Transition Huddle Toolkit

January, 2013
Welcome from the Director of Transition Management!

We are excited for you to begin the journey in the rapidly changing environment of patient transitions. The Transition Management Office was developed in June 2012 by David Posch, CEO of VUMC, in response to a senior leadership design session held in late 2011. These leaders recognize the importance of improving the way patients move through the Vanderbilt system, and are highly committed to this effort. The landscape has vastly changed over the last several years as industry leaders such as Eric Coleman, Mary Naylor, and the Institute for Healthcare Improvement launched a national discussion around improved transitions of care. In October 2012, the Centers for Medicare & Medicaid Services began penalizing organizations for patients that are readmitted within 30 days for the diagnoses of AMI, CHF and Pneumonia. COPD is targeted next, and additional diagnoses will soon follow.

As we move forward, “patient centered care” is the main goal for each initiative being implemented. The Transition Huddle is currently being rolled out across Vanderbilt University Hospital and will provide the scaffolding for other initiatives as they are implemented. This work will not be successful without you! Your ideas, your input and your help with this process are needed. As front line team members, you understand the opportunities and barriers you face every day as you work to care for and transition our patients to the next level of care. There will be bumps along the way, but Vanderbilt is committed to improving this process. We ask that you join us on the journey toward having every patient know what will happen next in their care (including when) and who will be involved.

The “Toolkit” you’ve been provided is intended to be a reference for learning more about the work that has been and is currently underway in transitions of care. You will find information on BOOST (Better Outcomes for Older adults through Safe Transitions), Project RED (Re-Engineering Discharges), and the Institute of Medicine’s six aims of patient care. You will find a Transition Bridge from Vanderbilt’s own, nationally recognized experts on transitions, Robert E. Burke, MD; Sunil Kripalani, MD, MSc; Edward E. Vasilevskis, MD; and Jeffrey L. Schnipper, MD, MPH. This graphic provides context for the numerous initiatives going on across the country as organizations wrestle with improving patient focused transitions of care. In addition, we’ve provided detailed information on the Vanderbilt Transition Huddle roles, five pertinent questions to answer on every patient, and ways to improve your StarPanel views of transition milestones. The use of technology is critical to improving communication and efficiency of patient transitions. Finally, there is a section on understanding data related to transitions. Monthly outcome data will be provided so you and your team will know if you are making an improvement in patient satisfaction and decreased readmissions. Process measures such as referrals to home health care will also be collected; however, your team will be instrumental in selecting areas to focus your improvement efforts.

Again, thank you for joining us on this very important journey to improve patient transitions and design reliable ways to treat every patient as individuals. Please feel free to contact me if you have any thoughts or comments about the toolkit or the initiatives being implemented.

All the best!

Beth Anctil, Director
Transition Management
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I. OVERVIEW OF CARE COORDINATION
The following information is directly cited from http://www.hospitalmedicine.org. The citation for this reference is located at the conclusion of this section.

Project BOOST: Better Outcomes for Older adults through Safe Transitions

Background:
According to recent research published in the New England Journal of Medicine, about 1 in 5 hospitalized Medicare beneficiaries were readmitted within 30 days after discharge. Unplanned re-hospitalizations cost Medicare $17.4 billion in 2004. Project BOOST is led by a national advisory board of recognized leaders in care transitions, hospital medicine, payers and regulatory agencies. The board is co-chaired by Eric Coleman MD, MPH and Mark Williams, MD, FACP, FHM and includes representatives from the Agency for Healthcare Research and Quality (AHRQ), Blue Cross and Blue Shield Association, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Institute for Health Care Improvement (IHI), The Joint Commission, and Kaiser Permanente. Medical, pharmacy and nursing professional societies, and patient advocates participate and contribute to Project BOOST’s development.

Vision:
By improving hospital discharge processes, Project BOOST aims to:
- Reduce 30 day readmission rates for general medicine patients (with particular focus on older adults)
- Improve patient satisfaction scores and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores related to discharge
- Improve flow of information between hospital and outpatient physicians and providers
- Identify high-risk patients and target specific interventions to mitigate their risks for adverse events
- Improve patient and family preparation for discharge

Goal: To improve the care of patients as they transition from hospital to home.

Objectives:
- Identify high-risk patients on admission and target risk-specific interventions
- Reduce 30 day readmission rates for general medicine patients
- Reduce length of stay
- Improve facility patient satisfaction and HCAHPS scores
- Improve information flow between inpatient and outpatient providers

Outcomes: By improving discharge processes, Project BOOST aims to:
1. Reduce 30 day readmission rates for general medicine patients with particular focus on older adults
2. Improve facility patient satisfaction scores
3. Improve the institution’s HCAHPS scores related to discharge
4. Improve flow of information between hospital and outpatient physicians
5. Ensure high-risk patients are identified and specific interventions are offered to mitigate their risk
6. Improve patient and family education practices to encourage use of the teach-back process around risk specific issues.

**Risk Assessment Tool: the 8Ps**

Numerous risk factors have been identified in the literature as being associated with increased risk of re-hospitalization, emergency department visits, or other adverse event. Researchers have developed a 20-item tool that predicts readmission to the hospital (Coleman, Min et al. 2004). There are, however, no externally validated, easily replicated tools to risk-stratify older patients transitioning out of the hospital. In light of this deficit, Project BOOST has compiled and refined the dominant patient-specific risk factors and created a user-friendly tool called the 8P scale (view the TARGET Screen which encompasses the 8P Scale, the link is just below).


This risk assessment tool is completed at admission highlighting the need to identify patients at increased risk of adverse events post-hospitalization, and utilizing the duration of the hospitalization to mitigate these risks as much as possible. Of course, all risks identified and efforts put forth should be communicated with the patient’s post-hospitalization providers.

**The 8Ps are:**

a. *Problem medications:*
   
   Some medications increase the likelihood of adverse events after discharge. Although the list of these medications is quite long, the most risky appear to be: warfarin, insulin, digoxin, and aspirin when used in combination with Clopidogrel. We recommend including all patients with prescriptions for these medications and perhaps focusing extra attention on patients newly started on them.

b. *Psychological:*
   
   Depression in older patients is common and frequently under-diagnosed. The presence of depression, either in screening evaluations or by history, has been associated with increased risk of re-hospitalization. The status of depressive symptoms has not been studied. Therefore, it is recommended you include any patient with a history of depression (i.e., formally diagnosed) as well as patients who screen positive for depressive symptoms.

c. *Principal diagnosis:*
   
   If patients have any of the following main reasons for hospitalization (i.e., their principal diagnosis), they are at increased risk of adverse events after discharge including re-hospitalization: cancer, stroke, diabetes or glycemic complication, and heart failure.

d. *Polypharmacy:*
   
   It appears that patients on 5 or more medications (scheduled, not as needed) are at increased risk of adverse event after discharge. It is also clear that with an increasing number of medications, adherence also decreases.
e. Poor health:
   Many validated tools evaluating general and health literacy have been published in the literature. However, most are cumbersome. Given that adherence and adverse events are increased among patients with poor health literacy, a simple screening tool is useful to clinicians to assess this risk factor for adverse events. We suggest clinicians use the **teach-back method** as their predominant method of patient preparation and education. It is patient centered, easy, and magnifies areas of poor understanding by patients, allowing you to correct misunderstandings while not taking excessive time. *View the Teach-Back Process* (the link is below.)

   http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/Teach_Back_.pdf

f. Patient support:
   Social support is critical to many older patients transitioning from the hospital. The absence of a formal or informal caregiver has been associated with higher re-hospitalization rates.

g. Prior hospitalizations in the last 6 months:
   Prior hospitalizations have been shown in multiple studies to be the single most predictive risk factor for future hospitalizations. A patient should thus be viewed automatically as high risk if an unplanned hospitalization has been identified in the six months (some authors studied up to twelve months) prior to the current admission.

h. Palliative care:
   Only the minority of patients qualifying for palliative care services receives them. Engaging these services actively has been shown to improve symptom management, patient satisfaction and limit resources, including re-hospitalizations for patients nearing end of life.

The admission 8P score should be generated at the time of admission and may be completed by a multidisciplinary team; however, the role of one specifically identified team member should be to ensure that the assessment is completed. Once risk factors are identified, the **Risk Specific Interventions** should be reviewed and addressed and the risk factors should be identified specifically to healthcare professionals assuming the patient’s care after discharge. Additional risk specific resources are provided in the **Clinical Tools** section and should be coordinated with those your organization may already have in place or may need to consider developing.

**References**

All information contained in this section may be found in it’s entirety in the following locations:

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/02FirstSteps/BOOSTfacts.cfm

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/Implementation.cfm#Project BOOST Literature Review:

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/03BestPrac/03_Literature.cfm
Transition in Care Bridge

“Moving Beyond Readmission Penalties: Creating an Ideal Process to Improve Transitional Care”

The authors of the article referenced above propose that there are key components of an ideal transition in care. This figure represents the 10 domains as structural supports of the “bridge” that patients must cross from one environment of care to another during a care transition (Burke et al., 2012).

As well as highlighting the key domains, this bridge represents structural stability and support. An absence of one of the domains makes the bridge weaker, potentially leading to gaps in care and poor outcomes. Additionally, this figure implies safety. The more components missing, the less safe the “bridge” or transition becomes (Burke et al., 2012).

These domains listed here are described in more detail, along with implications of the ideal transition in care within the journal article:

- Discharge planning
- Complete communication of information
- Availability, timeliness, clarity, & organization of information
- Medication safety
- Educating patients to promote self-management
- Enlisting help of social & community supports
- Advanced care planning
- Coordinating care among team members
- Monitoring & managing symptoms after discharge
- Outpatient follow-up

Please read the article in its entirety, the link is located below.
http://onlinelibrary.wiley.com/storge/e/10.1002/jhm.1990/asset/1990_fta.pdf?v=1&t=hb9rqxmd&s=3ce9cc4e1f0339b2a2975380027b15f7dc57d592f
The following information is directly cited from https://www.bu.edu/fammed/projectred/index.html.
The citation for this reference is located at the conclusion of this section.

Project RED: Re-Engineered Discharge

**Background:**
Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce re-hospitalizations and yields high rates of patient satisfaction. Virtual patient advocates are currently being tested in conjunction with the RED. In addition, Project RED has started to implement the re-engineered discharge at other hospitals serving diverse patient populations. We are also looking at the transitional needs from inpatient to outpatient care of specific populations (i.e., those with depressive symptoms). Finally, we are about to start a patient-centered project to create a tool that hospitals can use to discover factors (i.e., medical legal, social, etc.) in patients' readmissions.

Project RED is supported by grants from the **Agency for Healthcare Research and Quality (AHRQ)** and the **National Institutes of Health (NIH)-National Heart, Lung and Blood Institute (NHBLI)**, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute. The contents of this website are solely the responsibility of Brian Jack, MD and Boston University/Boston Medical Center and do not necessarily represent the official view of or imply endorsement by any funding institutions.

**Development of the RED**
https://www.bu.edu/fammed/projectred/development.html

**Components of Re-Engineered Discharge (RED)**
https://www.bu.edu/fammed/projectred/components.html

**Tools**
These tools were developed to facilitate the Re-Engineered Hospital Discharge intervention.

The RED toolkit provides complete implementation guidance and is adapted to address language barriers, cross cultural issues and disparities in health care communication and trust. The toolkit includes five tools that provide step-by-step instructions to provide a springboard for hospitals to proactively address avoidable readmissions. Below is a brief description of each tool.

1. **The Re-Engineered Discharge: How to Begin Implementation at Your Hospital.** This document outlines the steps you need to take to begin implementation at your hospital. It will help you consider all aspects of implementation, from planning your implementation team to identifying potential barriers. For example, it
reviews the advantages and disadvantages of integrating the discharge education functions into the duties of
the staff nurse responsible for patient discharge versus a strategy of hiring dedicated discharge educators to
perform these functions.

How to Begin the Re-Engineered Discharge (RED) Implementation at Your Hospital (PDF 642 KB)

2. How to Deliver the Re-Engineered Discharge. This document describes various tasks the Discharge Educators
undertake to implement the RED components, from reconciling medication lists to reviewing the After
Hospital Care Plan (AHCP) with the patient. The manual includes instruction about how to create the AHCP,
the booklet for patients with instructions about how to take care of themselves after leaving the hospital.
The AHCP includes a medication schedule, a schedule of follow-up appointments, information about the
patient’s condition(s), and guidance on diet and exercise. This document describes the various methods that
can be used to create the AHCP, either manually or using automated software. The AHCP can be generated in
English, Spanish, and Simplified Chinese, using the automated software. For all other languages, a hospital
can choose to manually create the AHCP in the patient’s preferred language or to print the AHCP in English,
with space where a translation can be entered.

How to Deliver the Re-Engineered Discharge at Your Hospital (PDF 1.49 KB)

3. How to Deliver the RED to Diverse Populations. A culturally competent approach ensures the effective
delivery of the RED to all eligible patients and improves the quality of health care service. This tool assists
Discharge Educators in delivering the RED to patients from diverse backgrounds, including diverse language,
culture, race, ethnicity, education, and literacy, and social circumstance. It includes some proactive
communication and relational strategies such as AskMe3.

How to Deliver the Re-Engineered Discharge to Diverse Populations (PDF 771 KB)

4. How to Conduct a Post-Discharge Follow-up Telephone Call. The post-discharge reinforcement phone call is
scheduled within 72 hours of a patient’s hospital discharge. The objectives are to review appointments,
medicines, medical issues, and what to do if a non-emergent problem arises. This document provides a script
for the telephone call, as well as scenarios of actual calls and a role play exercise that can be used in training
callers.

How to Conduct a Post-discharge Follow-up Phone Call (PDF 1004 KB)

5. How to Benchmark Your Hospital Discharge Improvement Process. This document will help you begin to
examine your hospital’s current rate of readmissions and implement a program to monitor your hospital’s
progress. It reviews the reasons for measuring transitional care, suggests outcome and process measures,
and reviews the availability of data to create benchmarks.

How To Monitor RED Implementation and Outcomes (PDF 830 KB)

After Hospital Care Plan (AHCP)
One of the principles of RED and of the NQF Safe Practice is that all patients should leave the hospital with a
discharge plan. We call our discharge plan the “After Hospital Care Plan” because in the course of our work we
realized that some patients are confused by the word “discharge.” The AHCP is a spiral-bound, color booklet that is designed to clearly present the information needed by patients to prepare them for the days between discharge and the first visit with their ambulatory care physician. We worked with consultants from the Rhode Island School of Design to help us with the graphic design. The personalized AHCP lists medications and upcoming appointments and tests; provides a color-coded calendar of upcoming appointments; and is designed to help the patient prepare for his/her upcoming appointment (patient activation).

After Hospital Care Plan (AHCP) Template - English (.doc)
After Hospital Care Plan (AHCP) Template - Spanish (.doc)

Assistance
For more information about Project RED, please visit AHRQ’s Frequently Asked Questions website:
RED FAQ’s (http://www.ahrq.gov/news/kt/red/redfaq.htm)

If you have questions or comments, or need assistance with the Toolkit, please contact:
Jessica Martin, MA, MPH-Project Manager, Project RED-Department of Family Medicine, Boston Medical Center
Email: Jessica.martin@bmc.org

For more detailed information regarding Project RED, please visit the Project RED website at
https://www.bu.edu/fammed/projectred/index.html
II. TRANSITION MANAGEMENT: VISION & AIM
Vision: Design standard processes to treat every patient as an individual

- What will new Care Transitions look like for the **PATIENT**? - Every patient knows what will happen next in their care (including when) and who will be involved.
- What will new Care Transitions look like for **VUMC**? – Every provider will know what is happening next and what providers and care teams are involved.

Meet the Institute of Medicine’s Six Aims (STEEEP):

- **Safe**: avoiding injuries to patients from the care that is intended to help them.
- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.


**Aim of Transition Management:** Flawless, explicit accountability for patient management.

**Approach and Commitment**

- Put everybody to work – there’s a lot to do
- Integrate the current work in progress
- Move toward standard work processes
- Adequately resource the “vital few”
- Stay patient-focused: “Nothing about me, without me.”
III. TRANSITION HUDDLE OVERVIEW
Developing the Vanderbilt Way for Transitions in Care

<table>
<thead>
<tr>
<th>Transition Bundle</th>
<th>Routine Care</th>
<th>Enhanced Care</th>
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<tbody>
<tr>
<td>Estimated Discharge Date</td>
<td>X</td>
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<tr>
<td>Follow-Up Appt. Scheduled</td>
<td>X</td>
<td>Based-on specific patient needs</td>
</tr>
<tr>
<td>Medication Management</td>
<td>X</td>
<td></td>
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<tr>
<td>Follow-Up Phone Call</td>
<td>X</td>
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<tr>
<td>Post-Acute Placement &amp; Needs</td>
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</tbody>
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HOSPITAL DAILY TRANSITION HUDDLE
- Interdisciplinary team huddle; early intervention on barriers to discharge
- Anticipate earliest date of discharge & post-acute placement and needs, review risks & initiate key actions for every patient, every day.

Transition Huddle Support Structure

- **Coach**
  - Owner of huddle
  - Directs team strategies
  - Mentors & supports facilitator
  - Analyze & disseminates data
  - Identifies & communicates barriers, issues, & opportunities to Sponsor & TMO

- **Facilitator**
  - Maintains huddle structure & process
  - Oversees core team preparedness
  - Collects process data
  - Communicates strengths & opportunities
  - Disseminates information to huddle team

- **Front line Huddle Team**
  - Interdisciplinary team assembles daily
  - Collaborate & communicate transition needs & barriers
  - Develop/communicate ideas for change/improvement

- **Sponsor**
  - Provides oversight & guidance to huddle efforts
  - Ensures sufficient resources & time are allocated
  - Removes barriers
  - Tracks outcomes

- **Transition Management Team**
  - Provide toolkit for huddle deployment (prompt list & data interpretation manual)
  - Train the Facilitator
  - Monitor & troubleshoot
  - Resources coordination

- **Transition Management Steering Group**
  - Lead collaborative, system-wide effort to improve patient care transitions
  - Coordinate & connect ongoing work in progress
  - Track metrics to ensure improvement
  - Redirect efforts when indicated
  - Report progress
  - Identify barriers
  - Recommend technology/people/process pilot efforts
  - Evaluate value of transition work

- **Executive Sponsor**
  - Establish strategic direction & priorities
  - Remove barriers
  - Set tempo for change
Transition Huddle Support Structure – Member Details

**Facilitator**
- Department-Specific

**Coach**
- Department-Specific

**Sponsor**
- Department-Specific

**Transition Management Team**
- Anctil, Beth
- Bruce, Pamela
- Cella, Donna Rice
- Devers, Cathy
- Hatch, Megan
- Mansolino, Adrianna
- Morris, John
- Muldowney, Nancy

**Transition Management Steering Committee Members**
- Anctil, Beth
- Benegas, Manny
- Bernard, Gordan
- Bonn, Danny
- Brown, Laura Beth
- Byrne, Dan
- Choma, Neesha
- Daniels, Titus
- Fortenberry, Ron
- Gregory, David
- Jones, Pam
- Kripalani, Sunil
- Merrill, Walter
- Morris, John
- Newman, Jim
- Patel, Neal
- Russ, Stephan
- Smith, Terrell
- Smith, Janice
- Starmer, Jack
- Steaban, Robin

**Executive Steering Committee Members**
- Dittus, Robert
- Dubree, Marilyn
- Edgeworth, Mitch
- Head, Margaret
- Kaiser, Allen
- Posch, David
- Stead, Bill
- Sternberg, Paul
## Roles & Expectations

<table>
<thead>
<tr>
<th>Role</th>
<th>Expectations</th>
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| **Physician Champion/Sponsor** | • Engage physician champions in huddles – more information to come!  
• More information to come |
| **Sponsor** | • Provide oversight & guidance to transition huddle efforts  
• Ensure that sufficient resources & time are allocated  
• Communicate strategies to motivate and mobilize  
• Celebrate successes  
• Remove barriers  
• Track outcomes  
• Set tempo for change  
• Set standards for accountability  
• Meet regularly with Coach to:  
  - Review huddle data & ensure that deliverables are being met  
  - Communicate successes, opportunities, barriers & issues  
• Meet regularly with Physician Champion  
• Routinely attend huddles & meetings |
| **Coach** | • Direct team strategies  
• Owner of transition huddle  
• Recommend huddle facilitator(s)  
• Mentor & support facilitator(s)  
• Analyze & disseminate data  
• Identify & communicate barriers, issues & opportunities to Sponsor & TMO  
• Communicate transition huddle strategies to all new employees  
• Provide oversight to transition huddle team  
• Communicate objectives & deliverables  
• Provide feedback about the transition huddle team participation to leadership  
• In conjunction with Sponsor & Facilitator, ensure accountability for deliverables among huddle team members  
• Observe huddle (frequency to be determined by Sponsor)  
• Ensure collection of process data  
• Attend training & debriefing sessions |
<table>
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<tr>
<th>Role</th>
<th>Expectations</th>
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<tbody>
<tr>
<td><strong>Facilitator</strong></td>
<td>• Maintain huddle structure &amp; process</td>
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<td>• Oversee core team attendance &amp; preparedness</td>
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<td>• Collect process data</td>
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<td>• Review all data</td>
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<td>• Communicate strengths &amp; opportunities</td>
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<td></td>
<td>• Disseminate information to huddle team</td>
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<td></td>
<td>• Attend huddle daily</td>
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<td>• Ensure core elements are reported</td>
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<td>• Maintain huddle tempo</td>
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<td>• Promote teamwork</td>
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<td>• Prompt focused discussion on key triggers</td>
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<td>• Elevate parking-lot items to Coach/TMO</td>
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<td></td>
<td>• In conjunction with Sponsor &amp; Coach, ensure accountability for deliverables among huddle team members</td>
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<td></td>
<td>• Ensure communication among care team</td>
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<td></td>
<td>• Onboarding new employees to transition huddle team</td>
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<td></td>
<td>• Support team dynamics: (form, storm, norm, &amp; perform)</td>
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<td></td>
<td>‒ Problem solving</td>
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<td>‒ Decision-making</td>
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<td>‒ Conflict resolution</td>
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<td>‒ CREDO behavior</td>
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<tr>
<td></td>
<td>• Attend training/debriefing sessions</td>
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<tr>
<td><strong>Transition Management Team</strong></td>
<td>• Provide toolkit for huddle deployment</td>
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<td></td>
<td>• Train the Coaches/Facilitators</td>
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<td>• Monitor and troubleshoot</td>
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<td></td>
<td>• Provide resources/evidence-based information to team members supporting transition efforts</td>
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<td></td>
<td>• Elevate parking-lot items to TMO senior leadership</td>
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<td>• Attend huddles as needed</td>
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<td></td>
<td>• Ensure standardization of core huddle concepts across enterprise</td>
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<tr>
<td><strong>Huddle Team Member</strong></td>
<td>• Open to change &amp; provide ideas</td>
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<td>• Drive the patient experience</td>
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<td>• Shared leadership</td>
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<td>• Follow-through/accountable</td>
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<td>• Communicate (provider, bedside nurse, &amp; other team members)</td>
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<td></td>
<td>• Attend huddle daily</td>
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<td>• Attend training sessions</td>
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<td>• Promote teamwork</td>
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<td>• Prepared &amp; engaged</td>
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IV. TRANSITION HUDDLE CONTENT
Team Members

Team members may vary by Transition Huddle area.

- Facilitator
- Charge RN
- Provider
- Case Manager
- Social Worker
- Discharge Planner
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Language & Pathology (Speech Therapy)
- Cardiac Rehabilitation
- Transition Care Coordinators
- Clinic Staff Member/Representative
- Pharmacy
- Nutrition Services
- Vanderbilt Psychiatric Hospital (VPH)
- Palliative Care
- Pi Beta Phi Rehabilitation Institute (PBPRI) Liaison
- Vanderbilt Home Care Services (VHCS) Liaison
- Vanderbilt Stallworth Rehabilitation Hospital Liaison
- Walgreens Infusion Liaison

"We make more referrals to home health care as a result of improved communications."

"The conversations change when everyone is at the table. It feels good to have us all in one room with the patient at the center of our work."

"Even if we haven’t moved the numbers, we have moved the mindset."

Quotes were obtained from the following source:

**Reducing Avoidable Rehospitalizations: Getting Started with Creating an Ideal Transition from Hospital to Home**

Last Modified: 12/4/2012

Gail Nielsen, Director of Learning and Innovation at Iowa Health System, and Peg Bradke, Director of Heart Care Services at St. Luke’s Hospital in Iowa, discuss the key design elements for engaging in this work.

[http://www.ihi.org/knowledge/Pages/AudioandVideo/GettingStartedCreatingIdealTransitionfromHospitaltoHome.aspx](http://www.ihi.org/knowledge/Pages/AudioandVideo/GettingStartedCreatingIdealTransitionfromHospitaltoHome.aspx)
**Tuckman’s Model of Group Development**

**Forming:** in which, the group is just coming together. It is often characterized by shyness, uncertainty and diffidence among the members, although extravert members may rapidly assume some kind of leadership. Maintenance concerns predominate.

**Storming:** in which, having been established, there is a period of jockeying for position, authority and influence among the members. In classes, this is the period of "testing-out" the teacher. Disagreements appear or are manufactured and roles are eventually allocated. The initial leaders may not survive this period: it is the most uncomfortable phase of the group's life—a sort of group adolescence.

**Norming:** having sorted out its internal structure, there is then the issue of what the group stands for. What kind of behavior and contribution is acceptable and what isn't? Members explore behind the power processes of storming and begin to form some idea of the group's identity: the "group in the mind". This is rarely done explicitly, of course, and it can readily slip back into Storming.

**Performing:** after all that, the group can begin to get some work done, on the basis of a relatively stable structure.

**Adjourning:** This is about completion and disengagement, both from the tasks and the group members. Individuals will be proud of having achieved much and glad to have been part of such an enjoyable group. They need to recognize what they've done, and consciously move on. Some describe stage 5 as "Deforming and Mourning", recognizing the sense of loss felt by group members.

**References:**
www.chimaeraconsulting.com/tuckman.htm
Core Questions

A goal of each Transition Huddle is to answer/discuss 5 core questions for every patient:

1. **Where did the patient come from?**
   - Skilled Nursing Facility (SNF)
   - Outside hospital/referral
   - Inpatient Rehabilitative facility (IPR)
   - VA Hospital
   - Assisted living facility
   - Long-term Assisted Care facility
   - Homeless/shelter
   - Home
   - Group home

2. **Why are they here?**
   - Diagnosis
   - Procedure
   - Elective
   - Non-elective
   - Readmission

3. **Where are they going?**
   - PT/OT recommendations
   - Nursing needs assessment
   - Patient, family, provider and care team decision

4. **When is the earliest time you think this patient will transition to the next level of care?**
   - Has the patient/family been notified?

5. **What do you think the challenges/barriers will be after discharge?**
   - What will the patient’s first day at home look like?
   - What is the patient’s/family’s biggest concern about going home
     - Potential barriers:
       - Transportation
       - Funding
       - Polypharmacy
       - Social concerns
     - Measures to address the challenges/barriers:
       - Home health consult
       - Pharmacy consult
       - Earlier follow-up appointment with provider
       - Discharge phone call (24-48 hours after discharge)
**Prompt List**

**Purpose:** The prompt list is a *guide* to facilitate conversations around patient’s transition and post-hospital plan of care. It can be used to assist the facilitator in recognizing which essential elements of the transition huddle (5 questions/bundle) have not been discussed and prompt discussion.

**How to use this Prompt List:**
Determine which prompt list items are relevant to your transition huddle team and indicate which role(s) are responsible for each item.

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<th>Where did the patient come from?</th>
<th>Facilitator</th>
<th>Provider</th>
<th>Charge RN</th>
<th>Case Manager</th>
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<th>PT</th>
<th>OT</th>
<th>Cardiac Rehab</th>
<th>Pharmacy</th>
<th>Stallworth Liaison</th>
<th>VHCS Liaison</th>
<th>Walgreens Liaison</th>
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How to use this Prompt List:
Determine which prompt list items are relevant to your transition huddle team and indicate which role(s) are responsible for each item.

<table>
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<tr>
<th>Consults (pending or needed)</th>
<th>Facilitator</th>
<th>Provider</th>
<th>Charge RN</th>
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VI. CONTINUUM PARTNERS
Pi Beta Phi Rehabilitation Institute/Vanderbilt Bill Wilkerson Center

Pi Beta Phi Rehabilitation Institute at Vanderbilt Bill Wilkerson Center is an interdisciplinary outpatient rehabilitation clinic serving older teens and adults with acquired neurological impairment.

Their mission is to assist those with traumatic brain injury and other acquired neurological impairments improve their quality of life by improving their communication and cognitive skills, psychosocial skills and physical independence.

They are committed to providing quality, evidence-based therapies to their clients and their families, educating future healthcare professionals, providing education to their families/caregivers and to the public on acquired neurological impairments and researching advancements in effective treatments and outcome measures.

**Triggers:**

1. Traumatic Brain Injury
2. Stroke/CVA
3. Brain Tumor
4. Anoxia
5. Multiple Sclerosis
6. Parkinson’s Disease
7. Meningitis/Encephalitis
8. Guillain-Barre
9. ALS
10. Amputation
11. Visual changes
12. Dementia
13. Learning Disabilities

**Admission Criteria:**

- Adults and adolescents with traumatic brain injury and other acquired neurological impairments.
  Younger children are accepted on a case-by-case basis
- Must be medically stable and mobile – with or without an assistive device
- Must be able to stay in the clinic with minimal supervision; not at risk for wandering
- Must pose no danger of injury to self or others

**Referral Process:**

- Referred by physician, case manager, patient and/or caregiver
- All referrals must be accompanied by medical and treatment records to allow for appropriate scheduling and assessment planning
- Physician orders are required for evaluation and treatment – PBPRI referral forms
- Insurance verification service is available to assist patients/families with insurance authorizations and verifications

**Other Important Information:**

- Transportation service: Provided for clients who cannot access transportation
  - Service dependent on availability
  - Transportation does not exceed 30 miles outside of PBPI
- Cost depends upon the distance from PBPI
- Driver Evaluation and Rehabilitation Program at PBPRI evaluates individuals with medical conditions to determine if they are able to safely drive a vehicle in a variety of environments. The program also provides training in driver safety and adaptive driving equipment for clients.
Vanderbilt Home Health Care

**Medicare Patients**

**Definition of Homebound**

To be eligible to receive home health care services the physician must certify that the patient is homebound, which means they routinely have an inability to leave home. Some patient’s may have a medical condition that prevents them from leaving the home. However, being homebound does not require the patient to be bedbound.

There are acceptable absences from home that Medicare allows without disqualifying the patient’s homebound status. The following guidelines are intended to assist the health care professional assess their patient to determine if they qualify for home health care.

Non-medical absences from home should be relatively short in duration and infrequent. These absences may include the following:

- To attend religious services
- To go to the barber or beauty salon
- To attend a unique family function or special occasion such as a family reunion, funeral, or graduation

Medical absences from home should be for the purpose of receiving health care treatment not typically provided inside the home and may include the following:

- Radiation
- Outpatient dialysis
- Day Care (certified or licensed by the state)

Requiring assistance to leave the home should:

- Be provided by another person and/or with a walking device such as a cane, walker or wheelchair
- Take a considerable and taxing effort such as developing shortness of breath on exertion or transporting necessary medical equipment (ex. Portable oxygen tank)

**Definition of Skilled Care**

Medicare defines three primary services it considers to be ‘skilled’ and qualifies to be the only service at start of care. These stand-alone services include Skilled Nursing, Physical Therapy, and Speech Therapy.

**Skilled Nursing:** Medicare defines three primary nursing functions that it considers to be skilled and reimbursable by Medicare. These include observation and assessment of the patient’s condition, teaching & training, and performing ‘skilled’ procedures. The following examples are not all inclusive, but may serve as a guide to identify the obvious and not so obvious patients appropriate for referral to home care.
Nursing Observation/Assessment of Patient’s Condition

- Diagnosis or exacerbation of a new or existing illness
- Vital signs that are fluctuating
- Changes in weight related to fluid retention/edema
- Changes in circulatory status
- Changes in respiratory status
- Administration of medical gases such as oxygen
- Monitor for drug toxicity
- Follow-up from recent hospital stay

Patient Teaching/Training

- Medication change in the last 60 days
- New medication within the last 30 days
- Medication regimen
- Performing bladder/bowel training
- Providing enteral/parenteral nutritional feedings
- Performing specific procedures:
  - Wound care
  - Urinary catheter care
  - Diabetic care
  - Ostomy care
  - Administration of injections

Perform Specific Procedures

- Medication administration other than oral:
  - Insulin and other injections
  - IV infusions
- Wound care
- Weights
- Catheter changes
- Tube feedings
- Ostomy care
- NP/Trach succioning

PHYSICAL THERAPY

If the level of care is such that intervention by a trained physical therapist is needed then PT may be indicated and is reimbursable by Medicare. The following examples are not all inclusive, but may serve as a guide to identify the obvious and not so obvious patients appropriate for referral to home care.

Key Indicators

- A risk for or a recent history of falls and subsequent fractures
- Need for Falls Risk Assessment
- Awareness for safety is poor and related teaching is needed
- Needs equipment such as wheelchair, walker, cane, etc...
- Activity induces shortness of breath
- Range of motion is limited resulting in decreased in sensation, contractures, or pressure sores
- Recent marked decline in functional status (strength & endurance) due to pain, stroke, etc...
Observe/Assess if the patient has difficulty with:

- Repositioning or getting in/out of bed
- Sitting or standing
- Getting on/off bedside commode or toilet
- Walking outside or inside
- Going up or down steps

**SPEECH THERAPY**

If the level of care is such that intervention by a trained speech therapist is needed then ST may be indicated and is reimbursable by Medicare. The following examples are not all inclusive, but may serve as a guide to identify the obvious and not so obvious patients appropriate for referral to home care.

- Voice disorders
- Speech Articulation disorders
- Dysphagia
- Language disorders
- Aural rehabilitation needs
- Non-oral communication needs

**HOME HEALTH AIDE (HHA) SERVICES**

If the patient requires assistance with activities of daily living (ADLs), and is receiving care from a qualified ‘skilled’ professional, then an HHA can be provided. The following are services an aide may perform:

- Assistance with bathing/grooming
- Assistance with transfers/ambulation
- Assistance with exercises

**The following services may be indicated, but do not qualify as the only ‘skilled’ service at the start of care:**

**OCCUPATIONAL THERAPY (OT)**

If the level of care is such that intervention by a trained occupational therapist is needed then OT maybe indicated and is reimbursable by Medicare. The following examples are not all inclusive, but may serve as a guide to identify the obvious and not so obvious patients appropriate for referral to home care.

- Training and assistance with self-care and other activities of daily living
- Injury and fatigue prevention
- Construct splints and adaptive equipment
- Guidance and planning for return to work and community life
- Patient/caregiver education

**MEDICAL SOCIAL SERVICES**

If the level of care is such that intervention by a trained social worker is needed then SW maybe indicated and is reimbursable by Medicare. However, medical SW does not qualify as a ‘skill’, and cannot stand as the only service. The following examples are not all inclusive, but may serve as a guide to identify the obvious and not so obvious patients appropriate for referral to home care.

- Education of or assistance with accessing Community Resources
- Assessment of social and emotional factors
- Counseling for long range planning/decision making
- Short-term counseling
Vanderbilt Stallworth

Vanderbilt Stallworth Rehabilitation Hospital is an 80-bed inpatient rehabilitation hospital that offers comprehensive inpatient rehabilitation services designed to return patients to leading active and independent lives. The hospital opened in November of 1993 and is a joint venture between Vanderbilt University Medical Center and HealthSouth, one of the nation’s leading rehabilitation services provider.

The hospital provides a wide range of physical rehabilitation services, a vast network of highly-skilled, independent private practice physicians and HealthSouth therapists and nurses, and the most innovative equipment and rehabilitation technology, ensuring that all patients have access to the highest quality care.

Vanderbilt Stallworth serves patients throughout the Southeast including all of Middle Tennessee, and is located at 2201 Children’s Way, Nashville.

In addition to caring for general rehabilitation diagnoses such as orthopedics, pulmonary and cardiac conditions, Stallworth has specialized inpatient programs for stroke, brain injury, spinal cord injury, amputations, hip fractures and neurological conditions.

Not only has Stallworth achieved Center of Excellence status within the HealthSouth network of hospitals, the hospital has achieved Joint Commission disease-specific certification for both their Stroke and Spinal Cord Injury Rehabilitation programs. Stallworth is proud to be the first and only to achieve the Spinal Cord certification in the state.

Rehabilitation is covered in full or part by most health insurance plans, including Medicare and certain Medicaid programs. The hospital has contracts with most major insurance companies and is willing to negotiate with other companies as needed.

For more information, please visit the Vanderbilt Stallworth Rehabilitation Hospital website: http://www.vanderbiltstallworthrehab.com
Walgreens Infusion Services

**Key Programs:**

- Provide comprehensive patient education prior to hospital discharge to promote successful transition from hospital to home
- Therapy specific welcome kit provided with tools to promote patient compliance with prescribed therapy including patient journal that includes pertinent medical information
- Provide patient welcome folder with key contact information for Walgreens Infusion and chosen home health agency
- Provide 24/7 access to specialty trained infusion nurses and pharmacists
- Provide follow-up after discharge
- Nationwide footprint allows patient to receive therapy across the country if needed or easily transition therapy to another branch if they relocate
- Currently tracking readmission rates including root cause analysis
- Current available outcomes data
  - 98% rate of incident free infusion encounters
  - <1% rate of unplanned hospital admissions
  - 98% patient satisfaction rate

Walgreens Infusion Services also supports the referral source:

- In-network with most insurance companies
- Easy referral process with StarPanel access
- Our intake dept. will verify insurance benefits and set-up home health with patients’ preferred agency
- Local branch covers all of Tennessee and parts of southern Kentucky
- We will transition the patient to another infusion provider if we are unable to accept their insurance plan or coverage area

Walgreens Infusion accepts nearly all insurance plans and provides infusion services throughout the states of Tennessee and Kentucky.

**Home Infusion Therapies include:**

- Antibiotics
- Inotropics
- TPN
- Enteral Nutrition
- Chemotherapy
- IVIG
- Hemophilia Factor
- Remicade
- Pain Management
- MS Treatment
VIII. DATA
Process Data

Process data will be collected by both the Huddle and Transition Management teams. The frequency of collection and types of data will be determined by your Sponsor and Coach. Below are suggestions for specific types of data that might be collected for your unit.

<table>
<thead>
<tr>
<th>Suggested data types to be collected by the Huddle Team</th>
<th>Data provided by the Transition Management Office (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily huddle start/stop time</td>
<td>Referral into Home Health Care</td>
</tr>
<tr>
<td>Number of patients discussed in huddle</td>
<td>Referral into Post-Acute care facilities</td>
</tr>
<tr>
<td>High Risk patients identified</td>
<td>Follow-up appointments</td>
</tr>
<tr>
<td>Adherence to the 5 questions</td>
<td>More to come, as technology allows</td>
</tr>
<tr>
<td>Time of day discharges occurred</td>
<td></td>
</tr>
<tr>
<td>Follow-up phone calls made within 24-48 hours post discharge</td>
<td></td>
</tr>
<tr>
<td>Follow-up appointments requested</td>
<td></td>
</tr>
<tr>
<td>Referrals to the Transitional Care Team</td>
<td></td>
</tr>
<tr>
<td>Others as defined by the team</td>
<td></td>
</tr>
</tbody>
</table>

Outcome Data

Outcome data will be provided through the Transition Management Team. Below is the list of data that will be provided for your Transition Huddle.

<table>
<thead>
<tr>
<th>Data provided through the Transition Management Office (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length-of-Stay (ALOS)</td>
</tr>
<tr>
<td>Readmissions Rate</td>
</tr>
<tr>
<td>Referrals to Home Health Care &amp; Post-Acute Care facilities</td>
</tr>
</tbody>
</table>

*PRC/HCAHPS

*Results of the PRC/HCAHPS survey questions that are provided on a quarterly basis:

Questions that are "transitions" related:

1. After (you/your family member) left the hospital, did (you/he or she) go directly to (your/his or her) own home, to someone else's home, or to another health facility?
2. During this hospital stay, did doctors, nurses, or other hospital staff talk with (you/your family member) about whether (you/he or she) would have the help (you/your family member) needed when (you/he or she) left the hospital?

3. During this hospital stay, did (you/your family member) get information in writing about what symptoms or health problems to look out for after (you/your family member) left the hospital?

4. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

5. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

6. When I left the hospital, I clearly understood the purpose for taking each of my medications.

7. Would you rate the overall teamwork between the doctors, nurses, and staff as:
   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

Additional PRC/HCAHPS tutorials for accessing your survey results may be found in the Appendix of this manual.
IX. RESOURCES
Transitional Care Team

**Purpose:** Manage complex patients (outliers) and their transition to Post-Acute Care.

**Criteria used to identify patients commonly referred to the service:**
- Patients in hospital >21 days
- Reaching DRG days
- Medically ready with no accepting facility
- Long-term IV antibiotic/TPN
- Family impeding discharge
- Cirrhosis PLUS major injury
- Patients needing intensive management
  - Assess high risk patients
  - Frequent admissions
  - Polypharmacy (the practice of administering or using multiple medications, especially concurrently)
  - Anticoagulation
  - CHF/AMI
  - PNA/COPD
  - Pancreatitis/Gastroparesis patient

**The Transitional Care Team includes the following roles:**
- Nurse Practitioner
- MD
- All interfacing Post-Acute care offices

**Referral Sources:**
- Transition Huddles
  - Referrals will be made directly to the Transitional Care Team
- Predictive Model
  - The 15 highest risk patients per day will be distributed to the Transitional Care Team
  - Plans will be formulated for these patients
  - Resource needs will be anticipated

**Barriers to Discharge:**

- **Identifiable on Admission**
  - Lack of family support
    - For any patient deemed not safe to be alone
    - Lack capacity
      - No surrogate decision maker
      - Homeless
    - Lacks mobility or requires follow-up care
  - Socioeconomic
    - Lacks funding
    - Does not meet skilled criteria needs
  - Bariatric patients
    - Typically BMI > 40
  - Undocumented immigrants
  - IV drug abuse
    - Need for PICC line & infusion
  - Med-psych placement
    - Self-inflicted injuries

- **Identifiable Late**
  - Tracheotomy patients requiring SNF
  - Long-term ventilator patients
    - Secondary issues:
      - Wound vac /dialysis
    - Placement including TPN
  - Placement with high cost needs
    - i.e. drugs, specialty equipment, complex wound care
  - Med-psych placement
    - Behavioral issues
  - Brain injury
    - Need for 24 hour supervision
To utilize the Transitional Care Team service, please follow these steps:
Have provider complete a WIZ order, consulting the Transitional Care Team – or – the provider can page the team at 615.835.1402

Information source: Dr. John Morris, and the Transitional Care Team
Customizing Panels

When viewing your list of patients in StarPanel, you have the ability to customize the information you want to see. Below are a few suggestions that will assist you when “customizing” your panel view.

1. Once in StarPanel, select **Inpt. census** located on the left within the black border. After you have selected your inpatient census panel, over on the right border you will see **Customize**.

2. Click “Customize”, then choose “Columns”
3. You will then see this screen

![Choose Columns dialog box]

4. Here you will click on which options you want to appear in your panel. They will turn blue when selected. When finished, click OK. To de-select, click on the option again, and it will return to gray. This screen shot has options selected that may be helpful to reference during the huddle.
Linking Panels

1. After logging into StarPanel, access "Panels" located on the left within the black border.

2. Next, select “Create a panel”

3. Name your panel, and then click ‘OK’. This new panel will now appear in your list of panels.
4. Now, create an inpatient panel by “Location.” After selecting location, choose the units that you want linked to your panel. You will choose “Location” each time before selecting the unit. These individual units will now appear in your list of panels.

5. Now, select your new panel, and within the yellow box choose “Link/unlink”

6. Now click on each of the units that you want linked to this new panel. Once you select these, they will be removed from your panel list.

7. Refresh your screen.

8. You will now see your new “linked” panel in your panel list. As seen below, it will indicate the number of units contained within your panel. When selected, you will be able to view all your patients in the specific areas.
Cornelius: Real-time predictive modeling to reduce avoidable readmissions

Cornelius Readmission Tool has been developed to help identify those patients at risk for re-hospitalization.

- It provides a score based on admission lab values, patient age, and previous admissions in the past six months.
- The intent for use is to augment other indicators that have been identified that could potentially indicate a patient’s increased risk for hospital readmission.
- Some of these other indicators may include:
  - Socioeconomic factors
  - Unfunded (lack of insurance)
  - Access to resources
  - Support at home
  - Transportation
  - Complexity of disease process(es)
  - Medication management (access to meds, understanding of use)

Benefits of the Cornelius Readmission Risk Score:

- Enables us to look at the highest readmission risk patients across the hospital for the first time.
- Based on existing admission data.
- Requires no time or effort to calculate.
- Shines a spotlight on patients at the highest risk.
- Provides risk stratification rather than a simple red alert for high risk.

How to access the Cornelius score:

After receiving access to Cornelius, you can customize your panel view to include the Readmission column. This is where you will find the Cornelius score. To customize your panel view, follow these steps:

- Select “customize” columns in the right margin
- Next, select “Readmit”
• The Readmit column now is now present in your panel view
• When you hover over the score, an information box now appears with specific Cornelius readmission criteria (ED admits, # of prior hospitalizations, and lab values)
Potential Future Resources

CareInSync
A proof of concept began in the Neurosurgery Huddle in January. Potential next steps may include a pilot within the same area. More information about CareInSync will be available soon.

- CareInSync is real-time software that improves: Collaboration, Coordination and Communication
  - Coordinating safe & timely care transitions
  - Improve care quality & efficiency
  - Platform that virtually connects the entire care team in real-time

TeleTracking
The Neuroscience Huddle will be beginning a TeleTracking pilot in the near future. More information about TeleTracking will be available soon.

- TeleTracking has the ability to provide an overview of milestones. This overview can be used to drive operational efficiencies with the discharge process by creating a discharge task checklist for each patient.

In Evaluation
Work continues to progress in the development of the following resources:

- Whiteboard
- Dashboard
X. CONTACTS
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XI. APPENDIX