Transitions of Care: Blue Envelope Process

Improving Care Transition between Assisted Living Facilities and Hospitals

Needs Assessment

- Based on data obtained from the State of Wisconsin Department of Quality Assurance (DOA) and Bureau of Assisted Living (BAL) citations related to:
  - Assisted living staff not communicating with hospital staff at time of transfer
  - Lack of communication during hospital stay
  - Family/POA not being notified of client transfer to hospital

(DQA Bureau of Assisted Living, 2017)
Protecting and promoting the health and safety of the people of Wisconsin

"No Blame Zone"

Background

• Ineffective transitions of care:
  – Adverse health outcomes—medication errors, complications from procedures, falls
  – Confusion about client’s condition, inappropriate care, duplicative tests, inconsistent client monitoring, delays in diagnosis, lack of follow through on referrals

(Kim & Flanders, 2013 & Hansen, et al., 2011)

Background (cont.)

• Burden the healthcare system with increasing costs—estimated that poorly coordinated care transitions from hospital to other settings cost $12 billion to $44 billion per year

(Kim & Flanders, 2013 & Hansen, et al., 2011)
Focus of Transitions Work

- Increase collaboration between sites and providers
- Improve communication
- Elevate quality and efficiencies
- Improve patient outcomes
- Decrease cost

Where To Begin?

Let's Talk

October, 2014
Acute Care-ALF Transitions Coalition

- Recognition that ALFs originally started in a business model vs health care model
- Increasing clinical complexity of the ALF resident population is challenging ALF staff and their skill-sets

Acute Care-ALF Transitions Coalition (cont.)

- Focuses:
  - Introduction to interfacing with health care systems
  - Understanding of workflows in each setting/limitations
  - Sharing of barriers and pearls surrounding transitions
  - Education on common clinical conditions and procedures
  - Collaborating with the state Division of Quality Assurance on joint projects

Identification of Issues Related To Transitioning Residents (22)

- Communication
- Timeline for receiving orders
- Understanding roles and abilities
- Education of AL staff
- Referrals to other agencies
- Baseline and changes
- Transportation issues
- Insurance coverage/financial issues
- Durable Medical Equipment (DME)
- Demential friendly education
- Access to technology
Identification of Top Issues to Work On

• Medications and reconciliation
• Understanding discharge processes and documentation
• Creating a discharge checklist
• Transfer documentation and forms
• Creating of a “capabilities form” that clearly communicates to next level of care what the facility can and can’t do

2018 Issue Identified: Clinic Appointments

• Understand your resident’s ability to engage in all that occurs during a clinic appointment
  – The clinic looks to you as resident advocate/ultimate responsibility
  – Are you using standardized communication tools/methods (bi-directionally) between sites? (Med list, MCO involved and notified, name of pharmacy, visit outcomes/changes communicated and completed)

2018 Issue Identified: Clinic Appointments (cont.)

• Does the healthcare system understand your capabilities?
• Do NOT assume that family member will communicate visit findings or changes (After Visit Summary)
What is a “Care Transition?”

• Anytime the resident’s care transfers from one setting to another …or even one caregiver to another…
  – Resident transfers from Assisted Living Facility (ALF) to hospital (back)
  – Resident transfers from ALF to home or Skilled Nursing Facility (SNF)
  – Resident transfers from SNF to ALF
  – Resident transfers from one level of care in your facility to a different level of care in your facility
  – Resident goes in for a clinic visit

What is a “Care Transition?” (cont.)

In each instance the quality of the information contained in the handoff affects
  – quality of care,
  – cost of care,
  – resident/family satisfaction,
  – staff frustration and satisfaction at each setting

Assisted Living Facility

• RCAC: Residential Care Apartment Complex
  – Greatest variance in size, type, nature
• CBRF: Community Based Residential Facility
  – 5 to 100+ beds; serves specific client group; licensed base on size and class
• AFH: Adult Family Home
  – 4 beds or less
• No Regulatory requirement for RN/LPN/CNA on staff
Regulatory Considerations
CBRF

Reporting requirements

- 83.12(4)(c) Report to the department within 3 working days of injury requiring Hospital Admission
- 83.12(5) Immediately notify resident’s legal rep. and physician when there is an injury, incident or significant change in the resident’s physical or mental condition

Resident Rights

- 83.32(2)(h) Receive medications in the dosage and at intervals prescribed by the practitioner
- 83.32(2)(i) Prompt and adequate treatment

Assessment and ISP update

- 83.35 (1)(a) and (3)(d) Change of condition
Regulatory Considerations
AFH

Assessment and ISP update

• 88.06(3)(f) ISP updated when needs change

Resident Rights

• 88.10(3)(p) Prompt and Adequate Treatment

• 88.10(3)(q) Right to receive medications as prescribed

Reporting

• 88.03(5)(e) Within 24 hours of an accident requiring hospitalization
Regulatory Considerations
RCAC

Services

• 89.23(4)(a)2 Delegated nursing services

• 89.28(6) Updating risk agreement

Chapter 50

Rights of Residents

• 50.09(2)(l) Receive adequate and appropriate care within the capacity of the facility

Regulatory Considerations
AFH

Medications

• 88.07(3)(d) Order to administer medications
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Regulatory Considerations

CBRF

Medication Orders

- 83.27(1)(a) Practitioner’s Order

RCAC

Tenant Rights

- 89.34(16) Receive medications as ordered

Physician Orders and Medication

<table>
<thead>
<tr>
<th></th>
<th>CBRF</th>
<th>AFH</th>
<th>RCAC</th>
<th>ADC</th>
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<tbody>
<tr>
<td>Written order indicating which staff can administer</td>
<td>Silent</td>
<td>Yes</td>
<td>Silent</td>
<td>No Facility policy required</td>
</tr>
<tr>
<td>Written order for each medication</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes All prescription drugs require</td>
<td>Yes</td>
</tr>
<tr>
<td>Written order for each medication when client self-administers</td>
<td>Yes</td>
<td>No All prescription drugs require</td>
<td>No All prescription drugs require</td>
<td>No All prescription drugs require</td>
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Case Study: Max

- 86 year old with dementia
- Sent to ED after a fall with minimal clinical information
- Max unable to answer questions and becomes increasingly agitated with ED staff
- Max is admitted to nursing unit and treated
- Days later: Physician states it is time for Max to be discharged today

Case Study (cont.)

- Discharge planners see that Max is from Rosy ALF and plan to send him back that afternoon via wheelchair van
- Max needs significant wound care, special diet, oxygen, new medications, and continued physical therapy
- Patient arrives back on your doorstep at 4:00 pm Friday afternoon with a packet of discharge information
- Caregiver, assuming that nothing has changed tucks Max into bed and puts the discharge papers in the Administrator’s locked office to “keep them safe” for his return on Monday

Questions

- What’s wrong with this scene?
- What could possibly go wrong?
- What could have been done differently?
- Are there tools already in place that could have been used that would have assured better outcomes?
Role of the ALF

Transfer out of the Facility

Contact
- EMS
- Legal rep/Family
- Hospital
- MCO
- Primary care physician

Transfer Documents/Emergency Transfer Packet:
- Blue Envelope
- ALF Client Face Sheet
- Assisted Living Capability Form (& Interact Tool)

*Section IV Resources*

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“Capitol Lakes sent a patient tonight with the most beautifully filled out sticker on the front of the blue envelope with all of the info inside. This is wonderful.”

– Val Mack, Care Team Leader, UW Health ED

UW Health Blue Envelope
Transfer Label

At the bottom, there is an area to check “Documents to include”

Role of the Assisted Living Facility

Additional Info to include in the packet/with the transfer:

- Past 48 hour progress notes
- MAR
- Code status
- Labeled assistive devices

Role of the ALF

“Maintain frequent contact with hospital staff & review facility clinical capabilities”

During the stay:

- Review meds
- Identify behaviors
- Discuss potential discharge date
- Conduct onsite assessment

Prior to discharge:

- Ensure prescriptions have been obtained
- Ensure DME is in place
- Coordinate transportation
- Update ISP
- Ensure staff are trained for any new treatments
- Inform Legal rep/family
Role of the ALF

Upon Return:

• Review discharge summary
• Review and process rehabilitation and treatment needs
• Process post discharge appointments and ensure resident attends the follow up appointments

Suggested Scripting for ALF Staff (cont.)

• **Suggested:** “I'm sorry but I am not able to take this information. Please call the [name of ALF’s preferred contact person] at [phone number]. May I have your name and phone number in case we need to reach you?”
Suggested Scripting for ALF Staff (cont.)

- It is suggested that ALF staff be instructed to notify a manager, or the ALF’s preferred contact person, per facility guidelines within no more than 15 minutes after the call from the hospital.

Suggested Scripting for ALF Staff (cont.)

- What could staff say when the ALF is unable to meet the client’s care needs or the ALF staff do not have the necessary skills to provide the required care?

Suggested Scripting for ALF Staff (cont.)

**Suggested:** The following should come from the ALF’s manager or preferred contact person:

- “After hearing of the client’s change in [health/care] requirements following [his/her] recent hospitalization and conducting an assessment of the client’s needs, we will be informing the client and [his/her] responsible party that we cannot meet the client’s needs and will be issuing a discharge notice. We will work with the [client/responsible party/managed care organization/hospital] to locate a suitable living arrangement.”
Tips

Blue Envelope

- Envelopes: Order 9x12" clasp envelopes in color POOL (turquoise blue color) from www.envelopes.com. SKU # is 73821
- Order the plain envelopes with no printing on them. Direct link: http://www.envelopes.com/business/clasp/9-x-12-clasp-envelopes-pool

½ Sheet Labels: Please order 4.25x11" vertical cut half sheet labels in color STANDARD WHITE MATTE. Product number is OL178WX

- Direct link: http://www.onlinelabels.com/OL178.htm

Pearl: INTERACT Program for ALFs (no cost)

- Stop and Watch Early Warning Tool
- Capabilities Form Deciding About Going to the Hospital
- Advanced Care Planning Form
- Clinical guidelines
ALF Coalition Biggest Win

“Assisted Living Facility and Hospital Interface: Improving Care Transition Between Assisted Living and Hospitals”

- A joint effort between the Wisconsin Department of Health Services Division of Quality Assurance Bureau of Assisted Living and ALF Coalition leadership and members
- P-02067 (1/2018)