SELHIN HOME FIRST REFERRAL PROCESS Data point: Service Provider # HF unable to serve admits n Patient team consider pre/ Care discharge OT HF meeting: Care On In patient Coordinator Hospital mos **CCAC** Coordinator If patient referral Service plan Inter-If patient responsible presentation Charge to contact professional Complete and Care proposed to arranges to ER or admitted ER 24 hour nurse to most team forward CCAC Coordinator patient and community admitted confirm from time of staff to responsible notice by completes consult to promote referral to completes caregiver by Patient services. D/C SW/DCP/ Physician of admission/ comwith health report Iome First SW/DCP/ HCC & SW/ Confirms Home activation/ initiate consult assessment caregiver PFC to conditional identify municate physiciar Eligibility PFC/CCAC DCP/PFC plan with mobility to for community ace to face agreeabl the EDD/ dentification discuss D/C when patient at community patient/ 24-48 hrs contingency prevent service risk of of risk to ensurina need/ stable placement if caregiver functional provision prior to plan for appropriate Waiting at designation npatient unit medical scheduling and referring while in ER decline ndicating Face D/C providers of ALC-LTC stability of HF Home to Face HF discussed meeting assessment No requested No CC/DCP/SW/PFC Data point: Refer to SW/DCP/ consult team for # HF Ineligible PFC F/U plan to and D/C barrier Inter-professional hospital team discuss barriers communication with patient and **iCART** family re: plan toward D/C Notifies CCC of initial Hospital most alternate destination contact responsible team Seek Physician e.g. CCAC, SSCC, rehab, to facilitate referral DCP/SW/PFC: involvement to ret. Home, BSTU, PC process communicate support discharge Mental health with MRP the need for ALC order Implement hospital HF - Provide escalation process Stage 1 copayment info. Data point: individual hospital -complete Data point: HF nonadmint # ALC LTC and # iCART escalation process health No D/C barrier, ALC conversion, ALC referrals designation before CCAC assessment assessment discussion with family CC/PFC/SW/DCP complete LTC Hospital escalation Patient meet with family placement Hospital escalation No No No process Stage 2 family team agree review solutions to application/ Stage 3 Successful to D/C plan identified barriers counseling CCAC notified to Senior Leader proceed with Yes Yes Yes Approved ALC Revised January LTCH Application LTCH Designation 2016

















Data Point:

