Summary of Discussion

1. Welcome and self-introductions
   Welcome to all!

2. Meeting objectives and expectations
   Lynne Ashbeck, Hospital Council, reviewed the meeting goals.

3. Review November 4, 2014 meeting summary/action items
   Lynne reviewed the November 4, 2014 summary.

4. Adopt Community Charter
   ♦ The community charter was reviewed by Jennifer Wieckowski, HSAG. Additional signatures from members were collected and will be added to the charter.
   ♦ A Steering Committee for 2015 was established. Michael Smith, Dignity Health, accepted the position as Chair.
   ♦ Data was shared for time period April 2013 to March 2014:
     o De-identified Kern hospital readmission rates ranged from 11.1% to 27.7%.
     o Average hospital readmission rates in Kern dropped slightly to 20.6%.
   ♦ 11 of the 18 (61%) nursing homes in Kern County have signed up with HSAG to be a part of the National Nursing Home Quality Care Collaborative. HSAG will continue to communicate progress.

5. CCTP update—report on the CCTP grant progress and Kern County’s performance among the other US communities engaged in this work
   ♦ Anwar, Partners in Care Foundation, reviewed the CCTP progress achieved.
   ♦ Hospital referrals and enrollments have steadily climbed.
   ♦ At a CMS meeting in Baltimore last November, Kern County received recognition for being one of the top five performing communities in the nation! Go Kern!!

6. Let’s Become Measurement Experts!
   ♦ Jennifer Wieckowski and Matt Lincoln from HSAG discussed the Charter goal to select interventions to solve problems, identify measures of success (process and outcome measures), collect data, and report results
   ♦ A draft logic model for Kern County featuring CCTP measures was presented. HSAG will continue to update the logic model to be a visual tool and framework that will help guide and document our community interventions.
   ♦ Tracking measures will help inform our community if the interventions are working and why or why not.

7. Selecting our 2015 interventions…to do, measure, and report!
   ♦ Three breakout groups were formed and the following notes were documented.
1. Community Resources
   ♦ Access to a pharmacy can be problematic (ex. 13 hour wait for patients). Solution could be forming an alliance with pharmacies to hand deliver the meds at the bedside or at home. Hospitals often have meds delivered to hospital before discharge; can SNFs do the same (give patient a month of meds)?
   ♦ Transportation to get meds and to physician follow-up visits is a problem
   ♦ Churches?

2. Communication Hand-Off Notes
   ♦ CSS begins on admission
     a. Welcome residents
     b. Inventory
     c. Surveys (admit/discharge)
     d. Communicate needs to team
     e. Follow up after discharge
   ♦ Discharge Process
     a. Residents belongings
     b. Equipment
     c. Maintenance issues

3. Medication Management
   ♦ Problem: The hospital reconciled med list is different than the actual med list the patient is following at home. Hospitals don’t have access to old med lists.
   ♦ Can EMRs between hospitals, SNFs, and home health agencies be linked together?
   ♦ The two SNFs at meeting are calling residents once a week for four weeks post-discharge from SNF to check in on them (i.e. sometimes home health never showed up as planned). Are all SNFs doing this? If not, can we make this a standard in Kern County if the data shows it averts readmissions?
   ♦ Some SNFs are also doing home safety checks. Should be a standard for all SNFs.
   ♦ Hospitals and SNFs can work on antipsychotic informed consent required in the SNFs. If hospitals got informed consent before the transition, that would make life better for the SNF and resident.
   ♦ Can SNFs call patient’s primary pharmacy to get original list of meds. Mail order meds are a problem. Can mail order list be provided to facility?
   ♦ Collect timely HCAHPS data from all the hospitals to evaluate progress in clearly communicating medications.
     - HCAHPS 25—Patient Understood Purpose of Medications
     - When I left the hospital, I clearly understood the purpose for taking each of my medications.
   ♦ Can Kern County solve this med rec issue? Create a med rec database.
   ♦ San Joaquin is introducing a pharmacist in their ER this summer and utilizing pharmacy students to educate patients. Can this model be expanded to other facilities if San Joaquin shows success?

8. Summary of next steps/homework
   ♦ Steering Committee will meet prior to the next community meeting to design a plan to move the collaborative forward to meet the Charter goals. (Committee is attached)
   ♦ Need to designate Team Leads for committees to select interventions and develop measurements to track so we can evaluate our progress.
   ♦ HSAG to provide updated readmission data at next meeting.

9. 2015 meetings at Bakersfield Memorial Hospital, Founder’s Hall, 9:00 - 11:30am
   ♦ Thursday, April 9 
   ♦ Thursday, June 25
   ♦ Friday, August 28 
   ♦ Thursday, November 5
KERN COUNTY CARE TRANSITIONS COLLABORATIVE
STEERING COMMITTEE

Chair: Michael Smith, RN, MSN Ed, PHN
Dignity Health

Physician Advisor: Dr. Sudhir Kakarla, Bakersfield Memorial Hospital

<table>
<thead>
<tr>
<th>Representing...</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>Jane Kach, SJCH</td>
</tr>
<tr>
<td></td>
<td>Olympia Durbin, BHH</td>
</tr>
<tr>
<td>Long-term care</td>
<td>Cari Walker, Lifehouse</td>
</tr>
<tr>
<td></td>
<td>Hania Jakyma, Golden Living</td>
</tr>
<tr>
<td>Home health</td>
<td>Dennis Black, Optimal Home Health</td>
</tr>
<tr>
<td>Pharmacy/medication management</td>
<td>Kevin Komoto</td>
</tr>
<tr>
<td>CCTP project/Partners in Care</td>
<td>Anwar Zouehid</td>
</tr>
<tr>
<td></td>
<td>Desiree Ingalls</td>
</tr>
<tr>
<td></td>
<td>Joyce (PIC)</td>
</tr>
<tr>
<td>Other CBOs</td>
<td>TBD</td>
</tr>
<tr>
<td>HSAG</td>
<td>Jennifer Wieckowski</td>
</tr>
<tr>
<td></td>
<td>Matt Lincoln</td>
</tr>
<tr>
<td>Hospital Council</td>
<td>©</td>
</tr>
</tbody>
</table>

**Steering Committee ‘logistics’**
- Confirm who to do the inviting, maintaining of the distribution list, etc.
- Determine meeting frequency/ ‘how’ to meet (in-person, via phone, etc.)
- Work group structure/reporting/accountability

**Steering Committee agenda items**
- Goals for the collaborative
- Principles to guide the work (e.g. transparency of data for improvement; sustainability over the time; collective community engagement is the only real way to affect readmissions over time; shifts in readmission require a realignment of thinking; etc.)
- Sustainability plan post-2015