*,* Namaste*,* Goldleaf*,* SuncrestDiscussion Covering Education of Benefits and Care Coordination Best Practices**

1. Accuracy in information
2. Communication/Care Coordination
3. Engagement (Patient/MD)
4. Staffing
5. Time/Planning
6. Resources
7. Education of Benefits

**Education of Benefits or in General about Services\Insurance dictates everything –**

**Hospice –**

* Families frustrated with treatments or meds that are not covered under hospice benefits.
* Education on hospice being non-treatment oriented. Comfort measures are primary. PCP wrote DC order for hospice – PCP cannot discharge a patient, they can qualify, but this is a revocable situation.
* Positive for Hospice, is addition of Palliative…this helps transitions and length of stays. 24 LOS with hospice before day of death. Better to have longer on service.
* Providers, the whole array, often do not understand benefits available and how to utilize benefits in best capacity. So information is given and we have to unwrap and re-educate.
* Although, are seeing some physicians becoming Care Navigators. In our role in the market, we are becoming more of care navigators as well. Peeling away the layers of crisis and re-addressing the available benefits.
* Care Coordination is also related to this topic.

**Best Practices:**

* Non-Medical – making themselves available for information sessions due to the number of questions and objections when something is privately paid. Case managers cannot be experts at everything; they need experts they can trust.
* Home Health – scope of practice of providers. Example is infusions – which is a different provider.
* Communication and Open Dialogues
* SNF – meet with family in hospital. BOM meets and speaks with patient once in SNF. Care Conference information is repeated as well – also including down-stream providers such as Home Health.
* ***Concierge HealthCare - Resource Meetings – bringing partners from SDCC in, early and often, to be the experts for our patients/residents.***
* ***Sense of urgency. Could we invite partners in at hospital? Could we invite partners in at Care Conferences at SNF? Could we invite partners in to home with HH partners? What does this look like?***
* ***What do handoffs look like between down-stream partners? (Once discharged from hospital.)***
* ***What is the diagnosis of patient? Who is the provider? Is it a planned admission (surgery) or unplanned admission? How does this differ?***