SUMMARY:

The Registered Nurse (RN), provides age-appropriate, culturally and ethnically sensitive care, maintains a safe environment, and educates patients and their families about healthy practices and treatment modalities. The RN will assure continuity of care, coordinate care across settings and among caregivers, manage information, communicate effectively, and utilize technology. Utilizes the nursing process to provide and plan care (i.e. assessment, nurse diagnosis, planning and coordination, implementation, and evaluation).

Jobs:

1) Maintain the Shared Lists. The list and the function are the following:
    a. Transition of Care Appointment List-CCC
        - This list is available to the hospital MDs and the Social workers.
        - The list is for patients who will soon be discharged from the hospital. The patient needs to be contacted to see if they would like a hospital follow up appointment/ TOC visit. The RN will then schedule the appointment at the patients convenience and Resident's availability.
        - The RN will review the inpatient chart to see the complexity of the patient. This will determine which resident year will be able to care for the patient.
        - The RN will confirm a contact phone number while the patient is still in the hospital and confirm they have transportation.
        - The RN will chart under notes the status of the conversation and the appointment date and time. The RN will also route the note if appropriate back to the social worker in the hospital.
        - The RN will check the Transition of Care Appointment List every hour during the day to reach out to the patient and schedule the appointment.
        - Once the appointment has been scheduled, the RN will move the patient from the Transition of Care Appointment List to the Current TOC list.
    b. Current TOC
        - This list is for patients who have been discharged from the hospital or are awaiting hospital discharge and an appointment has been made to be seen at the Community Care Clinic.
        - Place patients in order of Discharge Date.
        - Patients on this list must receive a phone call post hospital discharge. There have to be two attempts to contact the patient in two business days post discharge in order for the clinic visit to be billed as a TOC visit.
        - If during the phone call a concern arises, contact the on call TOC MD. If non-urgent, route in EPIC the telephone call to the on call TOC MD. If urgent, page the on call TOC MD or schedule a same day appointment.
        - During the phone call the following issues must be addressed and documented(see page 2):

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A. Health Status: Condition since discharge
( ) Patient states they are feeling better
( ) Patient feels about the same as when they were discharged
( ) Patient reports symptoms have worsened
( ) New problem and elaborate:

B. Medications: Do you have all of your medications in front of you now?
Is the Med Rec completed? ie. Every medication and dose reviewed with patient
( ) I have filled the prescribed medications
( )I have not filled the prescribed medications and reasons:
What questions do you have today regarding your medications?

C. Clarification of Physician Appointments and Lab Tests
Are you aware of your clinic follow-up appointment?
( ) Yes ( ) No

Any Pending Lab test or imaging (Based on D/C summary)
( )Yes   ( ) No
Any other referrals?

( )Yes   ( ) No
Elaborate

D. Coordination of Post Discharge Home Services (if applicable):
Have you been visited by any home health care services (i.e. nurses, respiratory therapist) since you were discharged?
Are you having any financial issues purchasing the prescribed medications?
( ) Yes   ( ) No
Do have transportation to get to the follow-up clinic appointment
( ) Yes ( ) No
Do have medical insurance?
( ) Yes ( ) No
Red flags?
( )Yes and what they are and how they are addressed:
( )No
Do you know what to do if your symptoms get worse?
( )Yes ( )No

CHF questions:

1. Are you able to weigh yourself every day at about the same time?
2. Do you know how much weight gain you should immediately report to your doctor?
3. Do you have any problems such as shortness of breath, fatigue, chest pain or swelling in your legs?

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4. Did someone at the hospital talk to you about your special diet? Have you been able to follow this diet? (If no: What problems have you had with it?)

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    c. Old TOC
- This is the list in which patients that have a TOC appointment and have received 2 attempts will be moved to.

    d. Possible TOC list
- This list will be created by the transition of care nurse. This list will include the different floors in the hospital. ie. 2 Observation Unit, 6 NRU, 6 Pulmonary
- List will include the following
  1. Primary Plan
  2. PCP
  3. Patient Name/Age/Sex
  4. MRN
  5. Admission Date
  6. Admission Dx
  7. Admitting Provider
  8. Anticipated Discharge Date
  9. Discharge Date
  10. LACE+ Score
     a. "L" stands for length of stay of the index admission
     b. "A" stands for acuity of the admission
     c. "C" stands for co-morbidiites
     d. "E" stands for the number of Emergency Department visits in the last 6 months
     e. Red score indicated high possibility of readmission, Yellow score indicated medium risk and Green score indicates mild risk of readmission. Red score means needs a f/u visit in one week.
  11. Discharge Order Signed
  12. CM comments
- The RN will review the patients being discharged. The RN will note the CM comments to see if they note a need for a CCC TOC visit. The RN will note the Primary Insurance Plan and the PCP. If a patient being d/c has neither, the RN will contact the patient via phone in the hospital room and explain the Community Care Clinic and offer a f/u visit.

2) Notify Residents via email when they are on TOC call. Then add the MDs to the Current and the Old TOC lists

    Sample email:

Welcome to TOC Dr.

I will be assisting with the TOC calls. Please complete a chart review to see if a patient needs a call that day before calling. Hopefully, this will help your work load! I am trying to utilize you only for patients that have medication problems or medical concerns.

You will be on-call for TOC for this week, your tasks are:

1. Call patients daily on current TOC list , document based on the template attached. Call on the first day after d/c. They must have 2 attempted calls in 2 days to be considered TOC.
2. To find the TOC list, go to the top right of the EPIC page and search for patient list. You will see a shared list under the patient list. Click on the shared list to find the current TOC list. – create a dot phrase of the TOC call template. Once in the patient charts, go to the telephone call and document there.
3. If they did not pick up on day one , call them again on the 2nd day and document that.
4. Once you document 2 phone calls or that you spoke with them, move to old toc list.
5. Report to me, Rebekkah, every day about the number of patients you called(you can send an email). I will try to touch base with you every day to discuss any concerns that you have! Shannon will help with any social work concerns.
6. **If you missed calling the patient in the window, we will have to report it as we cannot bill for the whole process.**
7. Please help your colleagues that will follow you understand the process for next week!

I can show you in EPIC on how to do everything!! Let me know if you need help!!!! Do not call pt until after they have been D/C.

We try to get you blocked from 3:30 - 5. Due to scheduling this can sometimes be difficult. Please let us know if we need to move anything around for your schedule!!!

If you have any questions please let me know!! Below is step by step instruction for EPIC

Thank you for all your help and hard work!!

Step by Step EPIC instructions
1) Go to the Shared List
2) Click on Current TOC
3) Double click on a patient
4) Click on encounter then on telephone call(this is found on the far left side of the screen. If you don't find it click on the more tab on the bottom left and you will find it)
5) Click on the out- going tab

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6) Click on the patients name…this brings in the patient's number. You can also click on the spouse and it gives you the spouse's number.
7) If you didn't reach the patient, you can click the left message or no answer tab. You also can click the magnifying glass to say spoke with patient
8) The next section you can write TOC as reason for call.
9) Next, scroll down to the documentation tab and click add note which will say 1st TOC call or 2nd TOC call
10) You can also create your .toccall under smart phrase editor.
11) After completion, Sign encounter.
12) You can look under chart review to see how may calls have been made

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