Building a Bridge to Better Health Coalition (BBBHC)

Enriching Community Transitions & Healthcare
through Communication, Collaboration and Coordination

Meeting Summary
Thursday, June 25, 2015, 11:30am
John T. O'Connor Senior Citizens Center, Knoxville, TN

ATTENDEES

39 people attended representing 23 different organizations.

WELCOME

Aaron Bradley, East Tennessee Area Agency on Aging and Disability, welcomed everyone and introduced our guest speakers.

SPECIAL PRESENTATION

Speakers:
Celeste Collins, Director & Bill Cooper, Care Transitions Coordinator
Bluegrass Area Agency on Aging and Independent Living

Terry Altpeter, Executive Director of Quality Outcomes
Baptist Health Lexington

Cindy Todd from the Quality Improvement Organization (QIO) in Kentucky was also recognized.

Celeste Collins shared that the Bluegrass Community Health Coalition has been meeting for three years. They started with the help of the QIO, and currently meet quarterly. They developed a Universal Transfer Tool that has previously been shared with the BBBHC. They began a pilot project with Baptist Health. They are now into one year of the project, which is at the Lexington and Richmond Baptist Health hospitals.

Terry Altpeter shared that Baptist Health is part of a 7 hospital system in Kentucky. All 7 hospitals are expected to have some type of transitions of care program. Baptist Health made a commitment to this project as they wanted to be a leader in improving health. The Health System is growing as a result of the program. Baptist Health plans to have a retail pharmacy at the hospital in December 2015. Terry shared that selling the program to the hospital involves bringing it down to the human element and explaining what is happening with patients and why transitions of care is needed.

Terry and Bill Cooper shared information about the joint pilot project between Baptist Health hospitals and Bluegrass Area Agency on Aging and Independent Living (Bluegrass AAA & IL). The program is called Bluegrass "TLC" Transitional Care Program. Highlights include:

- Piloted on 2 units at hospital over 6 months
- Patient criteria: LACE score greater than 7, discharged to home (using home health agencies), patient accepts program
- In beginning, problem with patients accepting the program, now 80-90% accept

- Coaches:
    - Are staff members (social workers) at the Bluegrass AAA & IL
    - Vetted by the Human Resource department at the hospital.
    - Go through training and receive a policies and procedures manual.
    - Visit hospitals and enroll patients
    - Participate in weekly meetings with hospital staff
    - Provide 1 home visit and 3 follow up phone calls to patients
- Model for program is closely modeled after the Care Transitions Intervention, and covers 7 areas (see PowerPoint).
- The cost per patient of $400 (paid to Bluegrass AAA & IL) covers the home visit, 3 follow up phone calls (7, 14, and 30 days), and any necessary services in the home to prevent unnecessary readmissions within the first 30 days after discharge. Services may include things such as meals, transportation to doctor appointment, respite care, homemaker services, etc.
- HomeMeds is currently used by the Bluegrass AAA & IL for patients enrolled in this program.

Bill explained that the Bluegrass AAA & IL also has a 90 day transitional model for those who are high risk patients.

Please see the accompanying PowerPoint presentation for more information and details.

CLOSING

Aaron asked members and guests to introduce themselves to the group. Aaron shared that the presenters are willing to assist our coalition going forward, and are willing to provide future presentations and/or webinars to provide more "in the weeds" details about their program. If interested in this potential opportunity, please contact Dottie Lyvers at DLyvers@ethra.org or 865-691-2551, ext. 4818.

NEXT BUILDING A BRIDGE TO BETTER HEALTH COALITION MEETING

Thursday, August 27, 2015 – 10:00am – Knoxville – Knox Co CAC, LT Ross Building