Promoting Safe Care Transitions

Care Coordination

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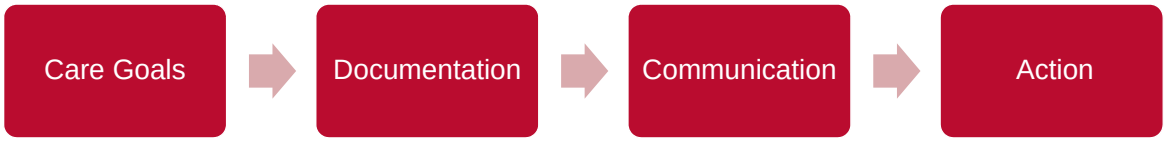
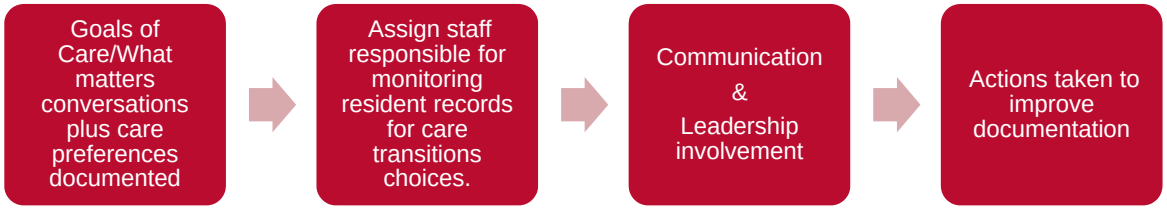
We are all in this together

4 Step Simple Flowchart Diagram
Promoting Safe Care Transitions– Advance Care Planning

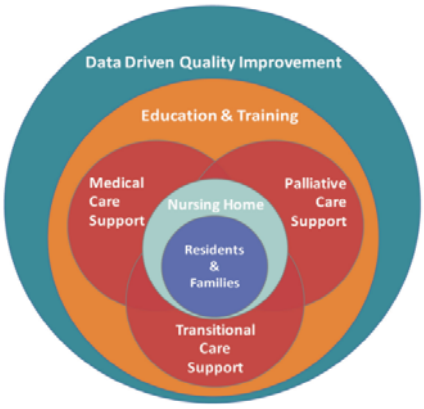


Promoting Safe Care Transitions– Advance Care Planning



Care Transition

The OPTIMISTIC Model



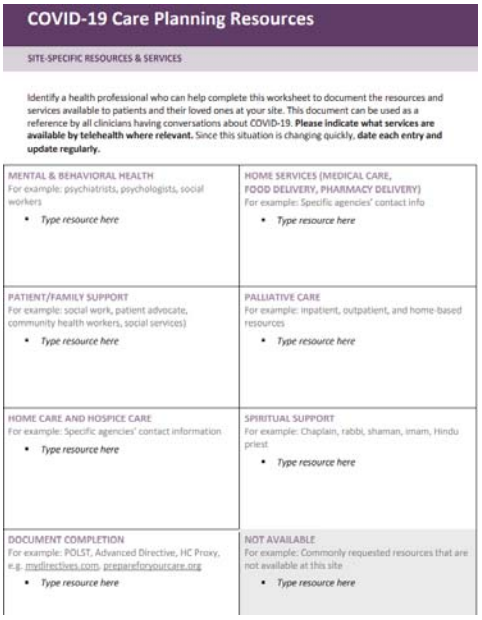
https://www.optimistic-care.org/

Resident Care Wishes shared between Care settings.

- Tools Used
- Who is responsible for Care Transitions
- Interdisciplinary team
- Care Planning Transition Resource:
  - Care Transition
- Written Policy
- Discuss in Team Huddle
- Reviewed

Care Planning

- Mental & Behavioral Health
- Patient/Family Support
- Palliative Care
- Hospice Care
- Spiritual Support
- Document Completion



COVID-19 Care Planning Resources

SITE-SPECIFIC RESOURCES & SERVICES

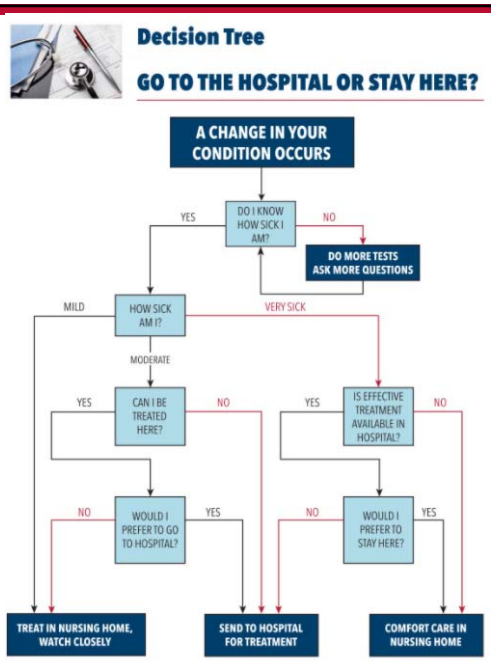
Identify a health professional who can help complete this worksheet to document the resources and services available to patients and their loved ones at your site. This document can be used as a reference by all clinicians having conversations about COVID-19. **Please indicate what services are available by telehealth where relevant.** Since this situation is changing quickly, **date each entry and update regularly.**

MENTAL & BEHAVIORAL HEALTH For example: psychiatrists, psychologists, social workers • *Type resource here*	HOME SERVICES (MEDICAL CARE, FOOD DELIVERY, PHARMACY DELIVERY) For example: Specific agencies' contact info • *Type resource here*
PATIENT/FAMILY SUPPORT For example: social work, patient advocate, community health workers, social services) • *Type resource here*	PALLIATIVE CARE For example: inpatient, outpatient, and home-based resources • *Type resource here*
HOME CARE AND HOSPICE CARE For example: Specific agencies' contact information • *Type resource here*	SPIRITUAL SUPPORT For example: Chaplain, rabbi, shaman, imam, Hindu priest • *Type resource here*
DOCUMENT COMPLETION For example: POLST, Advanced Directive, HC Proxy, e.g. mydirectives.com, prepareforyourcare.org • *Type resource here*	NOT AVAILABLE For example: Commonly requested resources that are not available at this site • *Type resource here*

Transition of Care Resources

- COVID-19 Conversation Guide
  - Serious Illness Care Program
- A Decision Guide for Residents and Families
  - www.decisionguide.org
- Respecting Choices- Person-Centered Care
  - https://respectingchoices.org/covid-19-resources/.org
- National POLST
  - www.POLST.org
- Oklahoma POLST
  - www.okpolst.org

Decision Diagram



Care Transition Conversation Guide

- Script includes:
  - Setup for the difficult conversation
  - Assess Feelings and understanding
  - Share- To gauge hospital transfer decisions
  - Explore Feelings and understanding
  - Close with supportive comments

COVID-19 Conversation Guide for Long-Term Care

Reflection and Action

- Share Successes and Challenges
- Identify one or more ideas to try
- Action: Continue PIP for ACP & Care Transitions