LCHCS Community Care Task Force
Purpose

Community leaders in Laurens and Clinton joined hospital and medical staff leadership to discuss patient discharge process from acute care to the next level of care.

The first meeting was a brainstorming session. Three common themes were evident and became the focus of our work.

- Medication Reconciliation
- Transition and Community Education
- Information Technology
Drill down teams were appointed from the Community Care Task Force. Team assignments included:

* Barriers
* Associated Concerns
* Recommended Interventions
* Responsible Person/Organization
Community Education

Goal: Discuss barriers associated with healthcare education in our community and make recommendations for addressing these barriers.
What are the issues?

• Healthcare literacy
• Understanding levels of care in the community
• Identifying services that are lacking in the community
• Identifying opportunities for health education in non-hospital healthcare facilities
# Healthcare Literacy

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<thead>
<tr>
<th>Recommendation/s</th>
<th>Barrier/s</th>
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<tbody>
<tr>
<td><strong>I.</strong> Increase cultural competency of healthcare staff to increase safe and equitable delivery of care. To assure that what we are teaching or sharing is understood.</td>
<td>1. Identify resources/tools (TJC Roadmap) (clinical practice checklist) 2. Time/funding to do self assessment of each organization. 3. Demographics</td>
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<tr>
<td><strong>II.</strong> Provide all education at correct reading level and language – by assessing all discharge media.</td>
<td>1. Funding 2. Time 3. Process for keeping it current</td>
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<tr>
<td><strong>III.</strong> Write and apply a <strong>Healthcare Literacy Policy</strong> that incorporates and assessment of how the patient prefers to receive information about their health care plan.</td>
<td>1. Change in policy/process 2. Time restraints. 3. Change in culture</td>
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# Healthcare Literacy

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<tr>
<td><strong>IV. Write and apply a <strong>Discharge Policy</strong> to all patients discharged from the hospital and include the following:</strong></td>
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<tr>
<td>• requiring that a family member/significant other is present for all discharge teaching</td>
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<td>• uses teach back methodology,</td>
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<td>• asks 3 important questions (why were you in the hospital, what do you have to do when you get home, why is it important that you do the things we discussed today),</td>
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<tr>
<td>• uses of a lot of pictures</td>
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<td>• addresses culture and language barriers, and</td>
<td></td>
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<td>• uses generic/brand names for medications.</td>
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<td><strong>1. Policy/Process change</strong></td>
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<td><strong>2. Culture change</strong></td>
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<td><strong>3. Time at Discharge</strong></td>
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<td><strong>4. No family or significant other</strong></td>
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<tr>
<td><strong>V. Investigate the use of video taping of discharge instructions.</strong> Vocera.com</td>
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<tr>
<td><strong>1. Funding</strong></td>
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<td><strong>2. Pilot a tool</strong></td>
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<td><strong>3. Timing</strong></td>
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## Healthcare Literacy

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| **VI.** Look at assigning specific nurses to provide discharge education to increase standardization. | 1. FTE’s  
2. Funding |
| **VII.** Make connections to the community services for each patient at the time of discharge and provide specific detail for them – i.e. directions, appointments, etc. | 1. Time  
2. Poor Follow through |
| **VIII.** Involve the Patient and Family as much as possible and prevent assuming that there is a low level of literacy – ask the patient/family what they know and want to know about their home care and discharge – focus their education around their needs. | 1. Canned Discharge Instructions  
2. Time at Discharge  
3. No standardized Approach |
# Understanding Levels of Care in the Community

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| **I.** Create a [Guide to Community Healthcare Services](#) and distribute to every admission to the facility. | 1. Funding  
2. Time |
| **II.** Develop a “**Next Level of Care Expectations**” [sheet](#) to be added to the discharge instructions for every patient/client. | 1. Unknown needs for each level of expectation or community service that is available. |
| **III.** Create and use standardized “**Transition Summary**” for all discharged patients (Consider NTOCC tools/CMS) | 1. Time  
2. Unknown needs for Transition Summary by all parties involved.  
3. Medical Staff buy in |
## Services Lacking in the Community

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<tr>
<td>I. Identify Psyche care programs and opportunities, work on supplementing those services thru affiliation or collaboration.</td>
<td>1. Entire mental health status in S.C.</td>
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</table>
| II. Missing services: chemotherapy/cancer care, invasive cardiology and vascular care, neurology, sick pediatrics, etc | 1. Timeline of affiliation form talks to actual offering services  
2. Long Term planning                                                        |
| III. Lack of **Community Healthcare Hotline** for patients to interact with a healthcare provider and get questions answered in a timely manner. | 1. Funding  
2. Staffing  
3. Liability                                                                        |
| IV. Lack of Medical Home – Identifying them and moving them towards a MH.       | 1. New Processes  
2. Culture Change from ED  
3. Unknown needs of these patients  
4. Communication                                                                 |
Opportunities for Health Education with Non-hospital Healthcare Providers

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<tr>
<td>I. Investigate educational and protocol opportunities in the community to assist with outpatient care and decrease re-Admissions</td>
<td>1. Time</td>
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<td></td>
<td>2. Unknown needs of the non-hospital facilities</td>
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Care Transition from Acute Care to the Next Level of Care
Goal: Discuss barriers to making efficient and successful transition of care from the hospital and other healthcare entities in our community and make recommendations for addressing these barriers.
What are the Issues?

• Standardization of transition process
• Gaining family/significant others engagement
• Access to post hospital care
## Standardization of Transition Process

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| I. Identify all of the different tools/forms used during transition of a patient to resident, or client in the community. | 1. Communication  
2. Involvement of Medical staff  
3. Timing |
| II. Write a **Discharge Policy** that encompasses the use of standard tools.       | 1. Communication  
2. Healthcare Literacy |
| III. Investigate the use of video/taping of discharge Instructions. Such as vocera.com | 1. Time  
2. Funding |
| IV. Consider asking the **Hospitalist Physician Assistant** to see all discharges early in the day to expedite transition | 1. Process Change  
2. Other uses of PA time/planning |
| V. Standardize required communication from physician office when sending patients to healthcare facilities (meds, office note, etc) | 1. Medical Staff buy in  
2. Process Change |
| VI. Increase the use of **Transition Care Standing Orders** that help predict needs at discharge (equipment, standard meds based on history or diagnosis) | 1. Medical Staff Buy In  
2. Evidence Based Orders  
3. Samples ?? |
# Gaining Family/Significant Other Engagement

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| **I. Create a **Guide to Community Healthcare Services Brochure** and distribute to every admission to the hospital/facility. Include definitions different levels of post hospital care | 1. Funding  
2. Time  
3. Literacy |
| **II. Identify Transition Care High Risk patients on admission** using a proven assessment tool and begin process early in hospitalization. Consider Project Boost – Tool for Addressing Risk (CMS) which includes 10 elements | 1. Proven Tool may not exist  
2. Pilot |
| **III. For High Risk Transition of Care patients – design a discharge plan with their family – consider Collaborative Agreements with community entities** to manage their care for the immediate post hospitalization period to allow more time for the patient/family to understand transition care needs | 1. Legal constraints may exist  
2. Screening criteria  
3. Family buy in |
| **IV. Investigate a hotline or reference source to answer questions for families and others post hospitalization. Investigate Grant Funding** | 1. Funding  
2. Liability  
3. Staffing |
## Access to Post Hospital Care

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<tr>
<td>I. Work with medical staff on access issues related to post discharge follow up/</td>
<td>1. Patients without medical home</td>
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<td>appointment</td>
<td>2. Physician office schedules</td>
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<td>II. <strong>Hospitalist Clinic</strong> for initial post hospital visit</td>
<td>1. Timeline</td>
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<td>2. Type of Services offered</td>
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<td>III. Lack of financial resources – have list of available financial resources</td>
<td>1. Resources, location</td>
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<td>to be given to all patients.</td>
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<td>IV. Legislation – Support Laurens obtaining increased Medicaid/Medicare</td>
<td>1. Time</td>
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<td>permanent days assigned to the county (or at least no decrease in days allowed).</td>
<td>2. Communication</td>
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Unresolved Issues

We discussed these issues --- but were not able to clearly define solutions in our meeting. These probably require additional task force commitment.

Transportation

Psyche/Behavior Issues

Increased Skill needs (Ventilator)

Bariatric >300-400 pounds

Unsafe Home conditions

Positive SLED Check (patient)

Deliberate Non-compliance
Where Do We Go From Here?

Intervention Teams were formed and required to make recommendations on what was reported by the Drill Down Teams. They had more specific assignments and were challenged to get things done.

1. Rank recommendations based on access, impact, and timeframe for completion
2. Identify funding sources
3. Assign intervention teams
4. Eliminate or deflate barriers
5. Determine “success” parameters
6. Monitor and report progress
Intervention Teams

Four intervention teams were identified – and assigned to a Community Care Task Force Member to chair or co-chair.

- Clinical Transitions Team
- Risk Assessment Team
- Access to Care Team
- Communication Team
Clinical Transition Team

Purpose: Standardization of the Transition Process

Methodology:
- Value Stream Map the current D/C process
- Identify tools and what needs to change
- Develop Community-Wide Transition Policy
  * Teach-Back Plan
  * Literacy Competency
  * Call Back Plan
  * Staff and Community Education Plan
  * Vocera—Good to Go
- Consider Discharge Nurse or Community Coach
- Develop an electronic interdisciplinary transition form
- Work with local skilled nursing facilities to develop standing orders for things like UTI, etc to implement care prior to decision to send to the ED.
- Provide education at appropriate literacy level (i.e. < grade 5, grade 5-9, > 12th, college)
Purpose: Provide early recognition of those patients who are at higher risk for readmission or transition error.

Methodology:
- Locate an initial assessment tool for identifying at risk patients – or
- Audit re-admissions for Laurens County to personalize the audit tool
Access to Care Team

Purpose:  
  a) Investigate telephone access for healthcare advice  
  b) Increase/Improve transportation access.

Methodology:  
  • Assess resources that are available  
  • Propose Business Plan for telephone access  
  • Investigate Grant funding  
  • Collaborate with The City of Laurens and Clinton
Communication Team

Purpose: Develop Informational Brochure of Community Resources.

Methodology:
• Address different levels of care and expectations
• Identify all resources
• Make brochure available to all patients in acute care setting
Summary

The entire Community Care Task Force will re-convene in May to discuss progress of the smaller groups.

The IT and Medication Reconciliation Drill Down Teams will provide progress reports at the CCTF meeting in May as well as the teams we discussed today.

Sandra Thompsons will talk to you about Vocera and PART progress.
Questions or Comments