Atlanta Metro Community Healthcare Connections Minutes

Meeting Name	Location		Minutes Taken By	
Atlanta Metro	**Dekalb Medical Hospital – Main Campus**		**Linda Kluge**	
Date	**Facilitator**	**Leaders**	**Actual Start Time**	**Actual End Time**
4/21/15	**Jessica Knopf**	**Sonya Green**	**1:06**	**3:00 p.m.**

Meeting Purpose/Objective: **Coming Together to Improve Care in the Community**

- ✓ Improve communication and patient care across the continuum
- ✓ Assist all facilities in meeting goals for Medicare quality improvement measures
- ✓ Discuss and implement efforts to increase communication between providers and settings
- ✓ Recognize current work and reward creative thinking.

Team Members Present

☒ A.G. Rhodes – Wesley Woods	☒ Barnes Healthcare	☒ Alliant Quality	☒ Grady Memorial
☒ WellCare Health Plans	☒ JenCare Med	☒ Apria	☒ Atlanta Regional Commission
☒ DeKalb Medical Center	☒ DeKalb Med Physicians Grp	☒ Open Hand	☒ Diabetes Community Action Coalition
☒ Grady Rehab	☒ Morehouse Healthcare		☒ Meals on Wheels Atlanta

DISCUSSION / Getting Started

- Jessica opened with meeting objectives and how this needs to be accomplished; the need for new members to sign the confidentiality statements; contact sheet/attendance updates needed. There were 22 participants in the meeting.
- Participants introduced themselves and shared a positive experience from the past month.
  - Working on reducing readmissions (multiple)
  - Approval for increased FTE's (Grady)
  - United Health Care grant for PCMH (Morehouse)
  - Identifying action items to address on "handoff" (DeKalb)
  - Offering ventilation products (Apria)
  - New agreement with MercyCare for follow up services (DeKalb)
  - Instituting Allscripts for documentation (DeKalb)
  - Receiving grant funding for increased meal deliveries to 17 counties for post acute care (Open Hand)

Discussion /Action Items

- Group reviewed results of previous barrier list and top barriers identified.
  - Coordination of care
  - Access to Care
  - Education/Training
- Participants identified specific concerns in the area of coordination of care. After identifying specific concerns, they broke into small groups to discuss concerns, what is measurable and data can be collected on, and what is actionable. Each individual was asked to identify the concern/barrier they believe the CHCC should address.
- Barriers/Concerns listed included:
  - Contact and communication with primary care and specialists
  - Specialist not able to lead/coordinate
  - Duplication of care increase costs of services
  - Coordination of inpatient/outpatient settings
    - Process is not working
    - Bigger gaps MDs/Health practitioners once patient leaves hospital
  - CTI or coaching model is valuable, not everyone has funds or is in CCTP
  - Patient must be engaged
  - Medication coordination
  - Everyone discharged differently; no common knowledge of process
  - Difficulty identifying the well-coached client, measuring quality of life
  - Health literacy – ineffective teachbacks or knowledge
  - Transition plan is too long/complicated
  - Too many people coming to the house

- After a voting process, participants identified Contact and Communication with PCP/Specialist as the initial concern that the group would like to address. The group then narrowed this down to a specific area – defining the problem as:
    - **Discharge Summary has not been communicated in a timely manner to the PCP, outside specialists and/or post-acute care.**
- The group discussed that people may not be aware of what is needed from each other, and that there is not a currently defined "standard" within the group.

CLOSING / Assignment

- By the next meeting – Collect data on 10 admissions – What went well, what, if any, information was missing. This should be for 10 admissions, not necessarily only ones that don't go well, but a random sampling or 10 consecutive so that we can then be able to track progress.
    - Data from different organizations/agencies may be collected differently, but is still valuable.
    - Please bring this data to the next meeting. If you are not able to attend, have a representative present or send to Jessica.
- As you go through the next month and gather your data, brainstorm ideas for interventions, or what is needed to address issue.
- Identify any members of the community that would be important to be at the table – SNF, ambulatory care, Physicians.

NEXT MEETING

Date: May 19, 2015 Time: 1:00pm - 3:00pm

Location: TBD

PLEASE EMAIL JESSICA by MAY 1st IF YOU WOULD LIKE TO HOST THE NEXT MEETING!

NEXT STEPS

Party Responsible	Activity	Due Date
All	Attend the next meeting –and bring a friend!	5/19/15
All	Collect data on 10 admissions	5/19/15
All	Brainstorm ideas for interventions	5/19/15

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