Atlanta Metro Community Healthcare Connections Minutes

Meeting Name	Location		Minutes Taken By	
Atlanta Metro	**Grady Memorial – Emory Faculty Bldg.**		**J. Knopf, J. Curry**	
Date	**Facilitator**	**Leaders**	**Actual Start Time**	**Actual End Time**
7/21/15	**J. Knopf**	**D. Wirth**	**2:07**	**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

☒ Philips Tower ☒ Grady Memorial – Heart Failure Program	☒ Emory Rehab ☒ United Way ☒ Barnes Healthcare	☒ Alliant Quality ☒ Apria	☒ Visiting Nurse Health System ☒ Altrus

DISCUSSION / Getting Started

- Reviewed objectives, confidentiality sheets and sent around sign-in
- The coalition meeting had 17 participants.
- Discussed need to have increased attendance with both administrative and clinical staff at the table.
- Minutes from previous meeting were reviewed.
- Revisited discharge process discussion from June meeting
- Many thanks for Diane/Grady Memorial for hosting today!

Discussion /Action Items

- Participants introduced themselves and their organizations
- Member announcements:
  - Diane announced $250,000 AstraZeneca grant that Grady was awarded to support patients in the heart failure program. Grant funding will provide: 20 telehealth stations for non-Medicare patients; 2 CHWs for high-risk patients; specialized equipment (e.g. easy-open pill boxes); transportation vouchers; and copay vouchers. Grady will be working with the FQHCs as required by the grant.
  - Scott announced the Georgia Tech Aging and Technology Symposium that will be held on 11/12/15. He will bring a flyer to the next meeting.
  - Scott heard a presentation by Home Care Medicine of Atlanta – a new practice in Metro Atlanta with a PCP who provides in-home visits. 1-800-609-7494
  - Jennifer also encouraged providers to refer patients and families to Georgia Cares (the State Health Insurance Assistance Program) for free assistance with Medicare navigation. http://www.mygeorgiacares.org/
- Updates provided by Alliant Quality:
  - Have received immunization task from CMS and will be working with pharmacies and organizations on increasing documentation on vaccine rates for influenza, pneumococcal and zoster
  - Recently received additional Behavioral Health Task to help address depression and alcohol abuse within the Medicare population
- Briefly reviewed assessment results: limited participation given size of community.
  - Only 7
  - One thing stood out with this group: many existing care coordination projects
- Discussion of barriers (see attached chart):
  - Lack of affordable and reliable transportation options; no standard transportation option for transfers
  - Patients lacking PCPs
  - Few PCPs accepting new patients w/Medicare, and difficulty identifying who those providers are
  - Timing of discharge process is ineffective and leads to unnecessary delays; many members feel that some discharge steps should start upon admission
  - Home Health agencies struggle to provide wound care in a timely fashion after discharge, due to the length of time it takes to obtain a physician's order

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- Provider discussion:
  - Data gathered from one organization indicated only 60% of patients had seen PCP in last year.
  - Home Health described difficulty in discharge process: not receiving orders in timely manner to see patient, insurance difficulties blocking process, lack of PCP making it impossible to see patient
  - Many members commented that Medicare website (provider search) is inaccurate and needs to be updated
  - Difficulty with specific coverage providers in care received and coverage of care
  - Emory Rehab: problem with patients being denied; varies by age
  - Bumps in the road with Kepro handling patient and family appeals and concerns
- Brief overview of Information and Referral services (including robust and continuously updated database with many transportation options) available from Georgia's 12 Area Agencies on Aging. Eldercare Locator is a great resource to determine the correct AAA based on a patient's county of residence. The AAA for the 10-county Atlanta region can be accessed at: www.agewiseconnection.com or 404-463-3333. Even if transportation services are not available for a particular patient, AAAs keep track of requests, and this type of data can be used to demonstrate a need for more options to potential funders.
  - Providers can refer patients and families to Georgia Cares (the State Health Insurance Assistance Program) for free assistance with Medicare navigation. http://www.mygeorgiacares.org/
  - The Atlanta AAA has peer-led presentations available on a variety of topics for older adults, including Medication Management. Presentations are delivered by RSVP volunteers/peers who are 55 years of age and older. The sessions educate and empower older adults to play an active role in their healthcare decisions.

CLOSING / Assignment

- Please let Alliant know if your agency needs assistance with data design, interpretation, etc., in order to communicate to CMS the great work that is being done.
- See Next Steps (below)

NEXT MEETING

Date: August 18, 2015
Time: 2-4p.m.
Location: TBD

NEXT STEPS

Party Responsible	Activity	Due Date
Everyone! -collect data that is relevant to your facility	• Continue to collect data on PCP appts. made before discharge/leaving facility ▪ Do they have PCP? ▪ When was PCP last seen? ▪ Is follow up appointment made?	8/18/15
Everyone	• Identify and invite more stakeholders to the table	8/18/15
Everyone	• Identify clinical liaisons or partner organizations that can assist with appt. scheduling	8/18/15
Jessica & Jennifer	• Explore whether CHC meetings can get approved for CEUs	8/18/15
Jennifer	• Bring Retired Senior Volunteer Program (RSVP) speaker request form	8/18/15

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Metro Atlanta – Identified Problems/Barriers

Problem/Barrier	Interventions	Needed
Accurate med list	Feedback to Quality	Educating staff on med documentation
Medical Home/PCP	-Process intervention -Discharge Process: Don't leave the facility until an appointment is made. -Receiving facility may need to require follow up appointment. – coming from final hospital that it is receiving.	FQHC input Education More social workers/CHW's Discharge clinics/Transition clinics RSVP volunteers coming to educate
Discharge process -does receiving get all info - is information missing?	-Ensure it starts at admission -INTERACT tools?	Face-to-face

What other ideas/suggestions do you have?
What interventions has your organization tried that should be on this list?
Can you or someone at your organization be a contact person for any of these interventions, to help support others in your community?

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