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**
6/23/15	**J. Knopf**	**D. Wirth, S. Green**	**2:05**	**4:00**

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	☒ Emory Rehab	☒ Alliant Quality	☒ Grady Memorial
☒ DeKalb Medical Phys. Grp	☒ Sanofi	☒ Apria	☒ Meals on Wheels Atlanta

DISCUSSION / Getting Started

- Reviewed objectives, sign in sheets
- Discussed need to have increased attendance with both administrative and clinical staff at the table.
- Contact list was reviewed with invalid contact information removed.
- Reviewed information from previous meeting.
- GAHIN – has a number of hospitals now that have sharing of information via a portal available
- Many thanks for Patty/A.G. Rhodes for hosting today!

Discussion /Action Items

- Reviewed the revised problem statement: Discharge information common elements need to be shared within 72 hours with anyone who will benefit from this.
    - Participants reported that when they received information, it was typically complete, but there were times information was not received.
    - Participants also stated that they shared common elements and agreed they were present in the discharge plans.

- Data Collection Process and Results: Grady shared information collected –
    - During discharge process, unable to follow through with follow up appointment. Out of 18 reviewed, 10 had no medical home and only 2 leaving hospital had appointment.
        - Group agreed it was not a form issue, but issues in the process and with PCP appointments, both in the hospital setting and in the SNF.
    - Barriers identified:
        - IT issues in discharge paperwork (some facilities still using dictation)
        - Need follow up process to get PCP appointment
        - Need to know who can take patients with Medicare
        - Transportation issues: cost – who pays?
        - **Who makes appointment? Hospital? SNF? Family?**
- Need to further refine the problem statement :
  From: Discharge information common elements need to be shared within 72 hours with anyone who will benefit from this.
  To: Discharge information common elements need to be shared within 72 hours with all of care team and ensure there is a follow up appointment with PCP.

- Brainstormed interventions/next steps:
    - Possible interventions were discussed
        - Gather information regarding availability of physicians accepting Medicare/Medicaid
        - Having question added to discharge form: Who is your PCP? When was the last time you saw PCP?
    - Need more information regarding if patient has medical home and has used in past year from each setting.

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-C3-14-01

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. • Thinking of whom your organization interacts with, identify a colleague you can bring with you to the next meeting.
NEXT MEETING
Date: 7/21/15 **Time**: 2p.m. – 4p.m. **Location**: Grady Hospital – FOB 103

NEXT STEPS

Party Responsible	Activity	Due Date
Diane, Abby, Sonya, Patty	• Identify 20 providers accepting Medicare/Medicaid within specific zip codes.	
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. This can be done as a file review or having staff member asking patients directly. • Bring a colleague in the health care continuum or who works with the Medicare population. We need more people at the table in order to create change!	

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-C3-14-01