Integrated Approach to Discharge Planning Results in Optimal Care for Patient

Jen was only 27, a single mom, with multiple health issues complicated by a history of drug abuse. At the end of last year, she was transferred from Mass General in Boston, to Samaritan Hospital, and then to St. Peter’s Hospital, where she ultimately spent more than three weeks.

A few years earlier she had undergone a total hip replacement. Now she was waiting for the same downstate surgeon who performed her hip surgery, and was familiar with her case, to replace her right knee. But the surgeon was out of town for the next month...and because her medical needs were great, it didn't appear she could be discharged home safely.
The search began for skilled nursing facility where Jen could get short-term rehab while she waited. But because of her age and medical history, there were no openings for her within a 50-mile radius of her home.

At that point, Kim Baker, president of SPHP’s continuing care network and the executive sponsor of SPHP’s integrated care coordination system, asked Deb House to step in. Deb, the director of case management at Sunnyview, did a full evaluation of Jen, reviewed her history, and came up with a solution that she convinced Jen would be the best option: enroll in the medical day program at Schuyler Ridge in Clifton Park, and stay at her mom’s house until her surgery.

“We were able to plan a safe discharge with appropriate psycho and social support to meet her needs,” says Deb. “Our goal is always to find the least restrictive environment that will keep the patient at home and not in a nursing home possibly many miles away. Now Jen can go home at night to her children...and she’s elated!”
Our Lady of Mercy is offering a first-of-its-kind dialysis program

In May, Our Lady of Mercy in Guilderland became the first non-hospital rehab center in the Capital Region to offer on-site peritoneal dialysis to patients with kidney disease.

Up until now, local patients accustomed to undergoing peritoneal dialysis in the comfort of their own homes faced a difficult decision if they required sub-acute rehab after a hospital stay. These patients had to move to a facility outside the Capital Region, sometimes to another state, or they would have to make the burdensome switch to hemodialysis, which requires several lengthy trips back and forth to a dialysis center each week.

“This is a huge step forward, allowing us to provide care for our neighbors here in the Capital Region,” says Dr. Vincent Carsillo, division chief of nephrology for St. Peter’s Health Partners. Our Lady of Mercy is part of SPHP’s continuing care division.

“With this new program, patients will no longer have to go someplace far away where it isn’t easy for family to visit, nor will they have to change to a different type of dialysis they might not be able to tolerate,” says Dr. Carsillo.

Nurses and other staff in Our Lady of Mercy’s rehab center have received extensive training. Fresenius Kidney Care, the world’s largest provider of dialysis products and services, will supply the necessary equipment whenever a peritoneal dialysis patient is admitted.

“Dialysis has been identified as one of the diagnoses that pose the most challenges to hospital care managers and discharge planners when they’re looking to place patients in a sub-acute setting,” says Sandy Sullivan-Smith, executive director at Our Lady of Mercy. “We’re proud to offer continuity of care to patients familiar with the quality-of-life benefits associated with peritoneal dialysis.”

Conveniently located on Route 20/Western Ave, between Albany, Colonie, Schenectady and Duanesburg, Our Lady of Mercy’s rehab unit can accommodate up to 40 patients. To make a referral, please call (518) 464-8150.
Zone Sheets: A Simple and Effective Tool

One tool we use which is especially beneficial for keeping high-risk patients out of the hospital is zone sheets. They’re one-page, color-coded sheets that offer patients guidance about their specific disease. Clearly and concisely, they provide helpful reminders to patients and tell them what to do if certain changes in their condition occur. For example, patients might be prompted to weigh themselves daily, take their medications or call their homecare nurse if they’ve gained weight or are short of breath.
Zone sheets can be distributed at various points across our system: during a primary care visit, an inpatient stay, or handed out and posted on the patient’s refrigerator when the homecare nurse visits. Our goal: standardize the zone sheets across all care settings, because there’s value for the patient to see a consistent zone sheet and have the education repeated more than once.

The Innovative Health Alliance of New York, our accountable care organization, is leading this effort. IHANY is a collaboration of health systems, physicians and health providers in our region, and has several SPHP representatives on the clinical committee which reviews the zone sheet content. All zone sheets are being reviewed, standardized, and translated into several languages. And in keeping with “health literacy” guidelines, they’re being written at the third grade reading level.

Zone sheets are a simple tool that can have a positive impact on reducing readmissions!

QUESTIONS?

If you have questions about care coordination, how it works or what we hope to accomplish, we’re here to help. Please contact:

Kim Baker M.A. CCC-SLP, President, Continuing Care Network; Executive Sponsor, SPHP Integrated Care Coordination System Kim.Baker@sphp.com | 518-525-5513

Tricia Brown, Director, Continuous Performance Improvement PatriciaA.Brown@sphp.com | 518-525-6044

Please consider submitting patient stories that cross care transitions and/or service lines to be highlighted in the “Did You Know?” section of the newsletter. Your input is welcomed.