Jefferson County Health Center

IHC

CareLink

Bridging the Gap for Optimal Recovery and Wellness

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OBJECTIVE

To improve the health and well-being for patients who have complex health needs receiving care from:

- JCHC Med/Surg Department
- JCHC Emergency Department
- JCHC Clinics

Bridging this gap supports continuity among providers, patients, family caregivers, and other agencies. The program seeks to:

- Maintain ongoing patient communication
- Improve compliance
- Reduce hospital readmissions
- Minimize duplication of services
- Enhance patient experience

BACKGROUND

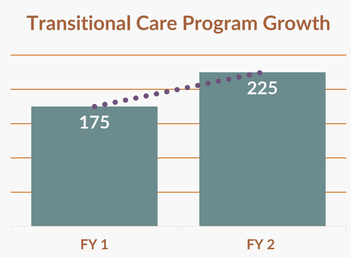
JCHC identified a gap in compliance for patients transferring to a tertiary setting and discharging home to continue care. Reasons range from:

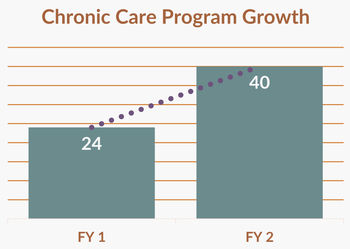
- Lack of general knowledge
- Cognitive decline
- Navigating available resources
- Environmental factors

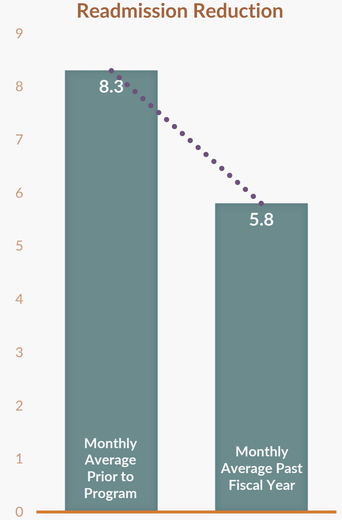
ANALYSIS

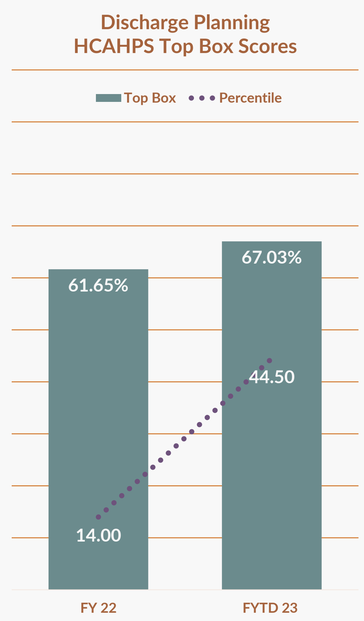
- Multiple factors influence patient's ability to successfully manage their health; such as scheduling follow-up appointments, lack of housing, food disparities, family support, transportation, funding, and ancillary health services such as mental health, dental care, or childcare.
- Navigating community resources can be a barrier for patients following health recommendations. JCHC developed a community directory to guide patients to additional resources.
- Patients in the transitional care program continue to require support beyond the 4-week program spawning the development of the chronic care program.

METRICS









ACTIONS TAKEN

- Partnered with U of I as a part of a grant establishing a multidisciplinary team with JCHC and U of I caregivers.
- Focus on services for patients discharging from the U of I back to Jefferson County.
- JCHC preserves the program with the expiration of the grant.
- Development of selection criteria includes patients with complex health and/or social deterrents and those with a LACE assessment score of 10 or above.
- Hospital patients receive nurse visit to inform patients about the program.
- Patients who accept the program receive one nurse home visit to assess the environment and medication management proficiency.
- Program can be ordered by hospital, emergency department, and clinic providers.
- Encounters are documented in the EMR and available to the primary provider.

NEXT STEPS

- Utilize interview tool for all readmissions to isolate gaps in our discharge process.
- Improve data collection:
  - % Compliance Follow-up Appointments
  - % Reduction in 48-hour ED returns
- Separate readmissions by diagnosis type.
- Incorporate other care disciplines in TCM/CCM management of patients.

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