Patient Transition Tip Sheet

Most of these require referrals and coordination with outside agencies. Preparation 1-2 days before scheduled discharge as planned is ideal

Service	iCare™ Intensive Ambulatory Care (IAC) (Arizona Only)	Ambulatory Case Management (Phoenix Only)	Banner Ambulatory Palliative Care (Phoenix Only)	Clinical Pharmacy Services: Population Health Mgt (Phoenix Only)	Ambulatory CM: Clinic Without Walls (CWW) (Phoenix Only)	Hospice (at home)	Banner Home Care (Phoenix Only)
Patient Selection	BHN with BMG, AIP, BPHO Primary Care Physician (and) resides in Phoenix Metro area including AZ East/West regions (see zip code list for detailed geo coverage)	BHN only	BHN Medicare	BHN Current focus: Full risk populations, complex chronic conditions, and at high risk for readmission based on flag	BPA only	Most all patients have hospice benefits	BHN or Banner funded charity care
Criteria	● Life expectancy > 12 months, (and) poorly controlled disease process defined as: ● A1C > 9 for 6 months ● (or) blood pressure: 180/110 or higher at 3 consecutive office visits ● (or) BNP 2 consecutive values greater than 800 ● (or) GFR lower than 39 ● (or) Anti-coagulation: 3 values out of the 2 - 3.5 range in 6 month period ● (or)Psycho-social issues defined as: can't afford medications (or) dementia (or) lack of home support (or) no transportation (e.g. can't get to Coumadin clinic) ● (or) Nutritional risk defined as: albumin below 3 and weight loss of 10% body weight in 3 months ● (or) High risk flag and 1 of the "or" conditions ● (and) multiple hospitalizations/ED visits ● (or) 3 office visits in last 6 months for same primary diagnosis	● High intensity flag ● (or) Emotional, social or financial problems complicating health status ● (or) Suspected knowledge deficit ● (or) Difficulty adhering with treatment plans ● (or) Needs support related to cognitive or behavioral medical issues	● Functional Limitation (3 or more ADLs) (or) ● More complex conditions or uncontrolled symptoms than primary care can provide and ● Cancer ● (or) Heart failure ● (or) Cirrhosis ● (or) Lung disease ● (or) COPD ● (or) Dementia ● (or) Frailty syndrome ● (or) > 10% weight loss in 6 months ● (or) 3 or more hospitalizations in 6 month period ● (or) Complex decision making around artificial hydration and nutrition, goals of care ● (or) Dementia of 7C or greater on FAST scale ● (and) Life expectancy approx. 24 to 36 months	● High cost medications (e.g. MS, RA, Cancer) ● Currently reviewing data to determine who to focus on next	● Acute and chronic health problems that may cause freq ED visits or hosp admissions ● (and) would benefit from intensive mgt by an IM physician ● (and) Must be willing to take active part and commit to plan of care	● Prognosis less than 6 months as identified by physician (and) ● Certification of Terminal Illness form (CTI) ● End of life determination from care team assessments, showing general deterioration ● Potential triggers: terminal diagnosis, no possible curative treatment, no curative treatment wanted, multiple ED or inpatient admissions ● Other general conditions: rapid weight loss (10% or more in past 6 months), decrease serum albumin, developing dysphasia, multiple co-morbidities that cause need for admissions, palliative performance scale (ability to function in ADLs) ● Recertification every 90 days twice then every 60 days thereafter to review continued eligibility	● Intermittent (approx. 2X/week) skilled need (and) ● Homebound if Medicare (and) must receive regular care from a physician (and) requires physician orders ● Narrative for services and plan of care established for services (note: not criteria but informational)
Exclusion Criteria	Primary illness cannot be uncontrolled psychiatric issue (or) member in locked unit					Cannot have the primary dx of Adult Failure To Thrive/Debility or Dementia (Alzheimer's OK, Lewy Body OK)	Examples: insurance, lives outside service area
Length of Service	Life-long	Generally 90 days; Needs to meet graduation criteria. ALOS 80 days.	As needed and/or transferred to hospice	Performed on one time intervention basis. E.g. one time medication review after discharge	As long as needed	Until death and 1 year of bereavement counselling for family or discharged for extended prognoses	If Medicare, 3 weeks. ALOS 24 days.
Other			Coordination with Home Care is common			CTI - States that the patient is eligible for hospice. Occurs after nurse assessment, nurse call to medical director, medical director gives verbal approval to bring in patient. Formal CTI completed by medical director.	

Service	Inpatient Skilled Nursing Facility (SNF)	Long Term Acute Care Hospital (LTACH)
Patient Selection	● Have a skilled medical need requiring monitoring or treatment ● Have a complexity and frequency of need that requires an inpatient setting ● The patient's needs can be reasonably met in terms of severity of illness, duration of treatment, and quantity of treatments	● LTACHs are designed for care of patients who, while clinically stable enough to not require ongoing critical care (eg, ICU), do require a level of care (wound care, nursing care, physician oversight) that is beyond the capability of other levels of post-acute care, such as a skilled-nursing facility. ● LTACH care is designed to apply to patients with this level of care need and who also are not expected to improve quickly; specifically, they are expected to require an LTACH length of stay of 25 days or longer ● These are severely ill patients, who are well enough to be cared for outside of an ICU, felt to have the potential for improvement, but this improvement is expected to take several weeks to occur, and the intensity and specialization of care required is beyond that provided in any other level of post-acute care.
Criteria	Must meet **One** or more of the following to qualify for admission to Skilled Nursing Service, Skilled Rehab Service or both: 1. **Requires Skilled Nursing** of RN, LPN, PT, OT, or SLP: Inherent complexity of service is such that it can be performed safely and/or effectively only by, or under, general supervision of licensed professionals and cannot be provided by non-skilled personnel. Requires skilled services on a daily basis. Patients functional or medical complexity are such that outcome would be compromised with less than daily skilled services. Multiple skilled nursing services are required daily 7d/wk. **Skilled Nursing Services** must meet **ONE or more** of the following: a. Injections: IV, IM, SQ (new &/or complex needs, not typically for insulin) b. Intravenous: fluids, meds, or line flushes c. Nebulizers: oxygen eval saturations when unstable, complex d. Enteral feedings new or enteral pt. with recent change in medical condition requiring monitoring e. Care of new colostomy or teaching ostomy care associated with complication f. Frequent suctioning, trach, &/or vent needs g. Frequent irrigation, replacement of urinary catheters; care of new/complex suprapubic catheter h. Treatment Stage III/IV pressure ulcers; widespread skin disorder or complex wounds requiring RN/LPN wound tx i. Nursing evaluation of unstable & complex medical condition, e.g. recovery from septicemia, coma, severe resp. disease, uncontrolled pain j. Nursing rehab teaching, e.g. bowel & bladder training, adaptive aspects of care.	• Admission to LTACH may be indicated by presence of **ALL** of the following • Patient is stable for transfer to LTACH as indicated by ALL of the following: • □ No intravenous vasopressor blood pressure support within last 48 hours □ No significant acute or ongoing hypotension (e.g., SBP less than 90 mm Hg, lactic acidosis) □ Cardiovascular status acceptable □ Stable chest findings □ Renal function acceptable □ Pain adequately managed □ No severe unstable neurologic abnormalities (e.g., altered mental status, ongoing evidence of CNS embolization or ischemia, worsening hydrocephalus) □ No acute significant hepatic dysfunction (e.g., encephalopathy) □ No active bleeding or unstable disorders of hemostasis (e.g., no recent need for transfusion, severe thrombocytopenia with bleeding) □ Intake acceptable □ Volume status acceptable (e.g., not significantly dehydrated) □ No need for respiratory or other isolation, or manageable at next level of care • Clinical assessment indicates expectation that patient will benefit from and improve with LTACH program care available at chosen facility (e.g., palliative care not more appropriate or preferred). • Interdisciplinary LTACH care is appropriate for condition as indicated by medically complex situation, including multiple comorbidities that will require ongoing acute care and complex nursing needs and close physician supervision as indicated by 1 or more of the following: • □ Respiratory failure requiring ventilation management and weaning. • □ Infectious disease condition requiring LTACH care (e.g., endocarditis requiring long-term IV antibiotics and acute care and monitoring for unstable features such as recurring embolic phenomenon, or heart failure requiring daily adjustment of diuretic therapy, fluids, and electrolytes) • □ Complex wound care condition requiring LTACH care (e.g., large wound with necrosis requiring daily physician supervision, recurrent wound debridement, and expected slow healing and possible prolonged delayed closure) • □ Cardiovascular condition requiring LTACH care (e.g., heart failure with pulmonary hypertension requiring long-term IV vasodilator therapy, continued support with high-concentration oxygen (greater than 40%), and daily adjustment of diuretic therapy, fluids, and electrolytes) • □ Rehabilitation care needs requiring LTACH care as indicated by **ALL** of the following: ➢ ○ Documentation that providing patient's specific rehabilitation needs in current or alternative (e.g., inpatient rehabilitation) facility has failed or is not appropriate ➢ ○ Patient can participate in planned rehabilitation activities despite the condition that requires ongoing acute care. ➢ ○ Other complex medical management situation requiring LTACH care (e.g., diabetic peripheral vascular disease with surrounding cellulitis unresponsive to standard IV antibiotic course that requires long-term IV antimicrobial therapy with daily monitoring and adjustment of diabetes treatment and skin condition)
Exclusion Criteria	Traditional Medicare patients who do not have a preceding inpatient qualifying hospital stay. Many of the Affordable Care Plans have an exclusion for SNF benefits.	Patients who do not have complex medical needs and an expected length of stay of at least 25 days **Many LTACHs in the Phoenix area are now requiring a minimum of a 3 day ICU stay during their index inpatient admission.** Patients who are not expected to recover to the point of being able to discharge to a lower level of care.
Length of Service	Medicare has varying copays depending on length of stay	
Other		**This is the most expensive level of care with payments often in excess of $100,000, authorizations are often difficult to obtain from commercial payers and Medicaid/AHCCCS insurance plans.**

Inpatient Rehabilitation Facility (IRF)

Patient Selection	➢ Patients are in need of a resource intensive inpatient hospital environment due to the complexity of their nursing, medical management, and rehabilitation needs. ✓ Patients are thoroughly screened to determine the medical necessity of the admission. A rehabilitation physician must approve of the admission before the patient is admitted into the IRF. ➢ Patients must be able to participate in an intensive rehabilitation program at the time of admission and throughout the course of stay. ➢ Patients are expected to benefit from an interdisciplinary team approach to rehabilitative care.

Criteria	➢ Patient requires the therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy.
	    ✓ Therapy services cannot be delivered by non-skilled personnel.
	➢ With the simultaneous need for a physician to manage their primary rehab diagnosis and active comorbidities that could not effectively be managed at a lower level of care, patients must be able to tolerate, and benefit from, an intensive therapy program. The industry standard for this is a minimum of 3 hours of therapy a day, a minimum of 5 days in the week. In certain rare exceptions, therapy services can be delivered over 15 hours in a 7 day consecutive period.
	➢ Patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation.
	    ✓ Medical supervision means that the rehabilitation physician must conduct face-to-face visits with patients at least 3 days per week throughout the patient's stay to assess the patient medically and functionally and to modify the plan of care, as necessary.
	➢ A coordinated and intensive approach to providing rehabilitation is in evidence through:
	    ✓ Approval by a rehabilitation physician of an overall, individualized plan of care by day 4 of the patient's admission.
	    ✓ A team conference being held in the first 7 days of the patient's stay and weekly thereafter.
	    ✓ A team that must be comprised minimally of the rehabilitation physician, RN rehabilitation nurses, physical therapy staff, occupational therapy staff, speech-language therapy staff, and a case manager or social worker.
	        ▪ The presence of 24 hour a day rehabilitation (RN) nursing is an assumption in the IRF.
	➢ Diagnostic conditions accepted into an IRF program can vary widely.
	    ✓ In a defined 12 month period of time, the IRF must demonstrate that 60% of the patients in its program fall into select diagnostic categories such as 1) stroke, 2) brain injury (traumatic and non-traumatic), 3) spinal cord injury (traumatic and non-traumatic), 4) amputation, 5) various neurologic disorders, 6) burns, 7) congenital deformities, 8) certain arthritic conditions, 9) select hip and knee replacements, 10) femur (hip) fracture, 11) major multiple trauma. 40% of the patients may have diagnoses such as those involving cardiac or pulmonary issues or the patients may be severely debilitated due to post-operative complications or medical complexity.

Exclusion Criteria	➢ Unstable psychiatric condition ➢ Profound anemia with decreasing hemoglobin/hematocrit of unknown etiology ➢ Chest tubes ➢ A Rancho Los Amigos Cognitive Scale of 1 – 3 ➢ Cardiac medication drips ➢ Intolerance to an intensive rehabilitation program ➢ Ventilator dependent
Length of Service	➢ The average length of stay in the IRF nationally is 13.3 days. Patients remain in the IRF until they no longer meet medical necessity for this level of care.
Other	**Benefits of Program to Patient** ➢ Inpatient rehabilitation affords patients who have suffered a significant injury or illness the opportunity for ongoing management of their medical conditions while they participate in an intensive therapy program to regain skills in activities of daily living. The ultimate goal is to discharge the vast majority of patients back into the community. As of August, 2016, one national database indicates that 77% of the patients admitted to an acute inpatient rehabilitation program will be discharged to a community setting. **How?** ➢ As noted above, a rehabilitation physician must assess the patient no less than 3 days in the week throughout the patient's stay in the IRF. Additionally, during the IRF stay physicians with other specialties manage the care of the patient as appropriate. RN rehabilitation nursing is available 24/7. Therapy programming is mandated to be extensive, with no less than 3 hours of therapy a day a minimum of 5 of 7 days in the week. A case manager or social worker or both must be involved in each admission. Dietary services or services from respiratory therapy are also frequently utilized. Psychology services are also often employed. **Recruitment** ➢ Inpatient case management. There is <u>no</u> mandate that a patient have a 3 day qualifying stay in a short-term acute care hospital for admission. While the vast majority of patients are admitted from a short-term acute care setting, patients may be admitted from home, from a physician's office, from the ED, and from observation units.