## Session 11: Promoting Safe Care Transitions during COVID-19: Admissions, Discharges and Transfers

Key Takeaways:

- **Older adults often move across care settings and may have multiple healthcare or social services teams over time.**
- **Information about 'What Matters' and how older adults wish to receive care and services when they become more seriously ill is not often shared between settings.**
- **Many nursing home residents have never been asked about their own goals, how they would like to be treated if they develop a serious or life-threatening illness, or about their end-of-life wishes.**
- **Care transitions may involve a discussion of whether or not the person would want to be transferred to a higher level of care (e.g., hospital) or remain and be treated in the nursing home.**
- **Communication regarding care and service options may enable residents' wishes to be more closely respected and followed.**

**The following question set can be used to facilitate discussions and reveal opportunities across and within key members of interprofessional teams, residents and visitors. Please consider using/adapting them in your next huddles or team meetings.**

| **Resources and Questions by Content** | |
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| Examples of Resources for Improving Care Transitions and Advance Care Planning | • Interventions to Reduce Acute Care Transfers: https://pathway-interact.com/<br>• Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care (OPTIMISTIC): https://www.optimistic-care.org/about/<br>• Ariadne Labs Serious Illness Care Program: COVID-19 Response Toolkit (a guide for long-term care, implementation tips, and a demonstration video)<br>• Respecting Choices COVID-19 Resources (for having conversations with older adults when planning care for COVID-19)<br>• National POLST: Long-Term Care Facility Guidance for POLST and COVID-19<br>• The Conversation Project and "Conversation Ready"<br>• My Personal Directions for Quality Living: https://www.lgbtagingcenter.org/resources/resource.cfm?r=916<br>• Go to the Hospital or Stay Here? A Nursing Home Guide: http://decisionguide.org/<br><br>What written materials is your nursing center using to discuss care transitions with residents and/or care partners? Is it clear which team members may have these discussions?<br>Are clinical team members able to access resources on all days/shifts? |
| Document and Report discussions on care transitions | Does each resident have a Goals of Care/What Matters conversation and decisions/preferences documented in their record?<br>Who monitors resident records to determine if choices around care transitions are clearly documented? How is this information communicated to leadership and all relevant members of the healthcare team? |
| Follow-Up Plan (monitoring over time) | What actions are taken if care transitions documentation is missing or inadequate for decision-making during an acute change in condition? |
| Improvement Concepts/Critical Questions for Leadership | Are there regular (daily or every other day) huddles or calls during which primary care providers (MD/NP/PA) discuss care transitions for individual residents with leaders, nurses and social workers? |
| **Key Concepts by Stakeholder Group** | |
| What do Medical Directors Need to know and discuss with the team? | Medical directors must be familiar with updated resources such as those listed above. They must also be familiar with the most up-to-date published guidance and recommendations from CMS and State Departments of Public Health or state survey agencies. Medical Directors must be prepared to respond to questions from attending physicians and other primary care providers, the Director of Nursing and/or Administrator, residents and care partners or family members. |
| What do DONs and nursing supervisors need to know? | DONs must have a system for assessing and monitoring staff knowledge and skills related to care transitions and communication with primary care providers, residents, and care partners or family members, particularly whenever there is a change in condition that might require a transition. |

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| What does the interprofessional team need to know? | Team members must know where to find updated information on care transitions for each resident.<br>Nursing Home policies should address care transitions conversations with new admissions, readmissions, change in resident condition, monthly reviews/visits, or at the resident or health care proxy's request.<br>Team members must consistently and reliably demonstrate that they document and report any concerns to their supervisor or leadership in a timely manner. |