Virtual Hearing - LTPAC Certification

December 12th, 2013

Oklahoma Report

Oklahoma is working with five nursing homes and are now expanding to 20 more and working with referring hospitals and an established regional health information exchange to implement key interventions to improve transitions. We are focused on improving information transfer in the patient's transition to and from nursing homes and an emergency department. The nursing homes have implemented a clinical documentation tool that includes the collection of change in condition documentation. At the time of a transition a "need to know message", based on a nursing document referred to as "SBAR" (Situation/Background/Assessment/Recommendation), is sent via Direct from the nursing home to the hospital. This provides the immediate information the ED needs. Once completed a universal transfer document will follow providing a more complete account of the patient. The hospital can query the regional HIE for information on the patient including labs, imaging reports, other results, and provider reports. A similar information flow is able to follow the patient back to the nursing home upon discharge from the hospital.

Oklahoma has shown that sharing more information during encounters in the ED results in reduced acute hospital admissions and more thorough evaluations targeting the indication for transfer more clearly. This also results in the safe return to the LTPAC setting with expanded care plans based on the ED evaluation. In addition to the implementation of the technology to support electronic exchange of patient-specific information, Oklahoma is focusing on improving the workflow and processes associated with care transitions to ensure effective use of information to improve patient care. Implementation of a scaled down "UTF" (Universal Transfer Form) has not resulted in any significant change due to poor adoption and complexity of the form and duplication with the simplified SBAR.

The significance has been related to implementation of "light weight EHR" that works with the nursing aids and helps generate "health alerts" within the LTC facilities and pre-populates the SBAR and stages the data needed for the HIE. No workflow is duplicated upon the aids or nurses in the LTC and subsequently feeds the care transition tools to the Acute Care Facilities in a very timely and clinically beneficial fashion to ensure the patients needs are clearly addressed and baseline patient status is understood to avoid working up the wrong issue or known issues previously established upon the patient that are not commonly communicated that results in more admissions, longer lengths of stays and poor provider handoffs in both directions between acute and LTC.

To date, Oklahoma through the "need to know message" via the SBAR and Direct and key ADLs being transmitted from LTC via the HIE have resulted in a 30% reduction in 30% re-admissions from LTPAC and a 40% reduction in return to ED only.

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