Building a Bridge to Better Health Coalition
Meeting Summary

February 28, 2013
11:00am – 1:00pm

Summit Medical Group
Knoxville, TN

Attendees
30 people attended representing 21 different organizations.

Committees
Members broke up into three committees:

1. Community
2. Hospice/Palliative Care/End of Life
3. Medication Reconciliation/Education.

Please see Committee Reports document for summary.

Getting to Know You
Judy Effler, Blount Memorial Hospital, shared what their hospital is doing to reduce hospital readmissions. Judy shared that they are conducting a root cause analysis, have developed steering teams, and developed a tool to spot high risk patients. They will be hiring a readmissions coordinator soon. Judy added that the hospital is working to improve communication, educate the community, and educate doctors about community resources.

David Lukens, Valued Relationships Inc. (VRI), discussed their services around medical alert systems, medication dispensers and telehealth monitoring. David discussed the technology and equipment for telehealth monitoring services. VRI has a call center. If the monitoring readings are off for a patient, the call center can talk with the patient and/or providers to get them checked and prevent hospital readmission. David shared that patient engagement is very high. Currently, insurance plans, TennCare and some hospitals are covering the costs of telehealth services. He added that terminating telehealth services for a patient is based on their plan of care.

Next Meeting
Thursday, March 28, 2013, 11:00am – 1:00pm
ETHRA Offices – Conference Room
9111 Cross Park Drive, Suite D-100
Knoxville, TN

Respectfully Submitted by:
Dottie Lyvers, East Tennessee Area Agency on Aging and Disability

Building a Bridge to Better Health
Committee Reports
February 28, 2013

Community Needs

Members in Attendance:

- Tim Howell, Senior Citizens Home Assistance Service
- Sheila Yarber, Sweetwater Hospital
- Misty Goodwin, Knoxville-Knox Co. Office on Aging
- David Lukens, VRI
- Aaron Bradley, AAAD
- Kerri Case, Humana
- Cindy Bolduc, Kindred
- Veronica Gibson, Homewatch
- Judy Effler, Blount Memorial Hospital

Overview of Notes:

Reviewed components of community response-the group identified the following issues:

- Communication- Within community, each other. Needs to be structured and effective.
- Patient Education-Lifestyle issues. Diabetes and diet, personal care. Group needs to share information on community events.
- Connection to Care Resources- Needs improvement at period of transition to help locate needed resources.
- Physician Education- Options for patients other than ER, Hospital intervention. Need to provide patient with resources such as nonmedical interventions, lower level of care, community concerns over personal finances and options for educating them on options- especially at discharge in lieu of rehospitalization.
- Standard Training for Community Caregivers in the Home- Personal services, CNA training and beyond- create a database for agencies to use on hire. Criteria would include specific criteria for hiring including specific training, background checks, “safe” to hire, employment history, testing and certification proof, etc.
- Transportation- Needs assistance for transportation (specifically first follow-up appointment and to pick up medications.
- Home Support- Patient support at home level. What family is available, and what skills/care do they provide, assessment of patient’s ability to remain independent and patients refusal of outside help, and patients lack of knowledge of assistance available. Would like to help patients plan ahead and not come to the point that

they are desperately in need of help before seeking assistance. "Patients will plan their funeral but not their care!"

- Mental Health- Access to services for support after discharge, capture issues, barriers between mental health and medical health-Integrate into care! SNF's require PASARS- hard to come together on this. Geriatric Assessment Programs- This is available to come into home on some occasions. The challenges of Alzheimer's progression.
- Funding- This is a requirement to make any/all of this happen. Awareness of community resources, and a way to help resources connect.

***Connect, Coordinate, Collaborate- learn about each other, reach out to each other, build TRUST in the community.**

***Group Questions:**

What are the barriers that make the patient/family nervous?

- Look into ways to identify persons at risk, prepare for discharge

How can we talk to people about:

- Accepting services
- Overcoming the fear of losing independence
- Working within generational issues
- Educating the public on available services for assistance and how to effectively present this to the public

How do change perception of SNF care?

- Educate patients that this is a short-term center of care to facilitate improved quality of life upon returning to the home environment, and is not a "place to die."

For More Information related to this topic:

The Hot Spotters
http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

Partnership for Patients
http://partnershipforpatients.cms.gov/

Bridging Troubled Waters: Family Caregivers, Transitions, and Long-Term Care
http://content.healthaffairs.org/content/29/1/116.full

Home Health/Hospice/End of Life Issues

Members in Attendance:

- Jill Beason, Tennova
- Karla McKinney, Brakebill Nursing Home
- Missy Weeks, Qsource
- Dr. Greg Phelps, UT Hospice
- Emily Feeback, Blount Memorial Hospice and Palliative Care

- Dr. Bob Kolock, Summit Medical Group
- Stefanie Cucciarre, East Tennessee Health Care
- Andy Houck, Stay At Home
- Dawn Carpenter, Sweetwater Hospital

Overview of Notes:

Discussed the difference in Advanced Directives vs. POST form

- Advanced Directives- more global, contains living will, DNR, assignment of Healthcare Power of Attorney, can be printed from internet, requires 2 signatures or a notary to be legal, driven by patient and patient wishes. Very consumer-driven.
- POST- Physician Orders for Scope Treatment. Must be signed by MD to be valid. Can transfer from facility to facility. Directs healthcare providers on end-of-life care.

Identified concern related to continuum of care related to POST/Advanced Directives across multiple facilities

- Electronic transfer of these type of documents would assist in helping patient's request for end of life care met.
- ETHIN portal would help with transferring this information between facilities.

Idea developed to provide education and information at the physician office level

- Posters to be developed discussing importance of Advanced Directives at all ages
- Adv. Directives forms to be available in Physician office.
- Importance of treating Advanced Directives as a preventative care-type measure. Everyone should complete to ensure your wishes would be observed.

Idea developed to begin community-based forums to educate public about the need for Advanced Directives

- Utilize existing programs or develop new program that can be used at churches, health fairs and expo's, any site where people are gathered to discuss health issues.

Idea developed to approach MCO's/Employee Benefits to offer incentives to members that complete Advanced Directives-

- Add this to other current programs that members enroll in- diet questionnaires, diabetes education, health coach, etc.

Group Questions:

How do we approach family/patient education regarding hospice care?

When should physician have "the talk" with patients?

For More Information related to this topic:
http://theconversationproject.org
http://www.advancecareplanning.ca/

Articles related to La Crosse, Wisconsin program known as "Respecting Choices":
"Why this Wisconsin City is the best place to Die" – NPR
http://www.npr.org/templates/story/story.php?storyId=120346411
http://respectingchoices.org/about_us

Medication Related Care/Education

Members in Attendance:

- Karen Clawson, Cherokee Health
- Kimberly Girbert, Pharmacy Home Delivery
- AJ Hoppenrath, South College Pharmacy Student
- Lettie Ailey, Summit Medical Group
- Patti Thompson, Sweetwater Hospital
- Joy, Pharmacy Student
- Laura Bullock, UT Medical Center
- Kara, Pharmacy Student
- Connie Rust, South College
- Gary Runyon, Walgreens
- Susie Painter, Pfizer
- Dottie Lyvers, AAAD
- Teresa Wild, Pfizer

Overview of Notes:
Projects currently in place or in development:

- Walgreens has begun pilot project in Tri-Cities
  - Prints out universal medication list to be included in "medication bag"
- UTK is opening an outpatient clinic this summer
  - Patients will be followed after discharge with a series of phone calls at 72 hours, 14 days, and 30 days.
- Pharmacy Home Delivery has PHD providing assistance
  - Provided through a grant program, works by referrals, can assist anyone who uses a pharmacy, works with TennCare, provides face-to-face visits

with 30 patients/day (1500 monthly), pharmacy location is in Cleveland, TN, calls healthcare provider and caregiver as needed, and provides follow-up care for patients in program. This is a maintenance program for patients.

- Cherokee Health Systems has a weekly clinic for Hospital After-Care patients
  - Provided in clinic for patients
  - Free medicines are provided for indigent patients in Knox County ($500 or less income)
- "Take Along for Good Health"- list given out by OOA

- Summit Medical Group is providing services through the ACO
  - Patients are referred by physician for services
  - 20 RN's and 5 SW's cover 11 counties and over 240 physicians
  - Allows improved access to high risk patients
  - Problems have been noted in finding SNF patients upon discharge due to lack of knowledge of where patient will reside post-placement
  - Improves communication between providers and specialists due to case management services
  - Case Managers educating and referring patients have shown a decrease in readmission rates, patients respond better to this service when referred by primary care provider

Other Notes:

Patients need to be informed and educated about drug interactions

- Older adults are on an average of 22 medications

Patients are going to multiple pharmacies to get lower cost medications

- $4 prescriptions, mail order pharmacies, different costs drive patients to use multiple sites
- No medical record or history is available to all providing prescriptions or care

Improvement is needed between patient and physician related to medication

- Patients need to be encouraged to talk with providers about medications
- Universal record and electronic health records would assist with communication among different providers

Themes for improving patient quality of care related to medication therapy

- Communication
  - Patients will use medication issues as an access point for "needy" type relationships with healthcare providers
  - Every patient needs an accurate medication list- and should be printed anew at each physician visit
  - Pictograms can be used for patients who are illiterate
  - Military uses scan card to keep medication list up to date.
- Education

  - Self-efficiency is important. Patients need to be responsible in knowing about treatments
  - App's to assist in medication management would be very useful to many patients- especially as medication reminders
  - Teach patients not to refill by bottles- but by list
  - Patients should read instructions again at every refill to ensure correct usage
  - Instruction is needed on storage of medications
  - Physcians need to be educated about how to use the pharmacist as a resource.
- Finances
- Access to care

Group Questions:

All addressed above

For More Information related to this topic:

How to Create an Accurate Medication List in the Outpatient Setting through a Patient-Centered Approach
http://www.patientsafety.org/file_depot/0-10000000/20000-30000/24986/folder/65244/medtoolkit.pdf
Patient and Provider Tools for Medication Management
http://www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx