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Providing patient-centered enhanced discharge planning and rural transition support: Developing a local health and human services resource bank for rural communities

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PROVIDING PATIENT-CENTERED ENHANCED DISCHARGE PLANNING AND RURAL TRANSITION SUPPORT

Developing a Local Health and Human Services Resource Bank for Rural Communities

The University of Montana

In Collaboration with

The International Heart Institute of St. Patrick Hospital

Missoula, Montana

This document is a brief practice guide. It describes one component of a comprehensive program of enhanced discharge planning and rural transition supports.[1] As such, it is designed to be used as part of that program but can be used independently by others, as well.

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[1] Seekins, T., Boehm, H., Wong, J., Yearous, L., & Smith, A. (2017). *Providing patient-centered enhanced discharge planning and rural transition support: Building a rural transition network between regional referral and critical access hospitals*. Missoula, MT: Rural Institute for Inclusive Communities, University of Montana.

BACKGROUND

Patients may have a wide range of needs when they are discharged from a regional hospital back home to a small town or rural community. Discharge planners and other staff at the regional referral hospital are seldom aware of the range of services and resources that a patient could use to facilitate their recovery close to home. Indeed, in our research, regional providers acknowledged that they lacked information about the many small towns they served in their catchment area. Patients, regional referral hospital staff, and small town providers all reported that this frequently led regional providers to refer patients to services and providers in the city. Surprisingly, staff at the local critical access hospitals we worked with acknowledged that they had difficulty keeping up-to-date with the resources available in their area.

Facilitating a smooth transition from a regional referral hospital back home to a small town or rural community requires that a patient be connected with as many local resources as possible to meet the needs they have. Obviously, it is difficult to know all resources available because they are widely dispersed and frequently change. We saw the connection between patient needs and community resources as a critical connection to facilitating successful transitions. We created a Rural Transitions Needs Assessment[2] that linked patient needs at discharge to locally available services using a tablet computer.

CHALLENGES

We discovered that it can be quite a challenging task to catalog the wide variety of resources available locally, even in relatively small towns. Further, we found that a surprising number of businesses and agencies did not describe their work or services effectively. Indeed, some advertisements and announcement did not really describe their services at all. They seemed to rely on people already knowing what they did or that the name of the agency or business was enough. In addition, the lists of services we did find in existence often focused on government or non-profit agencies. Similarly, they tended to ignore providers that did not specifically define their services as addressing a particular need. For example, if a patient had financial difficulties in paying for his or her utilities, they were likely to be referred to the Low Income Energy Assistance Program but providers either did not know or did not think to consider referring them to the local Wood Shed, a community program that shared wood for burning in fireplaces. Similarly, the form that many rural residents' needs take is different from those who reside in larger communities. For example, a rancher who is scheduled for surgery may have dependents that count on him or her, including cattle, sheep, horses, and people. Therefore, a veterinarian and a feed store may be important resources to consider. In general, we found existing service referral lists emphasized the so-called safety net programs. This tended to limit possibilities and interest in assistance.

SOLUTION: A COMMUNITY TRANSITION RESOURCE BANK

The purpose of this practice guide is to outline how you can develop your own health and human services resource bank. Referring patients to local services and programs can both facilitate a patient's recovery and enhance the local economy. This guide explains how to build a catalog of resources. A

[2] Seekins, T., Boehm, H., Yearous, L., Smith, A, Wong, J. L., Eisenreich, B., Greene, S. and Long, R. (2017). *Providing patient-centered enhanced discharge planning and rural transition support: Conducting a rural transitions needs assessment*, Missoula, MT: Rural Institute on Community Inclusion, University of Montana.

complementary document describes how to load and program a tablet computer with a resource bank. This complementary document creates a linkage between a patient's needs assessment and resources to address those needs and is available online.[3]

How to Develop a Community Transition Resource Bank

The first task is to assemble and organize information about local resources. You need to complete 13 steps to prepare a Community Transition Resource Bank. These include:

1. Define your community of interest
2. Form a committee to guide the process
3. Define the target population
4. Define the scope of patient needs
5. Define users and characteristics of useful information
6. Prepare a data framework
7. Develop a catalog of agencies, programs, and providers
8. Verify listing information
9. Enter relevant data into the data framework
10. Prepare a draft Resource Guide
11. Seek feedback from users
12. Phone follow-up as necessary
13. Finalize the Community Transition Resource Bank

Define a Community of Interest

The first step in developing a local health and human services resource bank is to define a community of interest. This involves clarifying the geographic boundaries of the area you intend to capture within the Community Transition Resource Bank. For example, you may specify that the area to be included is Custer County. Alternatively, you might want to expand the range by including some nearby towns in adjacent counties. You may also want to include businesses and agencies that provide services in Custer County but are not located there. Setting a boundary will help you judge which programs to include in the Community Transition Resource Bank.

Form a Committee to Guide the Process

The second step in developing a local health and human services resource bank is to form a committee to guide the process. This involves recruiting local experts and patients from the targeted community to work with you to develop a comprehensive listing of services in a community. For example, you might recruit a public health nurse, a staff member of a local center for independent living serving adults with chronic conditions, and a patient from your program to help guide your development of the local resource bank. Members of a committee can direct you to resources you may not know exist and can help you avoid pursuing some information that would not be useful.

[3] *Programming the Rural Transition Needs Assessment Tablet: A Technical Report*, available at: http://rtc.ruralinstitute.umt.edu/resources/roadmap/

Define the Target Population

The third step in developing a local health and human services resource bank is to define the target population. This involves describing as many specific characteristics of the population you intend to serve as possible. You may also describe characteristics of populations you do not intend to serve. For example, you might say that you intend to provide information and referral to adults who were treated in the regional referral hospital and discharged home to the target community. Similarly, you may want to clarify that your program will not provide support to those less than 18 years of age. In this case, the definition would probably lead you to exclude public school resources from your Resource Bank.

Define the Scope of Patient Needs

The fourth step is to define the scope of patient needs. This involves describing the kinds of supports patients who return home from treatment are likely to have. For example, we identified 18 needs that patients may have after being discharged home.[4] These needs are listed in Figure 1. This list can be expanded or reduced in scope. Defining the needs you expect to address helps further clarify the types of agencies or businesses that might be included in your Community Transition Resource Bank.

Areas of Rural Transition Needs	
Housing	Counseling and Emotional Support
Groceries and Meals	Medical Bills and Insurance
Medications	Scheduling Follow-Up Appointments
Personal Assistance for Daily Activities	Rehabilitation Appointments
Home Health Care	Transportation
Home Modifications	Recovery Expectations
Performing Daily Chores	Management of Treatment Tasks
Care of Dependents	Medical Contacts for Complications
Income and Finances	Long-Term Lifestyle Changes

Figure 1: Eighteen (18) needs that patients may have after being discharged home.

Define Users and Characteristics of Useful Information

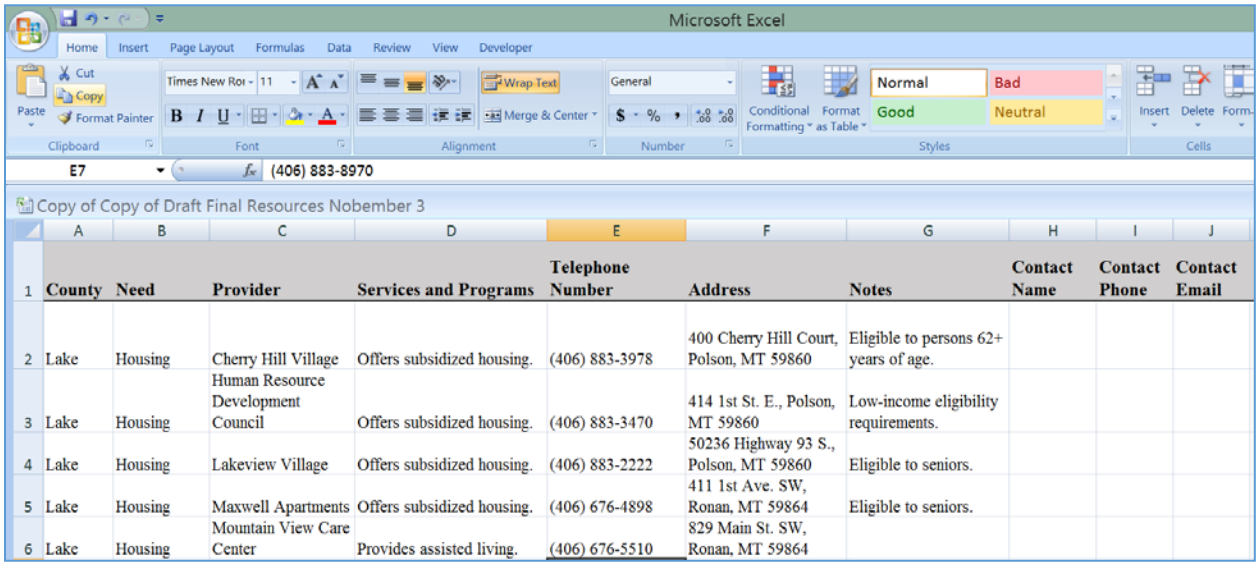
The fifth step is to define users and characteristics of useful information. This involves specifying who you expect to use the Community Transition Resource Bank, considering how they will use it, and developing a list of the types of information they might need to refer patients to the appropriate resources. Where community resource directories exist, they frequently list all the agencies that can be identified in a community in alphabetical order. This limits the ability to match patients to the most appropriate services. In our research, we organized resource listings around the needs addressed by the

[4] We identified 18 needs that patients might have. These are more fully described in the companion manual, *Building a Rural Transition Network between Regional Referral Hospitals and Critical Access Hospitals*, and a companion guide, *Conducting a Rural Transition Needs Assessment*. Both are available from the Rural Institute for Inclusive Communities. In those guides, we note that, after completing the research project on which this work was based, we recommend dropping two of these items (recovery expectation and management of treatment tasks) and including them in another process that includes a discharge orders verification checklist. This may be found in the companion guide, *Verifying Discharge Orders during Rural Transitions.* All related products can be found online here: http://rtc.ruralinstitute.umt.edu/resources/roadmap/

service(s) they provided. This included the critical information Local Community Transition Coordinators would need, including, the county in which the service was available, the need addressed (i.e., which of the 18 needs it addressed), the name of the organization or individual providing the service or support resource, a brief description of the service or resource provided, the contact information, and other notes (e.g., eligibility restrictions, time of service, etc.). In those cases where an agency provided services and supports that address more than one need, the agency and the specific services provided were listed in each relevant category.

Prepare a Data Framework

The sixth step is to prepare a data framework. This involves choosing a software spreadsheet to use in creating your basic Community Transition Resource Bank listing of resources and creating headers for data entry. For example, in our research, we used Microsoft® Excel 2013. This allowed us to easily manipulate the entries and keep listings up to date. Figure 2 shows one such data framework developed as part of the Montana ROADMAP research project.



	A	B	C	D	E	F	G	H	I	J
1	County	Need	Provider	Services and Programs	Telephone Number	Address	Notes	Contact Name	Contact Phone	Contact Email
2	Lake	Housing	Cherry Hill Village	Offers subsidized housing.	(406) 883-3978	400 Cherry Hill Court, Polson, MT 59860	Eligible to persons 62+ years of age.			
3	Lake	Housing	Human Resource Development Council	Offers subsidized housing.	(406) 883-3470	414 1st St. E., Polson, MT 59860	Low-income eligibility requirements.			
4	Lake	Housing	Lakeview Village	Offers subsidized housing.	(406) 883-2222	50236 Highway 93 S., Polson, MT 59860	Eligible to seniors.			
5	Lake	Housing	Maxwell Apartments	Offers subsidized housing.	(406) 676-4898	411 1st Ave. SW, Ronan, MT 59864	Eligible to seniors.			
6	Lake	Housing	Mountain View Care Center	Provides assisted living.	(406) 676-5510	829 Main St. SW, Ronan, MT 59864				

Figure 2: A sample resource catalog data framework developed as part of the ROADMAP research.

Develop a Catalog of Agencies, Programs and Providers

The seventh step in developing a local health and human services resource bank is to develop a catalog of agencies, programs, and providers. This involves using several strategies to amass a listing of businesses and agencies providing relevant services to the community of interest. For example, you may find that a local hospital discharge planner or social worker is willing to share a list of agencies they have worked with or referred patients to. Second, you can often find lists of businesses and agencies that provide relevant services in community documents (e.g., hospital and community needs assessments, hospital development plans, etc.). You can also scan through the local phone book to find relevant businesses and agencies. Of course, you can search the internet using the list of needs and the area of interest as search terms. You can also interview local hospital staff, staff of businesses, and agencies to ask for their recommendations for inclusion in the Community Transition Resource Bank. Finally, you may find it helpful to participate in public meetings of local health and human services agencies. This may lead to your participation in committees that may be trying to fill the gaps in local resources.

Verify Listing Information

The eighth step is to verify listing information. This involves checking to be sure you have the right information about each agency and business you intend to list in the Community Transition Resource Bank. For example, you might check the address of agencies by examining cross listings in the phone book or on the internet. You might verify the service an agency provides by calling the agency and asking. In our research, we found that many references to these resources were old, incomplete, or confusing. Verifying the information you plan to list for each agency reduces the chance of confusion between providers and disappointment and wasted time by patients.

Enter Relevant Data into the Data Framework

Once you have verified your information, it is time to enter relevant data into the data framework. This involves simply entering the data into the spreadsheet you prepared and ensuring that each entry is complete. For example, you might enter the first row of data into the spreadsheet shown in Figure 2 and save the file. You would continue to enter the information you have for each entity. If you encounter some incomplete or confusing information, you can verify it at that time. This produces a complete catalog of transition resources.

Prepare a Draft Community Transition Resource Guide

The tenth step in developing a local health and human services resource bank is to prepare a draft Community Transition Resource Guide. This involves formatting the completed data framework in a paper version for review. You can make the document easier to read and review by changing the font, spacing, and other features. In our case, we converted the data framework into a Microsoft® Word document and formatted it with some color. This prepares you to seek feedback on the contents of the Community Transition Resource Bank. Figure 3 shows an example of a draft Resource Guide.

County	Need	Provider	Services and Programs	Telephone Number	Address
Beaverhead	Housing	Beaverhead Villa	Offers subsidized housing	(406) 683 – 6428	400 N. Idaho Street, Dillon, MT 59725
Beaverhead	Groceries and Meals	Beaverhead Allied Senior Services	Offers home delivered meals	(406) 660 - 1978	PO Box 1422, Dillon, MT 59725
Beaverhead	Medications	Montana Migrant and Seasonal Farmworkers Council, Inc.	Offers prescription services including filling prescriptions, counseling, and education	(406) 683 – 5570	435 S. Atlantic Street, Dillon, MT 59725

Figure 3: Selected entries in one example of a draft Community Transition Resource Guide developed as part of the Montana ROADMAP research project.

Seek Feedback from Users

The eleventh step is to seek feedback from users. This involves asking your committee, your colleagues, and representatives of those you hope will use the Community Transition Resource Bank to review your draft for clarity, completeness, and accuracy. For example, you might ask a social worker at the local critical access hospital (CAH) to review the draft. Careful reviewers can improve the product by noting any errors of commission or omission. Importantly, they may add resources you missed.

Conduct Phone Follow Up

The twelfth step is to conduct phone follow up as necessary. This involves repeating the steps of verifying information that comes to you in the form of feedback. For example, a reviewer might ask if the listing for Performing Daily Chores provided by Pro-Shine should include a description of the housekeeping services they provide. If you agree that it should, you may want to verify that claim by contacting Pro-Shine.

Finalize Community Transition Resource Bank

The thirteenth step is to finalize the Community Transition Resource Bank. This involves making any last minute corrections to the entries in the data framework. For example, you may find that the veterinaries listed in dependent care will also provide livestock care for brief periods. This completes your catalog.

Updating the Community Resource Bank Catalog

Most providers and agencies rely on email addresses assigned to individual employees. This makes it difficult to use automated approaches to updating local resource lists. Simply, staff members change. Over time, the turnover means that an email contact with a staff member is lost, and along with it, contact with the agency. One lesson worth noting here is that agencies and businesses should develop one email account for the agency that is permanent. Updates to a Community Transition Resource Bank could be greatly facilitated if agencies had one, permanent email address to which requests could be sent. We strongly urge you to encourage providers to take this step. It would make it feasible to program automatic updates through a web-based resource directory.