Transition of Care

Schoolcraft Memorial Hospital
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Form your Team

Our Core team members includes:

* Pharmacy Leader
* Med/Surg Nurse Manager
* Clinic Care Manager or Coordinator
* Quality Director
* Infomatics

Collaborated across care settings is essential. Additional team members asked to join included:

* Social Workers
* PT/Rehab Manager
* Dietary
* Imaging/Lab
* Cardiopulmonary/RT

Strategize

- Set regular meeting dates and times and send invites
- Determine patient population to start with – *Inpatient D/C*
- Review Patient Discharge Process
- Review Cerner tools available, Review Ad Hoc forms currently used
- Design TOC Model
  - Inpatient Discharge – Admit through Discharge Workflow
  - Designed a Multi-Disciplinary Rounding Form
- Engage Nursing team and train on when to document on MDRForm
- Review program and make changes as needed

Day of Admission – D1

- Medication History – **ED Nurse**
- Medication Reconciliation prior to admit to MS- **ED Provider**
- MS Intake Assessment -**Primary Nurse**
- ***Adult Patient History (adhoc form)-*** complete all items on the form

- ***Discharge Checklist (adhoc form)***- Begin on Day 1- **Primary Nurse/Ward clerk/Charge Nurse/Pharmacy**

First Patient Rounding Meeting – D2

- **Morning Meeting**
- Provider, Mid-level, Social Work, Charge Nurse
  - Charge Nurse starts the Multi-Disciplinary Rounding Form
  - *Send communication for Morning Rounds*

- All disciplines use MDR Form during patient's *entire visit.*

- **Morning Rounds** - Provider, Nurse, Social Work, Rehab, Pharmacy, Charge Nurse and Dietary Manager

Day 2
Discharge planning starts at admission.

- **Social Work visit**
  - Begin D/C Planning assessment form and complete all necessary SW forms (there are five ad hoc forms completed in Cerner)
  - Document in MDR Form daily

- **Homecare Nurse Visit**
- Introduce patient to the program
- Verify appropriateness and inform patient of HH plan
- Document visit in MDR Form under MDR Notes section

- **Rehab Visit prn**
  - Document in MDR Form Notes Section

Day 2 CCM Visit

CCM Visit

- Introduce Patient to the Care Management Program
- Send Referral to provider for patient enrollment in CM Program
- Update on discharge phone call they will be receiving
- Document in MDR Form
- Non-SMH patients - Ward clerk works with patient on f/u info.

Clinic TCM Process

- Reviews patient discharge list daily to identify TCM patients
- TCM Call confirms TOC appointment
- TOC call by CC – takes place with 48 hrs. post discharge to home, TCM code added to visit
- TOC visit set within 14 days of d/c

Day of Discharge

Task	Responsible
• D/C Checklist Verified	Ward Clerk
• F/U appt/labs scheduled	Primary Nurse
• Medication Education provided	Pharmacy & Primary Nurse
• Discharge Instructions reviewed	Primary Nurse
• Vaccine administered prn	Primary Nurse
• MDR Form updated	Ward Clerk

- Document f/u appointment for non-SMH patients
- Sign and submit MDR Form prior to discharge

Post –Discharge

- Clinic CC completed TCM calls and documents
- Pending results, f/u post discharge management

Ongoing Project

Hospital TOC	start date May 1
Clinic TCM	start date with AOC strategy in 2018

Barriers/Challenges include Cerner and Pipeline