CARE CONNECT

Issue 8

PATIENT SUCCESS STORY

Sylvia Ellis receiving outpatient services at Sunnyview.

Coordinated care clears the path to recovery

As a result of an accident, Sylvia Ellis had a severe spinal cord injury that left her unable to move her lower limbs. After surgery, doctors were uncertain of her prognosis. “We really didn’t know what her prospects were,” recalls Sylvia’s husband, Lorne Erdile.

That was more than a year ago. Today Sylvia can walk using a rolling walker and she continues to make progress. The story of this remarkable recovery is also the story of smooth, well-coordinated handoffs between Sunnyview Rehabilitation Hospital, Eddy Heritage House, and Eddy Visiting Nurse & Rehab Association...where various staff members worked together to ensure that effective, excellent care coordination occurred.

St Peter’s Health Partners

Sylvia arrived at Sunnyview for rehab, made some gains during her one month stay, then transferred to Eddy Heritage House for several more weeks of rehab. Eddy VNRA has an embedded liaison there, whose desk faces the desk of the social worker who helps move patients out of sub-acute rehab. So the Eddy VNRA liaison was able to get the referral, meet the patient, and properly brief and prepare Sylvia's EVNRA team once she was discharged home in October. Later, her path to recovery came full circle...she was ready for Sunnyview's Outpatient Neuro-Rehab center, where she began a program of physical and occupational therapy, including one day a week of pool therapy.

When she started the Neuro-Rehab program, Sylvia needed maximum assistance for bed mobility and for dressing and sponge bathing. She couldn't walk and needed a mechanical lift to transfer to a wheelchair. Today Sylvia is not merely walking with a walker, she's going up and down stairs using railings, with very minimal help from a physical therapist. She also transfers independently using the walker and can mostly dress herself!

She's arrived at this point thanks to well-integrated care which occurred within the SPHP system when she was transitioning from place to place and team to team. And of course, it's also thanks to Sylvia's own hard work and all those who helped her along the way!

Congratulations to all these Rock Stars for facilitating Sylvia Ellis's inspiring rehab!

Kathy Rubin, RN, Sunnyiew; Paula Lawrence, OT, Sunnyview; Kerri Maloney, PT, Sunnyview; Brenda Kozlowski, OT, Heritage House; Cassandra Berghammer, PT, Heritage House (now at Sunnyview); Aja Simon, RN, Heritage House; Jodie Kiltz, LPN, Heritage House; Justine Pelcher, CNA, Heritage House; Lisa Sprague, RN, EVNRA; Jennifer Bruce, RN, EVNRA; Caitlin Miles, Home Health Aide, EVNRA; Lisa Lewza, RN, Heritage House; Lynda Shrager, OT, EVNRA; David Orenstein, PT, EVNRA.

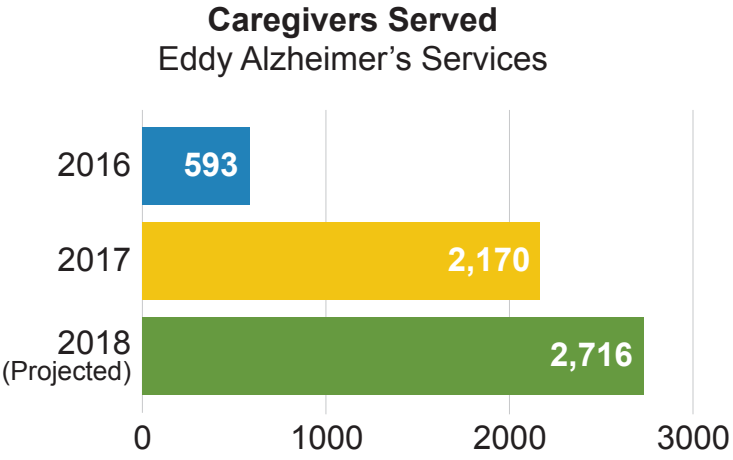
DID YOU KNOW?

An Alzheimer's Caregivers Support Group at Eddy Hawthorne Ridge in East Greenbush.

Through Eddy Alzheimer's Services, caregivers of people living with Alzheimer's can access a wide range of services to help loved ones stay in their homes.

These include:

- In-home consultations to address family concerns and help loved ones deal with behaviors associated with Alzheimer's
- General Alzheimer's education
- Personalized recommendations for additional services available in the community
- Support groups for family members
- A "Memory Cafe" that brings together people experiencing memory problems to enjoy various activities with their loved ones.
- Help with arranging respite care, giving caregivers an opportunity to take time off—possibly even to go on vacation.



It's all provided though the Alzheimer's Caregiver Support Initiative, which helps families in ten counties: Albany, Columbia, Delaware, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, and Saratoga. Additional services, like in-home care, adult day programs, transportation and case management, can be provided to people with Alzheimer's who live alone in Albany, Rensselaer, Saratoga and Schenectady counties.

Best of all, everything mentioned here is 100 percent free! To request services for a patient or family call **(518) 238-4164** or visit **sphp.com/alzcare.**

ICCS UPDATE

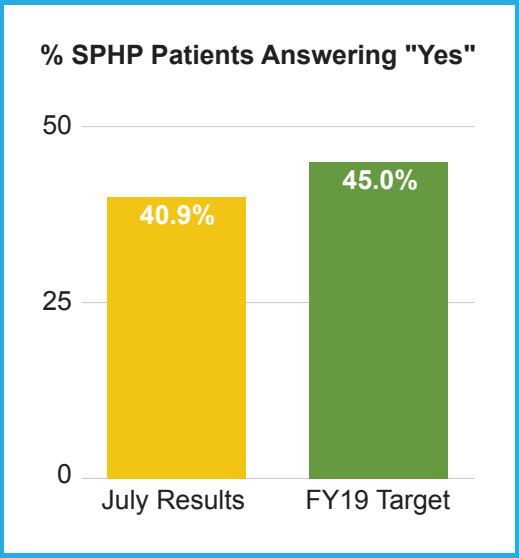
PEOPLE-CENTERED 2020

BUILDING A PEOPLE-CENTERED HEALTH SYSTEM TOGETHER

Trinity Health's inaugural strategic plan, **People-Centered 2020**, is a road map to help ensure we fulfill our mission and achieve our vision of becoming the national leader in improving the health of our communities and each person we serve. This year, one of the Priority Strategic Aims all Trinity Health colleagues are asked to focus on is Care Coordination!

For the first time, this important care coordination question will be included on the survey given to patients discharged home or to home care:

"During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left." (Answer: Yes or No)



Although the care coordination question is for patients leaving the hospital, remember this is a team sport involving all affiliates. The handovers between acute care managers, acute and sub-acute rehab screeners, home care RNs and other health care professionals throughout our SPHP continuum are critically important.

Here are other things we should be doing to meet patients' expectations:

- Arrange for follow-up care so patients experience an easy transition out of the hospital. *Make an appointment* with the patient's primary care physician within 72 hours of discharge, if he or she is at high risk for readmission.
- Ask patients, family and caregivers about preferences. ("What matters to you? What do you prefer?")

- Talk to patients, not at them!
- In order to learn more about their personal preferences and concerns, build a rapport with patients. (Connect with them on a topic outside of the clinical care, like sports, weather, family, etc.)
- Use information that you've learned in discussions about the patient's future health care needs.
- Give patients, family and caregivers a discharge-planning checklist. (Checklists can encourage patients and their families to express preferences).

Remember, patients consistently have the same needs. They want to:

- Know when they're going home. (Use the whiteboard in the patient's room to estimate the patient's discharge date)
- Feel safe and prepared to go home or to a lower level of care (Make sure they have the information they need to care for themselves post-discharge)
- Have their questions answered and feelings considered!

We know what patients want.
We know what patients expect.
Let's make sure we deliver excellent patient-centered care!

QUESTIONS?

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

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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.