

Mt. Division - Dalton

Community Healthcare Connections Minutes

Meeting Name	Location	Minutes Taken By	
Mt. Division CHCC	Dalton Community Center 218 N. Fredrick Street, Dalton, GA	Gaetane Wilder	
Date	Facilitator	Leaders	Actual Start Time
11/10/15	Gaetane Wilder		2:00 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

<input type="checkbox"/> Amedisys Home Health <input type="checkbox"/> Amedisys Hospice <input type="checkbox"/> Calhoun Health Care Center <input type="checkbox"/> Chatsworth Health Care <input checked="" type="checkbox"/> GA Mountains Health Svcs. <input checked="" type="checkbox"/> Gordon Health and Rehab <input type="checkbox"/> Gordon Home Care	<input checked="" type="checkbox"/> Gordon Hospital <input checked="" type="checkbox"/> Hamilton Med. Center <input type="checkbox"/> Hamilton Med Ctr. Home Hlth & Hospice <input type="checkbox"/> Hamilton Convenient Care <input type="checkbox"/> Homestead Hospice <input type="checkbox"/> Hutcheson Med. Center Sub Acute <input type="checkbox"/> Murray Med. Center	<input type="checkbox"/> NHC Healthcare Ft. Oglethorpe <input type="checkbox"/> NHC Rossville <input type="checkbox"/> NW GA Healthcare Partnership <input type="checkbox"/> NW GARC/AAA <input type="checkbox"/> Parkside at Hutcheson <input type="checkbox"/> Pruitt Health LaFayette <input type="checkbox"/> Pruitt Health Fort Oglethorpe	<input type="checkbox"/> Quinton Memorial <input type="checkbox"/> Regency Park <input type="checkbox"/> Rescare Home Care <input checked="" type="checkbox"/> Ridgewood Manor <input checked="" type="checkbox"/> Ross Woods Adult Day Svc. <input type="checkbox"/> Southeastrans <input type="checkbox"/> Wood Dale
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Other Attendees

DISCUSSION / Getting Started/Updates

- Welcome and Intros were made by Gaetane Wilder. Individuals present were asked to review and update the contact information available. Included reminder of history/purpose of group (previous focus on reducing pressure ulcers, use of restraints and improving communications. Current focus on better transitions of care with outcome of reducing readmissions and reducing healthcare acquired conditions.
- What's New in the Community:
 1. Alzheimer conference on March 24, 2016
 2. Gordon Hospital held a "Women's Night Out" with screenings and women were given health education. They also have "Evening with the doctor" and Diabetes Days where A1C, foot exam and vision screenings are done.
 3. Murray County gave "drive by flu shots". Due to more pharmacies giving vaccinations, doctor's offices are seeing a 50% decrease in administering the vaccinations. The location where the vaccination is given is responsible to insert information in GRITS.
 4. On August 15, Murray Medical Center provided health screenings, vision screening and gave out school supplies. About 220 people participated.
 5. Laurie at Rosswood shared a new process for the Sheriff's Department in Whitfield County. Frequent complaints that more could be done when delivering Welfare checks to isolated elders in the community triggered Quality Improvement! A team was formed and a new process developed. When deputies deliver the check they now visually see the individual and do a quick assessment of the situation (condition of individual, any needs verbalized, etc.), complete a check list and fax form to AAA and Gateway Counseling if further assessment is needed. New form attached. The Sheriff Department likes the new process and have shared with Floyd County.

ACTION ITEMS

Open Discussion was held which included the following:

- **Hamilton Hospital** reported on pilot with Quinton to assess and improve the transition process due to frequent readmissions (sometimes within hours of discharge). **They have noted that for past 60 days no readmissions!** New process includes provider to provider, nurse to nurse, and provider with family handoffs. Also provided additional clinical education to staff such as proper use of Bi pap machine, COPD, protocols after treatment and when to call provider. They have reduced time for lab results. Continue to have conversation with family members both at the hospital and the facility regarding the “new normal” concerning condition of individual. This reduces readmissions for symptoms/condition same as when they were discharged with no improvement while in the hospital. Now working with another SNF. Will continue until all are done. Noted improvement with how the ED physician looks at the nursing home resident.
- Hamilton Med. Center continues to fill RX at discharge for the patients who request it. This avoids the need to stop at a pharmacy on the way home and the necessary meds are given.
- Hospital is now asking family members who want to take the patient home, to spend a day/night to take care of the patient. The clinical staff instructs the family on what needs to be done and supervise how family completes the task. This helps to determine if they will be able to care for their loved one at home.
- Some providers are using the term “Comfort Care” for end of life conversations. Many people refuse Hospice but will agree to comfort care. Many people are uneducated about Hospice and think it will limit their options.
- Gaetane reminded the group of the importance of the “Facilities Abilities List” and making sure not just the hospital in general, but also the Emergency Rooms, have access to this information so that patients can be discharged to the facility most capable of meeting their individual needs. The form can be found at https://interact2.net/tools_v4.html
- Gordon Hospital now holding classes with patient and family members prior to having total hip and knee surgery. Discuss restrictions and how to care for to prevent readmissions.
- Hamilton has noted a decrease in COPD readmissions when using the Zone Tool and flash cards for patient and family education.
- Nursing home readmission data is now being collected and information will determine if need for penalty in 2017 or not.

DATA

- Use data to determine if need for quality improvement.

CLOSING / NEXT STEP Assignment

- Assess readmissions to hospital to identify if they could have been avoided. Evaluate handoff of information between providers for possible concerns and opportunities for improvement.
- Do you know your present readmission rate?? If not, find out what it is and what your facility is doing to reduce the rate. Ask other staff members if they know the readmission rate and what can they do to affect the rate.
- Encourage other providers to attend meeting.

NEXT MEETING

Next meeting scheduled for February 9, 2016