BIG Group/Accountability Meeting

Wednesday, April 19th, 2017

7:30 – 9:00 am

CLC Home Office – 7000 E Belleview Ave, Ste 150 Greenwood Village, CO 80111

1. **Welcome/Announcements – Maria**
    a. Sign-In - Attendance and Confidentiality Statement
    b. REMINDER on meeting format changes – combined BIG and Accountability
        a. Reminder of meeting time-frames 7:30am-9am
        b. Both company representatives welcome
    c. Medication Safety Committee – workgroup
        a. Meets monthly after this meeting – 9am
    d. April 28th – CMDA Conference (email went out with details)
    e. Q1-RTH Data DUE by Friday, April 21st – email to Michele_tusi@lcca.com
    f. Reminding folks about the website/minutes available online
    g. Survey Monkey coming……stay tuned! We need your feedback!
    h. Quarterly Focus Meetings
        a. Q2 – 2017 – HH/Hospice
            1. June 14th
            2. Location: Life Care Centers of America
    i. If you have general SDCC questions, please contact Maria: maria.oren@sclhs.net

2. **Presentation (unable to make it – will be rescheduled for August 16th)**
    a. Brenda Lewis, RN, MBA-HCM,CCM, ACM, Group Manager Care Coordination, Centura Health
        a. Overview of what's coming re: joint and cardiac - despite the recent delay in final ruling
        b. How entities can prepare/may be chosen for hospital RFIs specific to cardiac
        c. Updates on any cost-savings the hospitals have seen d/t CJR

3. **Membership – Gwenn Potts**
    a. Attendance/participation expectation – 75%
    b. Be sure to sign-in at each meeting
    c. If you have membership questions, please contact gwennpotts@gmail.com

4. **Website**
    a. Meeting minutes now available on http://southdenvercc.org
    b. Log-in information now available to all SDCC members
        a. Username: SDCC

Goal Statement: Promoting successful transitions of care through collaboration in the South Denver senior services community by reducing readmissions, ensuring appropriate care at the right time, and increasing patient satisfaction in care transitions through standardized language and processes.

b. Password: #caRe&lov!

5. Accountability Update – Pat McBride

a. All members expected to present data at least annually
b. Plan on presenting for 15-20 minutes
c. If you are unable to present on your date, please coordinate switching with another SDCC Partner and let Pat McBride know.
d. If you have accountability questions, please contact – Pat McBride pmcbride@clcmail.org
e. Expectations for data sharing
    a. How to choose the RIGHT case to present
        1. A challenging clinical case outside of payor or family dynamics
        2. Cases that did not go super great and expand on the learned lessons
    b. Use the REVISED SDCC Care Transitions QAPI Form and bring your INTERACT tools as needed
    c. ONLY need QAPI on 1-2 cases
    d. Contact transitions partners PRIOR to the Accountability Meeting for collaboration/review
    e. By the 5th of the month, please send the appropriate patient information to the following hospital leads:
        1. Parker (Karen Gacioch – karengacioch@centura.org)
        2. Swedish – (Marcia Miles - Marcia.Miles@HealthONEcares.com)
        3. Sky Ridge (Carol Schilf - carol.schilf@healthonecares.com
        4. Castle Rock (Jennifer Charles – jennifercharles@centura.org)
    f. If you have a case that was great or went poorly, with a peer of SDCC, contact them for drill-down PRIOR to presenting at Accountability meeting on your scheduled day.

6. Data/Case Study

a. HH: Halycon
    a. Patient CS
    b. GIP transfer TDH for agitation/delirium
    c. Sent patient to UCH to replace pulled nephrost tube
    d. UCH ran labs, chest xray and brain scan. Patient had to be put in 4-point restraints – wife revoked hospice to get nephrost tube (unable to get the tube replaced)
    e. Sent to TDH for agitation – he died 3 days later comfortably
    f. Halycon felt the hospitalization was warranted as patient was high functioning at home prior to agitation.
    g. Hospice RN went with patient to ER and UCH were aware of his hospice status.
    h. Halycon/TDH did not consult UCH for this meeting
b. ALF: Salus
    a. Patient: IA
    b. Lives at home experienced fall with broken sacrum
    c. Sent to hospital than SNF; Salus brought in to SNF for sitter/companion care

d. Declined at SNF – RTH from SNF to Rose to SNF to Rose to SNF to Rose to SNF
e. Unable to diagnosis real cause – finally Rose found bleeding ulcer on last admit
f. Determined that fall was d/t BP med and Flonase interaction which caused dizziness
g. Feels like original RTH could have been avoided had PCP been aware of medication
h. Patient remains at SNF for ongoing therapy services, Salus still involved

c. MD: Team Health
   a. Patient JD
   b. PA visits her at Caley Ridge
   c. Clinic visit 2/22 w/complaint of cough from lingering cold.
   d. RTH 2/25 for nausea/diarrhea dx – cDiff
   e. Patient did refuse HH services
   f. PA f/u visit on 2/28 – asking for direct admit to SNF; unable to go SNF d/t lack of 3day qualifying stay
   g. RTH ¾ for abdominal pain and multi-system failure dx – sepsis
   h. Preventable – RTH not really
   i. Family had told DTR/family that she was 'ready' to die.
   j. Family to provider communication went very well and keeping HH partner in loop

d. HH/Non: Touching Heart
   a. Patient: MC
   b. S/P SNF stay after severe MVA
   c. Service started 2/23 – RTH 3/8 with pneumonia than back to SNF
   d. Home again 3/18 from 2nd SNF stay

7. Lessons Learned/Open Discussion
   a. Patient/Family was educated about option to revoke hospice prior and during hospice services
   b. Various Levels of Hospice care include;
      a. Routine Hospice – patient is stable, no acute symptoms
      b. Care Connect – nurse/LPN 8 hours of continuous monitor
      c. Respite – 5 nights stay inpatient at SNF or hospice facility
      d. GIP – acute inpatient management
   c. Interesting that pharmacy did not pick up on medication interaction – Flonase and BP medication
   d. Inability to direct admit to SNF
   e. Tracking of RTH on Saturdays…could those visits have been avoided if it was during the week
   f. Ongoing education for ER Teams about what level of care post-acute can manage – revisit your INTERACT Nursing Home Capability List
   g. Need to do consistent job with communication hand-off from provider – SNF to Non-Medical – patient wanted to leave SNF sooner than recommended
   h. Opportunity for SNF to invite non-medical to DC planning meetings not just HH
   i. Non-medical to do better job with helping family/facility understand level of care that can be provided SAFELY
   j. Reminding non-medical about direct-admit to lower level of care

8. Success Stories, Trends and Best Practice
    a. Good communication with family/physician group

9. May Presenters
    a. Namaste – HH
    b. Namaste -Non-Med
    c. Team Select
    d. Gold Leaf

Next Meeting: BIG/Accountability Group Meeting May 17th @ 7:30 am @ CLC Home Office