CUYAHOGA COUNTY COLLABORATIVE HOSPITALIZATION MUI PROJECT

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A. BACKGROUND

- No change as a result of "Category C" reclassification
- Multiple entities investigating the same incident (provider, CCBDD nurse, IA)
- Inconsistent information and inefficient for all; multiple investigation reports/ prevention plans

B. PILOT PROJECT

- One investigation report
- Get info from those knowledgeable (provider and medical professionals)
- Eliminate inefficiencies; save IA time
- Better prevention planning
- 4 ICF providers (big and small) – 33 investigations since January
- Collaboratively develop reporting format

C. ROSE-MARY CENTER EXPECTATIONS

- Communication: Duplicate requests; right hand not knowing what the left was doing in our agency as well as CB
- Provider knowledge: knowledge of the person, the circumstances, and what was an important factor or not. CB IA or nursing doesn't always know what is important to/for the individual
- More efficiency and less duplication enable CCB IAs to focus on incidents that require more investigation

D. PILOT PROCESS

- Category C form changed to include all information needed for ITS
- Changes in provider process and CB process
- Provider is the lead; CB nurse reviews; IA coordinates communication and closes MUI

E. BENEFITS

- Better prevention planning
- More confidence in the report and prevention planning: previously with multiple reports there were variations in the prevention plan
- CCB nursing review adds clarification
- **COLLABORATION BENEFITS INDIVIDUALS, PROVIDER AND CB**

F. NEXT STEPS/QUESTONS

Unscheduled Hospitalization Form

Please complete this form and send electronically (via email when possible) to the County Board as directed.

NAME OF INDIVIDUAL/MUI #:

CONTACT INFORMATION OF REPORTER/AGENCY:

NAME AND TITLE OF PERSON COMPLETING THIS ICF FORM:

List of Documents Reviewed:

(Examples: IHP, Hospital Discharge Paperwork, Prior to Incident Nursing Notes, any and all relevant medical documentation, etc.)

SUMMARY OF INCIDENT

PROVIDE DATE AND TIME OF HOSPITALIZATION:

TYPE OF HOSPITALIZATION (MEDICAL OR PSYCHIATRIC):

NAME OF HOSPITAL:

NUMBER OF DAYS IN HOSPITAL:
***Consider the day of admission as first day and the day of release as the last day

REASON(S) FOR HOSPITALIZATION:
***Please include symptoms, issues and/or concerns that lead to hospitalization; description of incident; if symptoms were addressed in a timely manner and if not why

DESCRIPTION OF INDIVIDUAL'S HEALTH FOR 72 HOURS PRIOR TO HOSPITALIZATION:

PROVIDE DATE AND CAUSE OF MOST RECENT HOSPITALIZATION BEFORE THIS ONE:

PROVIDE INDIVIDUAL'S DIAGNOSIS AND MEDICAL HISTORY FROM THE IHP:

HOSPITAL DIAGNOSIS AND HOSPITAL DISCHARGE PAPERWORK INFORMATION:

WAS HOSPITALIZATION DUE TO FLU OR PNEUMONIA OR ASPIRATION PNEUMOMIA?
(If yes, did the individual receive the flu shot or pneumonia vaccine?)

FINDINGS AND CONCLUSIONS

CAUSE AND CONTRIBUTING FACTORS

PROVIDER (ICF) NURSING REVIEW

DATE OF REVIEW:

NAME OF REVIEWER:

ADDITIONAL NOTES:

INDIVIDUAL RECEIVED APPROPRIATE CARE FOR THIS INCIDENT: YES OR NO

DOCUMENTATION OF PROVIDER FOLLOW UP/THROUGH ON THE PREVENTION PLAN RECOMMENDATIONS:

CCBDD RN REVIEW

DATE OF REVIEW:

NAME OF RN REVIEWING:

ADDITIONAL NOTES: