Community Health Needs Assessment (FY 2022)
Implementation Plan (as of October 2022)

The RML CHNA process (approved by the RML Board of Directors in May 2022) resulted in the identification of ten key needs existing in RML's community. At the time, RML's CHNA team prioritized the ten needs as follows:

High Priority (full consideration and development of Implementation Strategy)

1. Training and education for caregivers.
2. Post-discharge care coordination, including changes to care plan.
3. Post-discharge social services (e.g., assistance with food, utilities, home services).
4. Post-discharge answers to medical questions.

Intermediate Priority (to be pursued if initiative is quick, easy, and with low resource needs)

5. Caregiver support (e.g., psychological).
6. Access to equipment, prescriptions, and supplies.
7. Transition to primary care physicians.

Low Priority (may be re-evaluated at a later time)

8. Setting of realistic expectations of time and energy post-discharge.
9. Respite care and/or in-house nursing.
10. Financial assistance.

To begin the development of the Implementation Plan, RML's CHNA team identified initiatives that could be implemented to address the needs identified during the CHNA process. A description of the initiatives follows below.

<u>High Priority Needs</u>

1. **Training and education for caregivers.**

   <u>Initiative 1a – Create Instructional Videos</u>

   Instructional videos would be developed on topics most salient to those providing care to Chronically Critically Ill (CCI) patients in their homes. It is possible that manufacturers have already developed these videos and permission would be sought to use them. These videos would be posted on YouTube, RML's Facebook page, and on RML's website. These videos would be available to anyone in the community.

   Topics for development could include ventilator management, rehab care (walking assistance, activities of daily living, lifting), central line care, nebulizer treatments, tracheostomy care and changes, basics of skin care and skin integrity, giving meds through an enteral tube, bed baths, and supplies to keep on hand.

   This initiative would be time consuming to implement and involve a lot of resources but would be relatively easy to manage once completed.

Initiative 1b – Expand Discharge Training

Discharge training and education would be spread out over multiple days. It would incorporate teach-backs and include blocks of time when family members could provide the care (under professional supervision) that would be required of them at home.

This initiative would be relatively easy to develop and implement as the content is already developed. However, there are questions about the time involved in supervising the caregivers while they are providing the care and the risk this may present to the organization.

Initiative 1c – Develop an Introductory Overview Course

An introductory overview course approximately two hours long would be provided to home caregivers prior to beginning discharge training. The topics would be similar to those for which we would develop instructional videos (see Initiative 1a – Create Instructional Videos). Additionally, the introductory course would incorporate material on the psychological components of home caregiving to give caregivers a better understanding of what to expect once at home (e.g., "a day in the life"), as well as tips to manage stress.

This initiative would be relatively easy to develop and implement as the content is already developed, except for the psychological component. For all of the topics, except the psychological components, the introductory course would not be as effective as teaching in a hands-on environment and may be considered redundant. Coordinating the availability of subject matter experts and home caregivers would be challenging.

2. Post-discharge care coordination, including changes to care plan.

Initiative 2a – Expand Use of Follow-Up Calls

Care Coordination would make 1-2 additional follow-up calls to patients discharged to home. Currently, one follow-up is call is made within 2 days of discharge. Additional calls would be made at 3-5 days and at around 7-10 days after discharge.

The implementation of the Expanse electronic medical record has improved the ability to track these calls. Having adequate resources to make the calls is a concern.

Initiative 2b - Hold Zoom Call with Patient and Care Team 2-3 Days After Discharge

A Zoom call would be scheduled with the patient, home caregivers, and professional care team (physician, home health nurses, therapists, DME providers) within 2-3 days after discharge. RML care coordinators and other providers (e.g., nurses, wound care specialists, respiratory therapists, rehabilitation therapists, psychologists) would attend the call, as appropriate. During the call, a progress update would be provided so that the care plan could be adjusted, social determinants of health addressed, and availability of supplies and equipment ensured. The need for this initiative would be further assessed after a review of the effectiveness of additional follow-up calls (see Initiative 2a).

The main challenge would be coordinating the attendees and ensuring the patient and home caregivers had sufficient technology to attend the call.

3. Post-discharge social services.

Initiative 3a – Provide Linkages to Community Organizations

Community organizations would be identified that would be able to address social determinants of health. For example, local departments of aging and social agencies would be sought out. The names and contact information for the organizations could be provided to patients and family as needs are identified, including after discharge. The organizations could be posted on YouTube, RML's Facebook page, and on RML's website and would be available to anyone in the community. Disadvantaged populations would be well-served by this initiative.

The challenge would be finding and vetting community organizations to assess the adequacy of the services they provide.

Initiative 3b – Involve External Agencies Prior to Discharge

Community organizations identified as part of Initiative 3a (Provide Linkages to Community Organizations) would be invited to meet with the patient and family prior to discharge so social determinants of health could be addressed proactively.

Initiative 3c – Provide Links to External Financial Assistance

Community organizations that could provide financial assistance to meet medical needs and other social determinants of health would be identified.

4. Post-discharge answers to medical questions.

Initiative 4 – Host a Help Line

A help line would be set up at RML. The help line would not be managed by live RML staff but would go to a voicemail recording. Staff would address questions about post-discharge care and health system navigation. Taking questions from the community may be possible. The help line would be checked at regular times by RML staff and questions would be answered within a stated period of time. There could also be links established on the RML website. Callers would be instructed to call 9-1-1 if there was an emergency.

The main challenge would be ensuring predictable and reliable response times.

Intermediate Priority Needs

5. Caregiver support.

Initiative 5 – Host Support Groups

Support groups would be started for caregivers of former patients. The support groups could be in-person or on-line. Topics could be general support or specific (e.g., ventilator support). Chat rooms are also an option. Support group participation could be extended to the community.

Challenges include arranging RML resources, organizing participants, and controlling content. Effectiveness is limited by the participation level and quality of the participants.

6. **Access to equipment, prescriptions, and supplies.**

   Initiative 6a – Make Sure Prescriptions are Written Appropriately

   It is sometimes difficult to provide patients with accurate prescriptions prior to discharge. Prescriptions written prior to discharge can change as instructions and the medications themselves can change right up to time of discharge. Expanse (RML's electronic medical record) offers a module to automate the process and electronically send prescriptions to a pharmacy, which would greatly improve coordination and accuracy, but the module requires a capital investment.

   Initiative 6b – Provide Financial Assistance to Purchase Equipment and Medications

   RML could budget money annually to provide financial assistance to patients to purchase equipment and medications upon discharge.

7. **Transition to primary care physicians.**

   Initiative 7 – Smooth the Transition to Primary Care Physicians

   The patient's discharge summary would be sent to the patient's primary care physician along with an offer of a physician-to-physician phone call to address questions and concerns.

Low Priority Needs

8. **Setting of realistic expectations of time and energy post-discharge.**

   Refer to Initiatives 1b and 1c.

9. **Respite care and/or in-house nursing.**

   Initiative 9 – Offer Respite Care to CCI Patients

   Respite care would be offered to CCI patients for brief periods of time. Respite patients can be placed in empty patient rooms and spare staff would be used. Patients would bring in their own medications and equipment.

   Currently, RML would not have the nursing staff to provide this care. There are also questions of liability and level of responsibility if a patient's condition were to worsen while at RML for respite care.

10. **Financial assistance.**

    Refer to Initiatives 3c and 6b.

RML's CHNA team then scored the initiatives across six dimensions. The following is the scoring system used for each dimension:

- Ease of Development and Implementation (1-5 scale)
  5: Easy to develop and implement.
  1: Difficult to develop and implement.

- Ease of On-going Management (1-5 scale)
  5: Easy to manage on an ongoing basis.
  1: Difficult to manage on an ongoing basis.

- Effectiveness in Meeting Need (1-5 scale)
  5: Highly effective at meeting the identified need.
  1: Relatively ineffective at meeting the identified need.

- Priority of the Need Addressed (0,2,5)
  5: Identified as meeting a high priority need.
  2: Identified as meeting an intermediate priority need.
  0: Identified as meeting a low priority need.

- Availability to Entire CCI Community (0,5)
  5: Initiative can serve the general community in addition to RML patients.
  0: Initiative serves RML patients only.

- Focus on Disadvantaged Populations (0,5)
  5: Focuses on one or more disadvantaged populations (minorities, women, permanently disabled).
  0: Does not necessarily focus on a disadvantaged population.

The scores for the first three dimensions (i.e., ease of development, ease of on-going management, effectiveness) for each initiative were multiplied together. The scores for the last three dimensions (i.e., priority need, availability to community, and focus on disadvantaged populations) were added to the product of the first three metrics. The initiatives receiving higher total scores were considered higher priority for development and implementation.

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The following table shows the scoring and total score (in descending order) for each initiative:

Initiative	Ease of Development and Implementation	Ease of On-Going Management	Effectiveness in Meeting Need	Priority of the Need Addressed	Availability to Entire CCI Community	Focus on Disadvantaged Populations	Total
2a. Expand Use of Follow-Up Calls	4	4	5	5	0	0	85
1b. Expand Discharge Training	4	3.5	5	5	0	0	75
3a. Provide Linkages to Community Organizations	3	5	4	5	5	5	75
6b. Provide Financial Assistance to Purchase Equipment and Medications	3*	4	5	2	0	5	67
7. Smooth the Transition to Primary Care Physicians	5	4	3	2	0	0	62
2b. Hold Zoom Call with Patient and Care Team 2-3 Days After Discharge	4	3	4	5	0	5	58
1a. Create Instructional Videos	2*	5	4	5	5	0	50
3b. Involve External Agencies Prior to Discharge	3	3	4	2	0	5	43
6a. Make Sure Prescriptions are Written Appropriately	2*	4	5	2	0	5	42
4. Host a Help Line	5	2	3	5	0	0	32
3c. Provide Links to External Financial Assistance	3	2	4	2	0	5	31
1c. Develop an Introductory Overview Course	3	3	3	2	0	0	29
5. Host Support Groups	4	2	2	2	5	0	23
9. Offer Respite Care to CCI Patients	1	1	3	0	5	0	8

* Initiatives would require administrative approval for funding. Scores for "ease of development and implementation" do not reflect investment costs.

High Priority Initiatives

Medium Priority Initiatives

Low Priority Initiatives

Five initiatives were identified by the CHNA team as the highest priority based on the calculated total score. All such initiatives could be implemented relatively quickly and easily during the current fiscal year (FY 2023) without any need for special funding, except for Initiative 6b (Provide Financial Assistance to Purchase Equipment and Medications). Budgeted funding for Initiative 6b would be requested for FY 2024. The five high priority initiatives are:

1. Initiative 2a – Expand Use of Follow-Up Calls
2. Initiative 1b – Expand Discharge Training
3. Initiative 3a – Provide Linkages to Community Organizations
4. Initiative 6b – Provide Financial Assistance to Purchase Equipment and Medications
5. Initiative 7 – Smooth the Transition to Primary Care Physicians

Four initiatives were identified as medium priorities. Although these initiatives are considered likely to be effective in meeting the needs of the community, they are relatively difficult to develop and/or require additional funding. Therefore, they will not be pursued immediately.

6. Initiative 2b – Hold Zoom Call with Patient and Care Team 2-3 Days After Discharge
7. Initiative 1a – Create Instructional Videos
8. Initiative 3b – Involve External Agencies Prior to Discharge
9. Initiative 6a – Make Sure Prescriptions are Written Appropriately

The remaining five initiatives will not be considered for implementation, unless something arises to change the scoring of the six metrics.

The anticipated timing of the implementation of the initiatives is as follows:

<u>December 1, 2022 – November 30, 2023</u>

- Initiative 2a – Expand Use of Follow-Up Calls
- Initiative 1b – Expand Discharge Training
- Initiative 3a – Provide Linkages to Community Organizations
- Initiative 7 – Smooth the Transition to Primary Care Physicians

<u>December 1, 2023 – May 31, 2025</u>

- Initiative 6b* – Provide Financial Assistance to Purchase Equipment and Medications
- Initiative 2b – Hold Zoom Call with Patient and Care Team 2-3 Days After Discharge
- Initiative 1a* – Create Instructional Videos
- Initiative 3b – Involve External Agencies Prior to Discharge
- Initiative 6a* – Make Sure Prescriptions are Written Appropriately

* Requires administrative approval for funding.