HHAVC Liaison Meeting Agenda

Agenda for Wednesday, August 21, 2019	
Item	**Who/What/How/Where/Why/When**
	OLD BUSINESS
Transfer to Acute Care	Dignity Health system process flow (attachment). - Sally
High Risk tool and HHAs	LACE Tool 1. Presentation/Review of collaboratively combined modified LACE tool used by Dignity and CMH. Intent is to create a common scoring language amongst the hospitals so HH agencies can uniformly implement best practice interventions based on the score...Low, Medium, High – Bonnie, Sally 2. HH Agencies to begin discussion at the partnership meeting on potential appropriate HH interventions for each scoring category on the lace tool - Tree
Introductory Letter (formerly: Patient preference letter)	Letter for hospital case managers still needs revision and "talking points" for case managers to help explain to patients the importance of home care, ie:"don't refuse home care, providing care in your home is very important to your recovery", etc. Molly working with Laura to make edits – Molly/Laura
Dignity referral policy change	Continue discussion on how this new process is going. Review any stats from Dignity if available. Discussion re policy letter that was sent out that states "Care Coordination staff can give access to post-acute providers if an in-person assessment is warranted for a safe patient transition"(attached). HH agencies wondering how this works with the liaison visit criteria. - all
Alliance SNF topic	Standing agenda item. Nothing from SNFS at this time
	NEW BUSINESS
Liaison Care Coordination Form	HH Agencies seeking clarification regarding to whom, how, and where to give the "Care Coordination Form" once the liaison has completed it in the hospital – Bonnie, Sally
Liaison hospital check in protocol	HH Agencies requesting review/revision of Liaison Hospital check in protocol (attached). Electronic version sent to Sally and Bonnie for revision. Will await Matt's return for VCMC revisions. – Bonnie, Sally
Alliance presentation dates to partners	HH Agencies requesting specific dates from Hospitals and Community Partners in which the HH Alliance Agencies can present to Discharge Planners and Care Managers. The agreement from the steering committee is 3 dates per year from each entity. – Bonnie, Laura, Sally, Sue/Lynette
community partners	Discussion regarding adding community based partners into the Alliance. - all
	Round Robin - all
Next Meeting	Wednesday, September 23, 2019; 4-5pm

HHAVC
Hospital to Home Alliance of Ventura County

HH ALLIANCE LIAISON COMMITTEE

Date / Time:	July 17, 2019; 4 to 5 pm
Location:	Livingston's Camarillo Office
Conference Call Info:	
Recorder:	Tree Pavan

Invitees---**Bold indicates attendance**

Mary Leste (Access TLC)	**Molly Buck (Los Robles)**	**Lynette Harvey (CHCD)**
Shelley Chilton (Access TLC)	**Lorie Fleming (Los Robles)**	Sue Tatangelo (CHCD)
	Steven Zlomke (Los Robles)	Bonnie Subira (CMH)
Cecille Luna (Assisted)	Amanda Larson (Mission)	
Carmen Cano (Las Posas)	**Amber Herman (Mission)**	**Sally Grove (Dignity) CHAIR**
Teri Helton (LMVNA)		**Laura Zarate (Seaview)**
Tree Pavan (LMVNA) SECRETARY	Jasmyn Tapia (Summit)	Cindy Jordon (shoreline SNF)
	Keon Mardanpour (Summit)	Matthew Tufte (VCMC)

Old Business	Topic	Action Items
Mission/Purpose Statement	***Ensure an optimal transition for patients across the continuum of care by adopting a person-centered approach of care and enhancing communication between acute and post-acute settings.***	.
Transfer to Acute Care	The "transfer to acute care from home health" form was approved with minor edits. Every attempt should be made to hand deliver the form to the appropriate hospital, in person, so that a face to face conversation may occur. If this face to face conversation about the re-hospitalized patient cannot occur in a timely manner, it is acceptable to fax the form to the hospital care coordination office. If an agency feels there is pertinent information, in addition to this form, that the agency feels the hospital should have, the agency may include it along with the one page transfer form.	Tree to make approved edits then re-distribute to committee members for immediate use.
High Risk Tool and HHAs (LACE Tool)	1. Sally presented Dignity's LACE Tool. The purpose of sharing this tool is to help provide a common language that both the hospital and HH agencies understand. Ideally, when a hospital indicates a LACE score on a referral, the HH agency will understand where that patient falls in terms of re-hospitalization risk, essentially giving the HH agency a "heads up" on whether or not this patient might be a high risk for re-hospitalization. This should help the HH agency in the creation of the POC, for	1. HH Agencies are to share the tool with their staff so they will be educated on what the scoring results mean for the patient. 2. HH Agencies to begin a discussion at the partnership meeting re this form and possible HH interventions that might be appropriate for each risk category.

Old Business	Topic	Action Items
	example, the LACE score might indicate that front loading visits may be beneficial. 2. The Hospitals are interested in having the HH Agencies populate the "LACE" tool with interventions that are appropriate for the home health setting for each score on the tool. For example, at the hospital, on the LACE tool, a patient scores a 16 so the hospital screens the patient for palliative care, when that patient goes to HH, because they scored a 16 at the hospital, the HH agency might make a social work visit within the first 3 days. This intervention is based on the HH agencies use of the same LACE Tool, but with different interventions.	
HHAVC Introductory letter (formerly patient preference letter)	Provider letter to help providers/CM understand what makes an alliance HH Agency different than other HH agencies. The letter continues in draft form. The committee asked that the following content be added to the letter: a. Talking points/ scripting for the hospital case managers to explain why it is important that the patient accept HH to come into their home to provide care. b. A stronger "story" of what make the alliance HH agencies different from other HH agencies. The suggestion was made to use language that has already been established in the "charter".	Molly to work with Laura Z. to make edits to the letter.
Provider/MD Focus Group results Planning	The draft form was approved with some minor edits. Agencies will use the edited form, once distributed, and collect feedback from the receiving physicians on whether or not the form was useful.	Tree to make the final edits and re-distribute to the committee members for immediate use.
Dignity referral policy change	Sally reported that Dignity is conducting internal analysis on statistics related to timely booking. Sally is working on process improvement initiatives within the Dignity system to make improvements. Sally reports while there is room for improvement, there has already been data to show significant, positive results in the booking process. An honest, open discussion occurred regarding some concerns the HH agencies have been having when sending referral questions through Navihealth as well as some concerns with customer service with some dignity discharge planners.	Sally to follow up at Dignity with the concerns that were raised today.
New Business	**Topic**	**Action Items**
HH Alliance SNF Presence	Having an alliance SNF administrator attend liaison committee meetings will help bond the alliance SNFs and HH agencies through information exchange via open	Tree to reach out to Cindy Jordon of Shoreline to request that if she is unable to attend a liaison committee meeting, she

Old Business	Topic	Action Items
	dialogue and collaboration. Therefore the committee felt it would be helpful to have a standing agenda item related to this relationship on the Agenda as well as request one of the alliance SNF administrators attend liaison committee meetings. Cindy Jordon has agreed to be the SNF representative but was unable to attend today's meeting.	work with the other alliance SNFs to send a different administrator in her absence.
Dignity inpatient video series	Sally reports that Dignity is working on possibly implementing an education video series for their patients. Included in the series would be a video that explains the importance of Home Health called "Why Home Health". This could help with patients' acceptance rate of Home Care when they discharge home.	

NEXT MEETING: **Wednesday, August 21, at 4 PM at LMVNA's Camarillo office.**

Transfer to acute for the Dignity Health System

Below is the process

For SJPVH:

Fax to (805) 389-5960

They are a locked area, so non hospital personnel cannot go into office.

If they need to speak to a case manager they can call them.

For SJRMC

Fax to (805) 981-4432

The liaison can also drop off in the Care Coordination office, the attached photo shows what the files look like and it will be located, as you face the desk where the CCA's are it is hidden (HIPAA) on the lower right hand side.

For both hospitals:

CCA will enter a note so all disciplines can see in computer the information and the Care Coordinators will bring to rounds

Modified LACE Tool

MRN:

Patient Name_____

Completed By_____

Attribute	Value	Points	Prior Admit	Present Admit	Final Score
Length of Stay	Less 1 day	0			
	1 day	1			
	2 days	2			
	3 days	3			
	4-6 days	4			
	7 - 13 days	5			
	14 or more days	7			
Acute Admission	Emergent Admission	3			
	Planned Admission	0			
Comorbidity Circle all that apply *(Comorbidity points are cumulative to a maximum of 5 points)*	No prior history	0			
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD, CAD	1			
	Mild liver disease, DM with end organ damage, CHF, COPD, Leukemia, lymphoma, any tumor, cancer, or moderate to severe renal disease	2			
	Dementia or connective tissue disease	3			
	Moderate or severe liver disease or HIV infection	4			
	Metastatic cancer	5			
Emergency dept. visits during the previous 6 months	0 visits	0			
	1 visit	1			
	2 visits	2			
	3 visits	3			
	4 or more visits	4			
	Totals				

- All Inpatient"& Observation patients over age 18 will be assessed using this LACEtool
- Assess Prior Admit by reviewing the chart. If no prior admit in last 30 days, Total Scoreof all categories is 0.
- Assess present admit using a:projected LOS of 3 days for Inpatient. If OBS, 2days
- Co morbidity section score has max of 5.
- ED visit in last 6 months include those that resulted in hospital admission or discharge home
- Write final LACE score on front of worksheet.

Minimal Risk **LACE: 0-6** **DHI: 0-15%**	**Low Risk** **LACE: 7-10** **DHI: 16%-39%**	**Moderate Risk** **LACE: 11-15** **DHI: 40%-59%**	**High Risk** **LACE: 16 and higher** **DHI: 60% and higher**
• Discharge Planning ▪ Routine care ▪ PCP visit as appropriate ▪ Surgical f/uas appropriate	• Discharge Planning/SS evaluation ▪ Refer to evidenced based wellness classes & other community resources as needed • Routine Care ▪ PCP visit as appropriate • Surgical f/u as appropriate	▪ Discharge planning/SS evaluation ▪ Transitional Care Services including *discharge* call within 2 business days of *discharge* ▪ PCP visit within 7 to 14 days of *discharge* • Pharmacy Med Rec prior to *discharge* • Screen for Palliative Care services	• Discharge planning/SS evaluation • Screen for Palliative Care services • Screen for ICM services • Pharmacy Med Recon prior to *discharge* • PCP visit within 7 days of *discharge* • Surgical follow up as appropriate

Thank you for being a valued partner of Dignity Health! As a partner we wanted to inform you of our enterprise discharge policy change, beginning July 1, 2019, that will impact our post-acute care providers. Our goal is to assure privacy for our patients, respect the choice process, and the respect of time of all of our providers.

Dignity Health Care Coordination staff will obtain at minimum 2 choices for post-acute services. Care coordination staff will send the referrals to those 2 choice agencies *as well as* Dignity Health's Preferred Provider Network (PPN). The patient's choice agencies/facilities have 30 minutes to accept and will be booked by patient order of preference. If the patient's 2 choices are not available or do not respond within 30 minutes, the Care Coordination staff will book with an accepting Dignity Health Preferred Provider

Post-Acute providers and liaisons are not to contact patients nor approach patients or caregivers *until after* the Care Coordination staff have *Booked* the referral in naviHealth. Care Coordination staff can give access to post-acute providers if an in-person assessment is warranted for a safe patient transition.

Once a liaison has been given permission to visit and has come to the hospital campus to see the patient, they are to depart the campus *immediately* after interaction. They are not to solicit additional referrals from any hospital personnel.

If a post-acute provider is found to be non-compliant with these rules, access to patients may be restricted to telephonic engagement only. This will be at the discretion of the local leadership.

Attached you will find our FAQ's

If you have any questions regarding this policy change, please contact:

Sally Grove
Care Coordination Program Manager, Post-Acute Care
Dignity Health
St. John's Regional Medical Center & St. John's Pleasant Valley Hospital
sally.grove@dignityhealth.org

Hospital to Home Alliance of Ventura County
Home Health Liaison Hospital Check In Protocol

Community Memorial Hospital (CMH)

1. Go to Front Door – Vendor Mate is visible and stands alone in front of the column closest to the Front Desk (between the front desk and gift shop). Type in your information and go to the closest window behind the Vendor mate for your badge.
2. Go to Case Management Office on the 4th Floor to sign in.
3. Go to the patient's floor to check in with Case Manager on that floor, and the charge nurse.
4. See patient – advise patient of why you're there – get details of discharge, complete Liaison Forms, give patient a copy of form.
5. Give the report to Case Manager who is in charge of the patient and give the copies of Liaison Forms.

Ventura County Medical Center (VCMC)

1. Go to Front Desk in the Front of the Building Entrance 1st Floor to get visitor wristband.
2. Go to Social Services/Case Management office on 1st Floor - ring bell (door locked) – Advise Social Services/Case Management that you are there to see a patient for the Hospital to Home Alliance.
3. Give the patient name to Discharge Planning Assistant to verify if the patient is still admitted.
4. See patient – advise patient of why you're there – get details of discharge, complete Liaison Forms, give patient a copy of form.
5. Meet with Charge Nurse, if needed
6. Return to Social Services/Case Management with completed forms & to sign out.

Home Health Liaison Hospital Check In Protocol(cont.)

Dignity Health - St. John's Regional Medical Center (SJRMC)

1. Vendormate kiosk is located in the hospital lobby (between the front doors and the gift shop).

OR (if kiosk is not working)

2. Vendormate computer is located at the Materials Management office on the ground floor behind the cafeteria. Also, need to sign in on the paper. DO NOT WRITE PATIENT'S NAME(S) on that form.
3. The badge prints out on the printer in the next room.
4. There are signs posted to not use your phone or have conversations while you're in the Materials Management office.
5. ~~The Care Coordination department is located on the 2nd floor (exit to the right off of the main elevators).~~
6. ~~Need to check in at their desk to let them know you're on site for your patient. If you do not have a patient, you will not be seen.~~
7. Contact the Care Coordination Assistant (CCA) at 805 988 2500 ext. 1690 for readmissions or regarding missing documentation on referrals.
8. ~~To contact the case manager, you need to know the case manager name and call Vocera 805 988 7070. VOCERA TIP: you can also spell the person's name into the system.~~

Dignity Health St. John's Pleasant Valley Hospital (SJPVH)

1. Vendormate kiosk is in the lobby behind the Volunteer desk. It prints out on the printer above to the left.
2. ~~The Care Coordination department is located on the 2nd floor (in the closed L&D unit – through the double doors).~~
3. ~~Need to check in at their desk to let them know you're on site for your patient. If you do not have a patient, you will not be seen.~~
4. ~~Contact the Care Coordination Assistant (CCA) at 805 389 6040 for readmissions or regarding missing documentation on referrals sent.~~
5. Care Coordination department 805 389 5887
6. Each CM has a direct number.

BOTH HOSPITALS' DEPARTMENTS CLOSE FOR LUNCH FROM 12-1230pm

After 430pm, contact the SJ ER RN Care Coordinator for both hospitals at 805 981 7378 or the PV 3-11 ER RN Care Coordinator at 805 389 6041