QUARTERLY MEETING 2/27/2019

AGENDA

- Welcome & Introductions
- SNF Nursing Competency
- Skilled Nursing Facilities Criteria
- Home Health Liaison
- Home Health Data Workforce
- Home Health Provider
- Home Health Criteria
- Steering Committee
- Grant Initiative
- Communications

SNF NURSING COMPETENCY SUBCOMMITTEE

PALLIATIVE CARE

Hospitals including notes in transfer packets to SNF.

SNFs including notes in transfer packets if palliative conversations have occurred during the SNF stay.

Acute Care Palliative Care Contact list developed and distributed to each HHAVC skilled nursing facility.

POLST

Hospitals to send the POLST upon transfer if available. SNFs will ask for it if notes indicate it, but it did not come.

SNFs to include POLST in transfer packets to hospitals.

Subcommittee will have more follow up in a few months to evaluate improvement.

SURVEYS (being conducted to gather information that will improve continuity of care for patients as they move from one level of care to another.)

Long Term Care Ombudsman

- Each SNF got their individual results
- Common themes for complaints were call lights and food.
- Best practices were shared between facilities.

EMS/Fire Department

- Pilot survey done and findings showed that Ambulance does not understand the difference between Board and Care, Assisted living and SNFs when answering questions (opportunity). Committee reviewing how to gather full survey and education of EMS/fire.

EMERGENCY DEPARTMENT PERSONNEL

- Currently in process with ER Managers, MDs, nurses, clerks and other front line staff

EMR

Continuing to work on getting all SNFs access to Acute EMRs:

- Mobile MD (Dignity)
- Patient Keeper (CMHS)
- VCMC – On hold for now

Naloxone at SNFs

Presentation by Deputy Administrator from Ventura County EMS as they have been tracking opioid use in Ventura County since 2012.

Currently being discussed in committee:

- SNFs having Naloxone onsite in e-kits,
- parameters for identification and use,
- possible need for SNF physician education

SNF CRITERIA FOR GOOD STANDING COMMITTEE

In 2018 the SNF Criteria for Good Standing Committee performed the following;

- ➢ Tracked LOS for the year- separated by Medicare/Managed Medicare
- ➢ Tracked Readmissions per quarter
- ➢ Sent letters to new general memberships as well as established preferred memberships with status for Criteria for Good Standing

HHA LIAISON TASKFORCE

Forms:

- Acute to Transfer Form – processes in place for all hospitals. Hospitals being provided more details as requested.

Hospitals:

- Solidified process for Liaison visits & communication
- Preference is in-person hospital visit but if not notified within the 24-48 hrs., phone call is okay.
- Reminder for liaisons that Dignity Health patients - referral needs to be booked in Curaspan prior to visit or phone call. Notify Sally on patients if double booked.
- Ok to ask if referral has been turned down by other agencies.
- Monitoring: Same day & late notification of discharge – To ensure smooth transition for patient
- Social Worker assessment & notes being sent if seen in the hospital
- Developing Checklist for specialty care
- Process Development for L.A.C.E./Predictive readmission tool

HHA DATA TASKFORCE

- **Development of the Data Committee Mission and Purpose:**

  The Data Committee collects and analyzes data available to HHAVC. We develop and initiate data driven initiatives and work in partnership to improve health outcomes in our community consistent with the quadruple aim. We continually consult with the Committee Members for collaboration with providers within the Alliance.

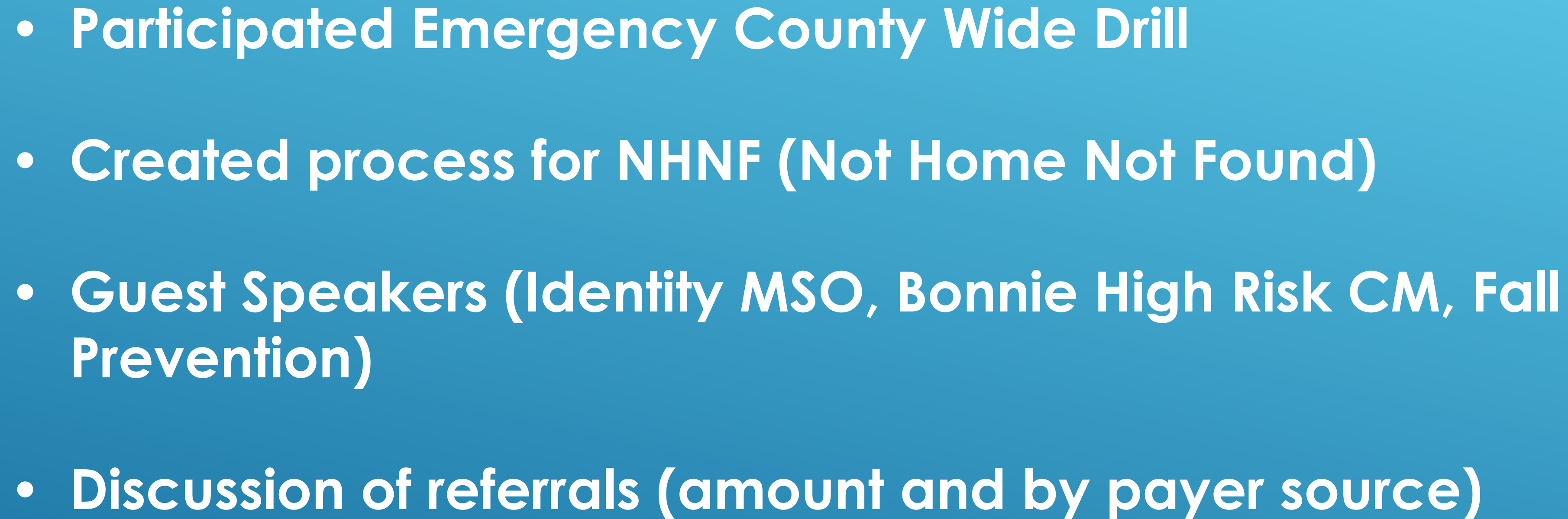
  Data Sharing agreement between Home Health Agencies and HHAVC has been drafted and pending further discussion.

- **Person centered care 3 questions "what matters most" implemented by all home health agencies June 1, 2018.**
  1. *"Are there things you enjoyed doing for yourself that now you cannot do since you've been diagnosed with this disease?"*
  2. *"What are your dreams and goals for the future? (What would make it a really good day for you [Things you want to do, People you want to see, Goals for your health, ETC.])"*
  3. *"When I leave today what are you most concerned, afraid, or nervous about?"*

Update on:

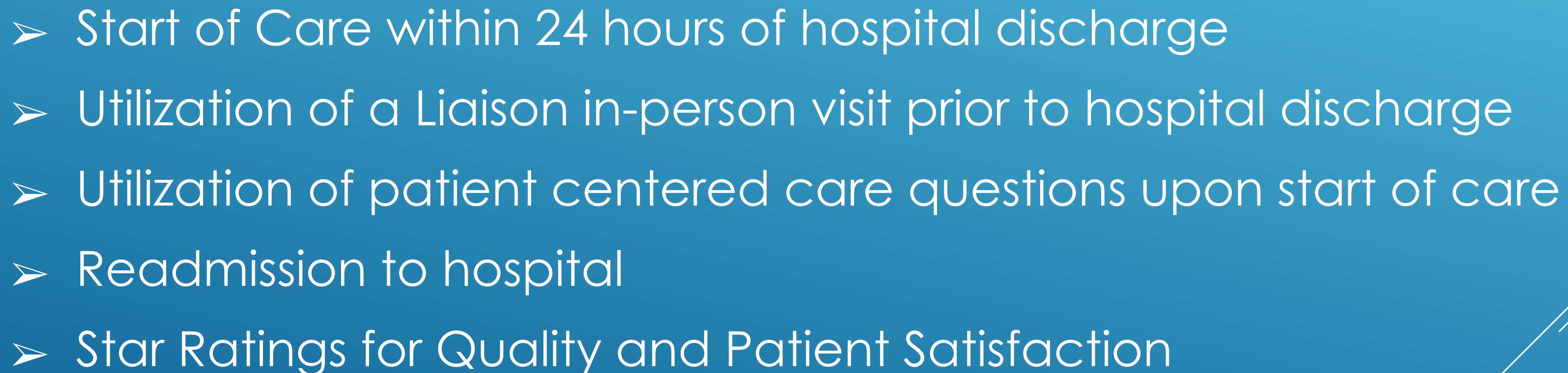
- Data audits per each agency started on July 1, 2018 for compliance on asking the questions upon admission.
- New focus study of readmissions by diagnosis for analysis, readmission trending, recommendations for best practices and coordinating.

Home Health Provider Monthly Meeting

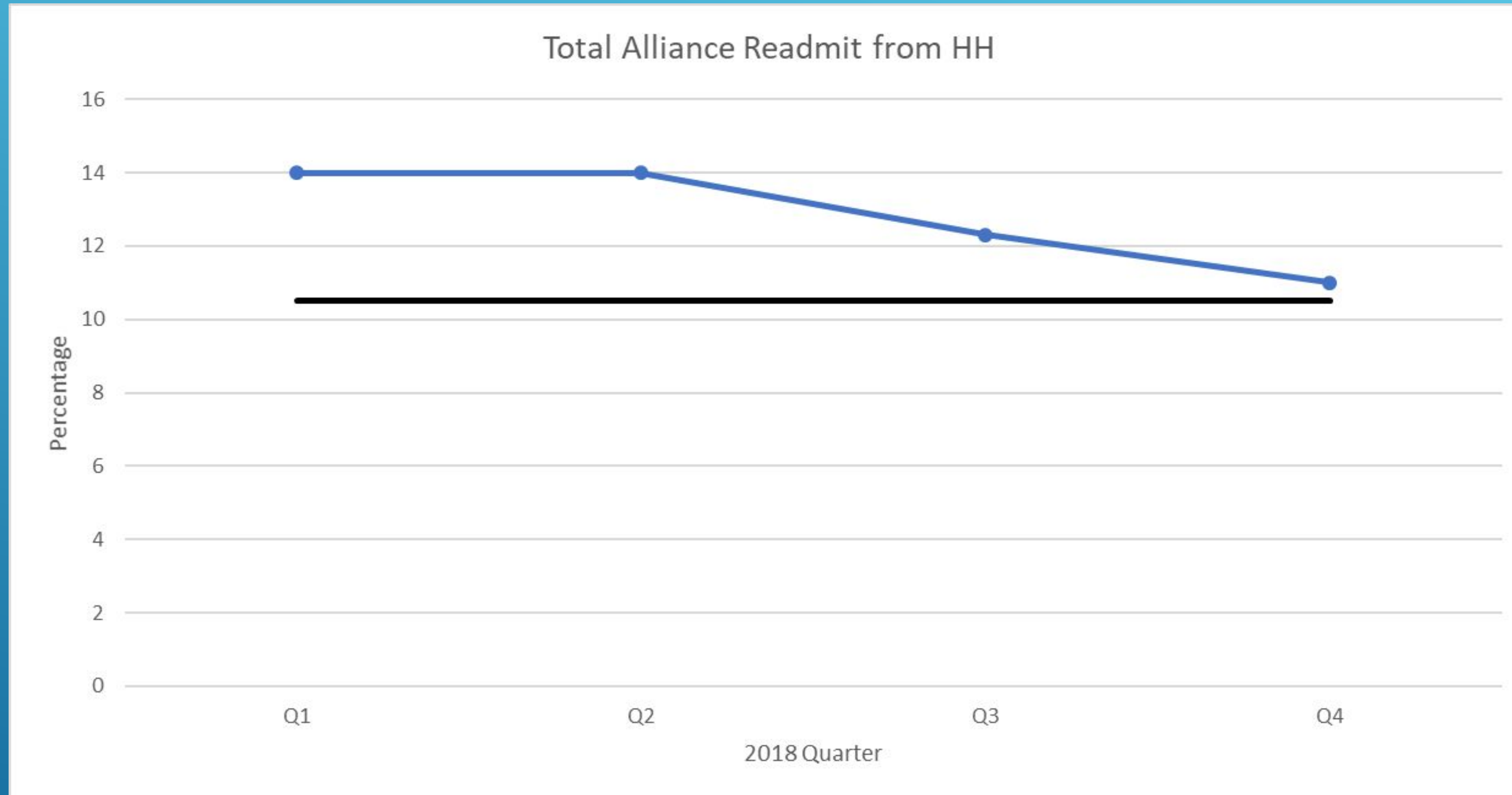


HOME HEALTH CRITERIA FOR GOOD STANDING COMMITTEE

In 2018 the Criteria for Good Standing Committee sent letters on a quarterly basis to involved agencies who were not meeting set criteria guidelines in the following areas:



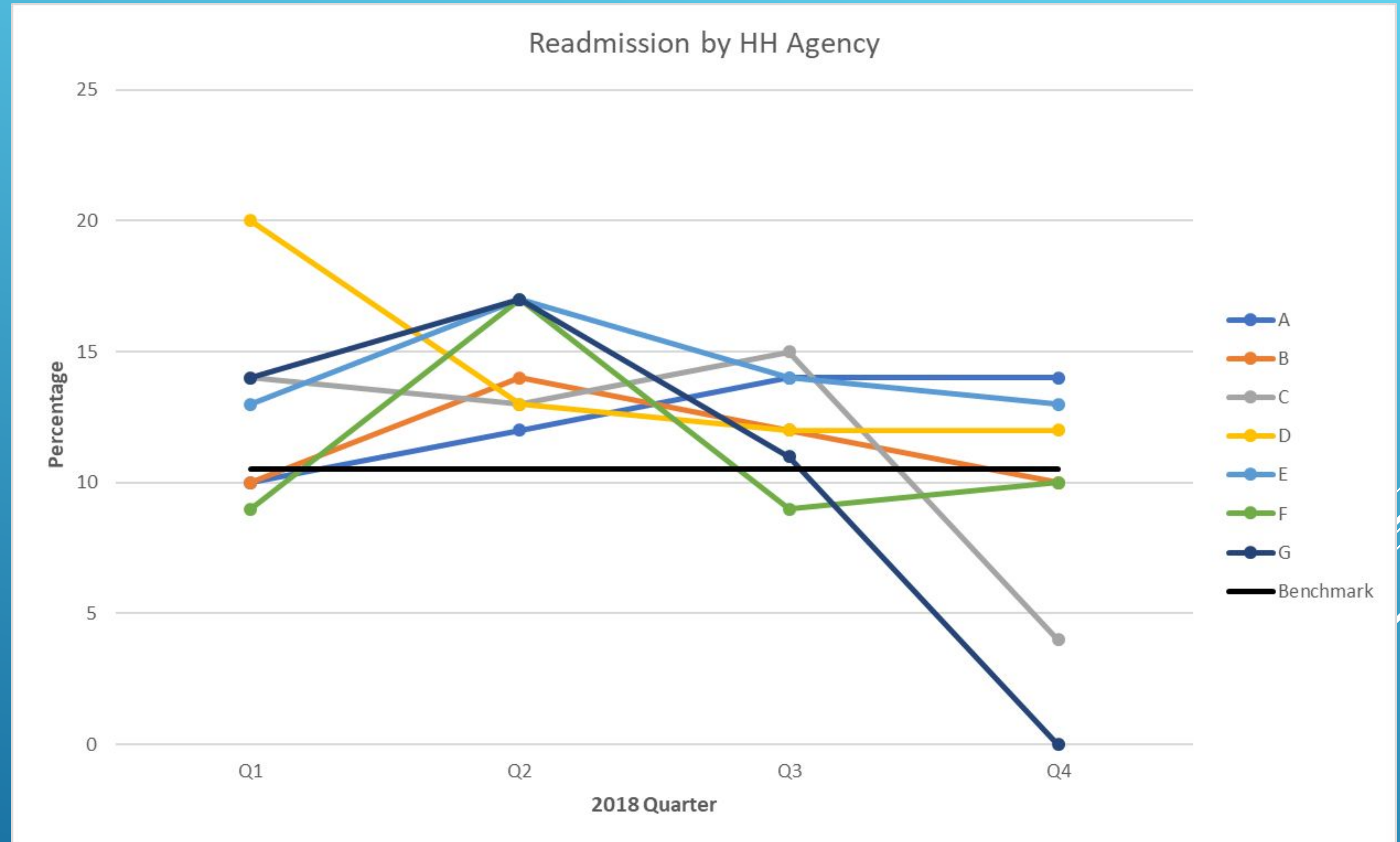
The Goal of the Home Health Criteria Committee is to put a process in place to measure outcomes. By setting a standard criteria of services, and being sure it is met, we are able to report true progress and raise the bar for patient transitions to home.



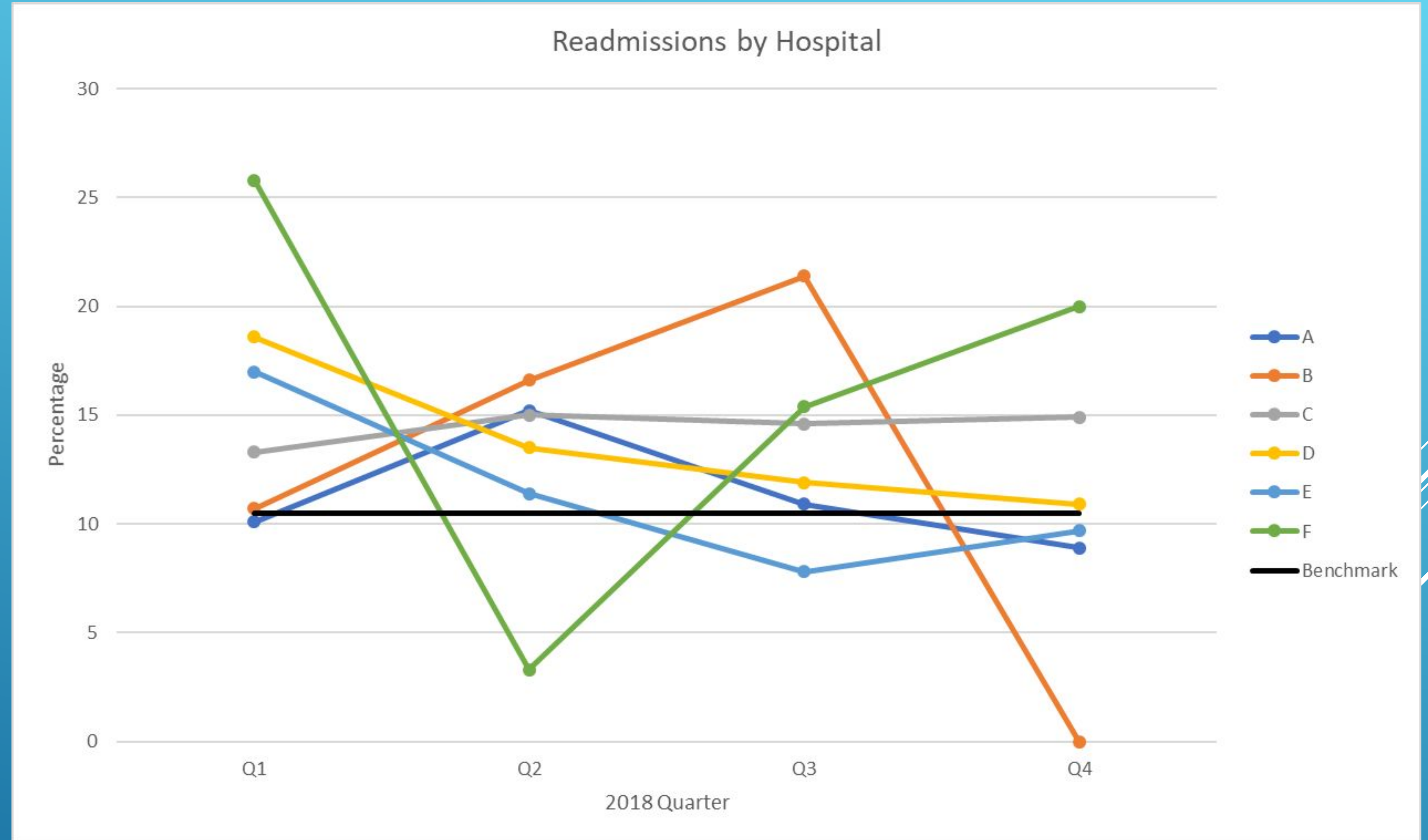
With standardization of the process for patient transition from Hospital to Home, we have seen an overall reduction of readmissions throughout 2018 toward our goal of 10.5%.

Blinded Home Health Agency information shows the progress of reducing readmissions by agency.

We can see a trend in most agencies showing considerable reduction is readmission percentage and the majority of agencies were below the 10.5% readmit goal by the end of 2018.



- Trends within each of the hospitals blinded compared to that same benchmark of 10.5%.
- We can look for opportunities.
- *The lines for B and F represent smaller hospitals that have less discharges causing more volatility in percentages.*



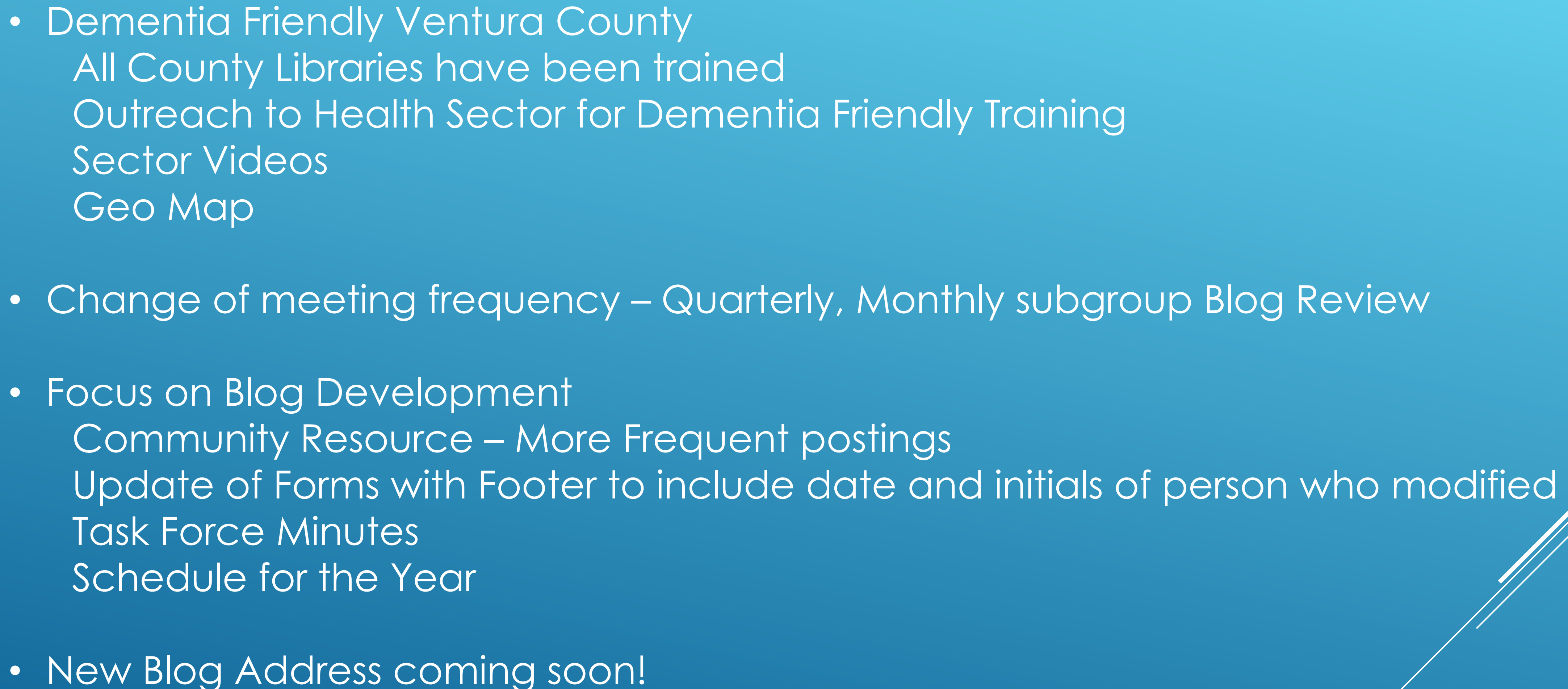
STEERING COMMITTEE UPDATE

- Finalized Steering Committee Criteria for Good Standing
- Charter Update
- Steering Committee members have also been involved in many health related projects directly or indirectly supporting the Hospital to Home Alliance goals, including our work with ambulatory care partners.

Grant Initiative Updates

- The Scan Foundation Grant Opportunity – Sue Tatangelo
- Gold Coast Health Plan – Social Determinants of Health Outcomes - Lynette Harvey
- Hospital Association of Southern California – Person-Centered Care Update – Bonnie Subira
- Partnership to Improve Care for the Cognitively Impaired Outcomes – Lynette Harvey
- Social Innovation Grant Update - Sally Grove
- Transitional Living Center Update – Matthew Tufte

Communication Task Force



Blog Talk

The blog continues to see a healthy number of visitors. We do have our challenges fetching information at times; however, Cerri has been a wonderful addition and has helped in the pursuit of information.

Facts and figures below:

- We have an average of 59 visitors per month using the blog.
- The website, in the next 60 days, will go from www.vchospitaltohomealliance.org to www.hospitaltohomealliance.org. This will happen automatically.

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