March 28, 2013

Community Needs

Members in Attendance:

- Cindy Bolduc, Kindred Healthcare
- Karen Lamon, Blount Memorial Hospital
- Judy Effler, Blount Memorial Hospital
- Veronica Gibson, HomeWatch
- Melinda Bryant, Office on Aging
- Sheila Yarber, Sweetwater Hospital
- Andy Houck, Stay At Home
- Kerri Case, Humana
- Kim Ross, Humana
- Warren Serrest, CAC
- Michael Thomas, Knox Co Health Dept

Overview of Notes:

Reviewed components of Community Response- the group discussed the following issues:

- Reviewed notes from previous meeting
- Discussion of what utilization management is- Karen Lamon shared what BMH is currently doing with communication. Shared transition of care form for promoting communication to providers.
- Discussed "discharge disposition" aspect as far as the homeless population is concerned- setting patients up with homeless shelters, rescue missions, etc.
- Kindred has experienced alert and oriented patients who made the choice to be discharged to the street. Some refuse alternatives.
- Appropriate vehicle for discharge discussed
- Releasing patients with dementia- concerns over meds- consider discharge with bubble packs
- Would be ideal to have meds delivered to patient prior to discharge- financial and medicine issues addressed prior to discharge.
- Humana's Senior Bridge Program was discussed to prevent readmissions. Services provided are helping readmissions hopefully- data due soon.

- Kindred's Transitions Case Manager role was discussed-
- Cindy reviewed some of the and the population individual needs- not always concrete- talked about needing to see progression and days allowed with benefits-Kim Ross of Humana discussed this from a benefit provider aspect
- How is it defined that a person can move to another level of care? Patient must be stable and must qualify for lower level of care.
- Veronica presented an article that she will share to members on telehealth technology.
- Group discussed reasons for readmissions:
    - Meds-not taking, can't afford, etc
    - Needed follow-up with providers
    - Communication gaps- misunderstandings, etc
    - Self-Care- hydration, nutrition, falls, etc
- Group reviewed points identified last meeting on accepting services what services are, allowing patient to remain independent-
- What are follow-up issues? Transportation is a big issue. CAC's Volunteer Assisted Transportation program was discussed. Drivers are trained as are volunteers. Assurance of appointment times are done. Challenges of transportation of people with disabilities was discussed. Program has $3 charge. Person must have need for qualification and 10 day notice requested.
- Nutrition issues- are they discussed prior to discharge? Andy Houck reviewed services available

Group Questions Identified This Meeting:

- **How do care providers get notified when patient goes to the hospital? There is communication between case managers but still some gaps in understanding, skill definitions, and classifications.**
- **Identified need for guidelines to home services to understand regulations, qualifying care levels for skilled levels, etc.**
- **The group really does feel that there is a need to identify what services are and what they mean for continued independence.**
- **The group also agreed that there is room for services at the table to learn about each other and how person qualify for services.**
- **Need to identify choices for patients- how do we talk about the services available.**
- **3 aspects to explore:**
    - **Public Education**
    - **Provider Education**
    - **Discussions with Families**

Hospice/ End of Life Issues

Members in Attendance:

- Dr. Greg Phelps, UT Director of Hospice
- Nikki Walker, The Home Option
- Dawn Carpenter, Sweetwater Hospital
- Jill Beason, Tennova
- Cynthia Finch, Smoky Mountain Hospice
- Karla McKinney, Brakebill Nursing and Rehab
- Diana Goad, UTMC Case Management
- Dr. Bob Kolock, Summit Health Solutions
- Teresa Gregory, NHC Home Health Care

Overview of Notes:

- Dr. Phelps shared a discussion with KAM and ___________ to develop a video to educate re: CPR.
  - Community Education related via ET Quality Alliance and Knox Consortium Ethics Committee
- Discussed "uncoordinated" coordinated care can become an issue when insurer, PCP, and hospital are all contacting patient attempting to coordinate care needs.
- Dr Kolock- Need to define an avenue where patient has better knowledge of disease and disease process.
- Jill- Providers need to acknowledge that education is not a one-time event.
- Group discussed that 80-20 drives and leads cost of care in the hospital setting. Need to discover a way to identify patients with chronic readmissions.

Group Questions Identified This Meeting:

- **Need to identify the "desires" of the patient- what is the best outcome that meets the needs/wants of the patient without unrealistic expectations?**
- **Develop ways to identify patients with chronic readmissions and provide improved case management.**
- **How to coordinate care for thse without insurance and/or pcp coverage?**

- **Develop a DVD for Physicians/ Booklet for community discussing end of life issues, advanced directives**
- **Members submit community education tools and bring copy to next meeting**
- **Develop script for group leaders**

Medication Related Care/Education

Members in Attendance:

- Karen Clawson, Cherokee Health
- Kimberly Girbert, Pharmacy Home Delivery
- Laura Bullock, UT Medical Center
- Rob Lucas, Blount Memorial Hospital
- Becky Crabtree, Gentiva Home Health
- Patti Thompson, Sweetwater Hospital Association
- Gary Runyon, Walgreens

Overview of Notes:

- Blount Memorial update: Pharm Resident project for discharge counselors:
    - started July 2012
    - Identified that 46% of patients have medication issues or problems
    - Project identifies patients and problems prior to discharge
    - Trigger tool is used to identify those at high risk for readmission
- Cherokee- Special Clinic visits post-discharge:
    - Patients previously waiting weeks for post-discharge appointments are now seen in a special clinic every Monday
    - Follow-up appointments are made with a multidisciplinary approach to prescription therapy, case management, etc
    - Identified need to show value on prescription/pharmacist health management to management to improve staffing.
- Walgreens- has an adherence follow-up hone call at 7 days post-fill.
- Issue identified- staffing must be adequate to meet needs and notifications must be made in a timely manner prior to discharge.
- Home health medication management is covered by Medicare part A- this could be an option for all patients at discharge that qualify. Patients need to be seen within 48 hours.
- Disconnect- each practice/discipline is not aware of what the others are doing. Improved communication is needed in the healthcare community.
- Teaching- patients need to know proper care/storage for all medications- not just the usage and side effects.
- Hospitals- need “Anticipated Discharge” communication plan to improve education prior to the discharge process being complete.

Group Questions Identified This Meeting:

- **Multiple diagnoses are one of the leading causes of readmissions leading to need to work on reason/risk stratification.**
- **Develop program with retail pharmacies providing "1st fill" at d/c prior to patient leaving the hospital:**
  - **Community 340B pharmacies to help with 1st fill**
- **Root Cause Analysis on LEAN discussion to tease out process and work on improvements:**
  - **Improve communication**
  - **Educate community**
  - **Educate clinicians on community resources**
  - **Lunch LEAN with CME's and at mandatory yearly meeting**
- **Can there be improved communications within pharmacy- hospital records to pharmacy?**
- **Medical records- "trash in =trash out."**
- **Must engage primary care providers:**
  - **Begin intro to Pharmacy Services/processes**
  - **Begin education in medical schools for root understanding of pharmacy process**
  - **Find a way to bridge the gap between pharmacists and primary care physicians**
- **EHR for patients as well as all providers of care to coordinate care across all disciplines.**
- **Does the continuity of care or lack of contribute to hospital readmissions?**
- **Have a post-DC team in specific settings to help with identification of at risk patients and improve continuity of care.**
- **How to help with self-management focus.**