#OHCA2018

2018 OHCA Convention & Expo

Session #: W27

Optimizing Transitions of Care: Real life SNF to HHA experiences

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Objectives:

Upon completion, participants will be able to:

- Discuss barriers to communication between SNF and HHA Providers
- Describe specific methods to improve successful discharges from the SNF setting
- State two approaches to educating staff, patients, and caregivers in care transitions from SNF to HHA

Why Optimize Transition of Care: SNF to HHA?

- Does optimization matter?
- How or why?

- ✓ Quality Measures
- ✓ Continuity of Care
- ✓ Patient Centered Care
- ✓ Bottom Line…

Acute Stay: Sally Smith

- **72 yo widowed female, lives with daughter**
- **CHF, Type 2 Diabetes, 275#, 5 ft 5 in tall**
- **Stroke 2 years ago**
  - Minimum assist for transfers and ambulates with rolling walker
  - Daughter becomes primary care provider
- **4 weeks ago, another stroke**
  - Hospital x 1 wk then to SNF
    - Requires maximum assistance for transfers and ambulation
    - Patient's goal is to go home with daughter ASAP

Transition Acute to SNF: Sally Smith

- Referral process
- Admission process

SNF Stay: Sally Smith

Challenges

- Payer identification & understanding
- Staff coverage/training for acuity of patient
- Insufficient communication on patient progress
- Caregiver involvement

Success

- Discharge planning from day of Admission
- IDT meeting within first 7days to establish plan
- Family/patient education
- Home evaluation
- Check off sheet for proper discharge
- IDT meeting 5-7 days prior to DC

Transition SNF to HHA: Sally Smith

Challenges

- SNF not knowing what documents HHA needs
- SNF not understanding requirements to certify
- SNF explanation of HHA services
- HHA provider staff resources for SOC
- DC orders for HHA, DME, Meds

Success

- Review documents received from SNF
  - Continuity of Care Info
  - Face to Face (F2F) Encounter Doc
  - Designated Community PCP
- Initial Assessment within 24-48 hours of SNF discharge

Transition SNF to HHA: Sally Smith

Best Practice for transition from SNF to HHA

- Educate SNF DC Planners, Patient and caregivers
- HHA Liaison works with SNF DC Planner
- HHA benefits brochure available
- SNF Medical Directors aware of HHA certification requirements
- Community Primary Care Physician (PCP) aware of transfer
- Communication between SNF and HHA
  - ER or back to SNF within 30 days

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Home Health Stay: Sally Smith

Successful Community DC to Age in Place

- Inclusion of Patient and Caregiver in:
  - Development of Plan of Care
  - Start DC Planning
  - Visit schedule posted
  - Medication list in home
  - Each visit: Discussion of treatments, expectations, and progress towards goals

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Walk Away Message?

Communicate, Collaborate, Coordinate…

Working together optimizes transitions of care.

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Questions?

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