



HH ALLIANCE LIAISON COMMITTEE

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

Invitees---**Bold indicates attendance**

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| 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 |
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| Mission/Purpose Statement | <i>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.</i> | . |
| Transfer to Acute Care | <p>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.</p> <p>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.</p> | Tree to make approved edits then re-distribute to committee members for immediate use. |
| High Risk Tool and HHAs (LACE Tool) | <ol style="list-style-type: none"> 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 | <ol style="list-style-type: none"> HH Agencies are to share the tool with their staff so they will be educated on what the scoring results mean for the patient. 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. |

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| | <p>POC, for example, the LACE score might indicate that front loading visits may be beneficial.</p> <p>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.</p> | |
| <p>HHAVC Introductory letter (formerly patient preference letter)</p> | <p>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:</p> <ol style="list-style-type: none"> 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”. | <p>Molly to work with Laura Z. to make edits to the letter.</p> |
| <p>Provider/MD Focus Group results Planning</p> | <p>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.</p> | <p>Tree to make the final edits and re-distribute to the committee members for immediate use.</p> |
| <p>Dignity referral policy change</p> | <p>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.</p> | <p>Sally to follow up at Dignity with the concerns that were raised today.</p> |
| <p>New Business</p> | <p>Topic</p> | <p>Action Items</p> |
| <p>HH Alliance SNF Presence</p> | <p>Having an alliance SNF administrator attend liaison committee meetings will help bond the alliance SNFs and</p> | <p>Tree to reach out to Cindy Jordon of Shoreline to request that if she is unable to</p> |

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| | <p>HH agencies through information exchange via open 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.</p> | <p>attend a liaison committee meeting, she work with the other alliance SNFs to send a different administrator in her absence.</p> |
| <p>Dignity inpatient video series</p> | <p>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.</p> | |

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