Atlanta Metro Community Healthcare Connections Minutes

Meeting Name	Location		Minutes Taken By	
Atlanta Metro	**Emory Rehabilitation Hospital**		**L. Kluge**	
Date	**Facilitator**	**Leaders**	**Actual Start Time**	**Actual End Time**
5/19/15	**L. Kluge**	**Diane Wirth – Grady**	**1:10**	**3:00**

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

- Reviewed objectives, sign in sheets
- Each attendee thought on a care coordination experience - these included: issues with pain management, good experiences with OT and PT advocating for the patient and family, stress of elders declining after inpatient stay, home health experience, support for therapy services.
- Updates from each setting shared. Grady is to start using a company (Jouvan?) who will data mine the 1-50 top risks for admissions and review the past 12 months of data.
- Many thanks for Tom / Emory Rehab Hospital hosting today!

Discussion /Action Items

- Reviewed the problem statement identified from the last meeting.
- Data Collection Process and Results: Reviewed the data that had been collected from the 3 settings present. Findings of those readmitted included –
  - Grady :
    - unfunded patients, without disability insurance, needing public assistance, need an advocate to help
    - EF at 10%
    - Patient cannot refill meds, cannot afford the $20 copay
  - Apria
    - Patients/families do not understand the insurance requirements and cannot pay for the services
    - Expectations for services are not communicated or understood for the responsibilities of others/self
  - Emory
    - 60% of cases reviewed were within Emory system
    - 40% were not from Emory and the issues were found to be
      - Unable to see EHR to see what had been done in advance
      - Discharge summary not available/ missing
      - Records are not concise so there are volumes of information sent that is not useful
      - Lack of access to the people who can explain what is going on with the patient
      - Status change with the patient cannot be explained and meds need evaluated
- Refined the problem statement

  From: Discharge Summary has not been communicated in a timely manner to the PCP, outside specialists and/or post-acute care setting.
  - Concerns that the d/c summary varies with each setting but common elements can be identified
  - What is timely? Established that 72 hours should be the goal
  - Who needs this – everyone – not just the PCP, outside specialists and NHs – and needs to include the patient/family.

  To: Discharge information common elements need to be shared within 72 hours with anyone who will benefit from this.

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- Brainstormed interventions/next steps:
  - Need a list of the elements needed for every discharge – what does everyone need to have
  - If we are promoting self-management then we need the patient to have 2-3 copies of their discharge summary to share with others
  - Goal needs to be 72 hours, not 30 days for communication between settings
  - Patients do not have a medical home/ PCP, we need to know more about how to improve this
  - GAHIN – has a number of hospitals now that have sharing of information via a portal available – people do not know about this and it would save time, money on tests, etc. and promote sharing handoffs between settings
  - Concerns with poverty/underserved patients – how to assist with Social Services needs in the metro area
  - Use of a Community Health Worker program - to follow up with patients being discharged to home

CLOSING / Assignment

- Look over the last 20 readmissions to see if there is any indication that the patient saw their PCP in the last 12 months – to determine if there are actually issues with this handoff to the PCP.
- Bring your setting's discharge form to the next meeting so others can share / id areas of detail that are needed
- Please make sure to complete the annual assessment of our community. We need your input!

NEXT MEETING

Date: 6/23/15 Time:

(NOTE – discussed the desire to move this meeting to a little later in the day as 1-3 is too early. Find a new time – ie. 2:30 – 4:30 or 2-4 to aid with traffic/travel to work and home. Will be evaluated and shared in the coming month!)

Location: Discussed the possibilities of meeting at AG Rhodes Boulevard – need to call the Administrator and ask!

PLEASE EMAIL JESSICA by June 15 IF YOU WOULD BE ABLE TO HOST THE NEXT MEETING!

NEXT STEPS

Party Responsible	Activity	Due Date

Jessica/Linda	Provide more information on services/agencies of interest to the group:
	• Georgia CARES – for medication assistance: http://www.mygeorgiacares.org/
	• GRAND Aides – send information from this Houston based program - http://www.grand-aides.com/
	• Share information on GaHIN - http://www.gahin.org/ and affiliated providers
	• Share information $4 formularies that are available for medications ie for patients who shop at Kroger's - https://www.kroger.com/asset/generics-list
	• Invite key leaders from Emory to the group next time –
	  ○ Carol P. – 404-712-4223
	  ○ Karen O. – 404-686-2819
	  ○ Talley Edge from Midtown	

All	Come prepared to share with the assignment above: • Look over the last 20 readmissions to see if there is any indication that the patient saw their PCP in the last 12 months – to determine if there are actually issues with this handoff to the PCP. • Bring your setting's discharge form to the next meeting so others can share / id areas of detail that are needed	

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