Community Coalitions

"Working Together to Enhance Quality Outcomes"

Pauline Breaux , RN, BSN

There is no conflict of interest or commercial support to disclose

Objectives:

- Steps in developing a community coalition
- Effective communication between levels of the continuum
- Standardizing transition tools
- Significance of education of all stakeholders for change
- Importance of data collection and transparency

Acadiana Health Coalition

Acadiana Health Coalition

Objective # 1

- Steps in development of a community coalition

- Initial Coalition Strategy Team:

Our Lady of Lourdes- Pauline Breaux
FMOLHS- Karen Cormier
Lafayette General Medical Center- Melissa Folse, Ruth Evans
Grace Home Health/LGMC- Heather Hardy

Established 8/13

Strategy Members : 2019

Pauline Breaux, RNC	Our Lady of Lourdes Regional Medical Center
Heather hardy, RN	Grace Home Health
Guy Davis	Evangeline Home Health
Abby Fontenot, RN	
Karen Buroker, RN	OPH
Kevin Dore	New Iberia South
Monette Villien	Lourdes Hospice
Karl Broussard	Hospice of Acadiana
Emily Hunter	Compass Health
Amy Dysarat-Credeur	Oceans Behavioral Health
Tammy Prejean	Our Lady Lourdes Regional Medical Center
Tracy Vincent, APN	Our Lady Lourdes Regional Medical Center
Holly Howat	Justice and Criminal Coalition
Tyler Hebert	Oceans Behavioral Health
Donnie Simon	Region 4 ADRC
Joe McPherson	Maison de Lafayette
Claire Collins	Behavioral Health Unit
Alicia Kline	Fresnius
Myra Foley	LHA
Donna WAscom	Quality Insights
Dr. Andy Blalock	Our Lady of Lourdes Regional Medical Center

Mission Statement

"To work collaboratively as providers, to facilitate improved transitions of care based on best practices that achieve the best quality outcomes for the patients that we serve within our community"

Acadiana Health Coalition

Goal:

Improve the quality of care at all levels and reduce readmissions for our patient populations

Acadiana Health Coalition

Barriers:

- TRUST
- Breaking down the walls between providers.
- Willingness to share information between levels of care.
- Limitations within each computer software.
- Attendance

What helped?

- Sharing information/Open Communication
- Acute/Subacute providers working together to help resolve issue as a community
- Taking time to learn the needs of the different level
- Working one on one with providers in their environment
- Holding each other accountable to the patient
- Support from the experts : LDH, OPH,CMS, OBH , Emergency Preparedness, EQ Health, LHA

MENTORS/ADVISORS:

Dr. Vitalis Okechukwu M.D.	**Infectious Disease Specialist**
Myra Foley , BA ,RN , CIC	Quality Improvement Specialist, Louisiana Hospital Association
Belinda Wilber, RN	Infection Control Preventionist
Donnie Simon	Safety, Security , Emergency Preparedness – Our Lady of Lourdes Regional Medical Center, Administrative DRC for Region IV
Donna Wascom , MHS, RRT, CHC	Quality Improvement Specialist
Holly Howat, PH.D	Executive Director Beacon, Criminal Justice Coordinating Committee
Karen Buroker, RN	Office of Public Health
Andrea Salinas, MPH	Healthcare-associated Infections Epidemiology
Betsy Welch, RN	Public Health Nurse Coordinator
Cecile Castello, RN	Director Health Standards Section
Barbara Anthony, RN, LNC	Dementia Partnership Project Coordinator Louisiana Dementia Partner Coalition
Linda Sadden, RN	Louisiana Department of Health and Hospitals

Objectives # 2:

- Effective communication between levels of the continuum
  - Monthly meeting with each 5 sub-acute providers : NH, Hospice, H/H, Assisted Living, LTAC

Quarterly meeting with all sub-acute providers : Psychiatric and Dialysis added

Objectives # 3 :

- Standardize Transition Tools
  - Acute Discharge Form: focus on meeting needs of all providers (Care Needs / Regulatory)
  - Standardized NH Admit Orders

Development of Workgroups: Meets Monthly

- Infection Control Workgroup = Quality, Safety and Infection Control W/G
- Psychotropic Workgroup
  - Reduction of psychotropic drug use
  - Enhancement of care and resources to patients/providers in our community
- Dialysis Workgroup (2019)

Standardize Community Policies and Procedures

- Handwashing
- Decontamination and cleaning of vehicles utilized in transportation of patients
- Clostridium Difficile
- Development of Diarrhea Decision Tree/Special Considerations :
  - Guide used in avoiding unnecessary collection and treatment of false positive stools for C-Difficile
    - Stool collection guide
    - Transport/Refrigeration
- Isolation Policy

Department: Patient Care Services	**Subject:** Infection Control- Handwashing
Effective Date: July ,2015	**Resources:** **Center for Disease Control and Prevention: Guidelines for Hand Hygiene in Healthcare Settings**

I. PURPOSE:

Provide specific infection control guidelines for hand hygiene to all healthcare workers engaged in direct patient contact.
Reduce transmission of pathogenic microorganisms to patient and staff.
Hand-washing is the single most effective method to prevent the spread of infection.

When caring for a patient with *Clostridium difficle*, use soap & water. Alcohol based sanitizers are not recommended by CDC when caring for these patients.

These practices are consistent with the Center for Disease Control (CDC) recommendations.

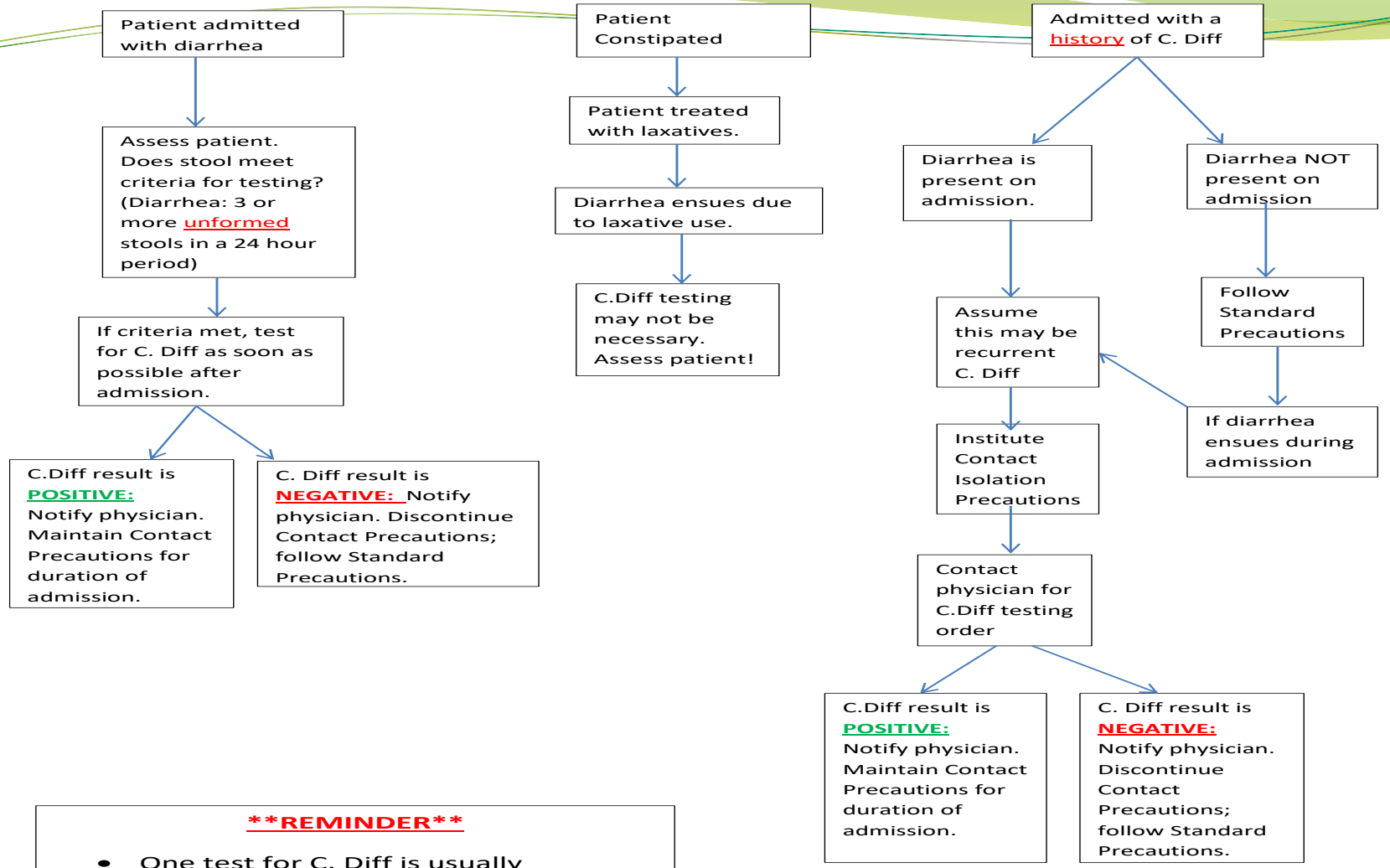
II. Procedure:

I. Indications for hand-washing and hand antisepsis:
1. Upon reporting to work
2. Prior to any patient contact
3. After handling dirty or contaminated equipment and upon leaving department
4. Before gloving
5. After glove removal
6. After contact with environmental sources likely to be contaminated
7. Before handling any medication or treatment
8. Before eating and after using a restroom
9. After contact with a patient's intact skin (i.e. when taking a pulse, blood pressure and after lifting a patient
10. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound care
11. Hands are visibly soiled

II. Hand – Hygiene Technique

1. Wash with soap and water when hands are visibly soiled.
2. If the dispenser allows, pull paper towel down prior to initiating hand washing to avoid recontamination of the hands.
3. Wet hands under warm running water.
4. Keep hands lower than elbows, apply soap or antiseptic agent
5. Employees will utilize the facility approved hand-washing agent and perform at least a 15 second vigorous hand wash covering all surfaces of the hands and fingers with attention to fingertips and nails. Rinse hands with water and dry thoroughly with a disposable towel.

DIARRHEA DECISION TREE – SPECIAL CONSIDERATIONS



****REMINDER****

- One test for C. Diff is usually sufficient. Multiple testings are NOT recommended.
- If ordered, C.Diff testing will NOT be performed more than once every 7 days. More frequent specimens will be rejected by Lab.
- Testing of cure is NOT recommended.

URINE DECISION TREE

WHEN SHOULD URINE BE COLLECTED FOR Urinalysis?

Patient – **without an indwelling urinary catheter** with these **SYMPTOMS:**

- Elderly patient with new-onset acute mental status changes
- Urgency or sensation to urinate
- Gross hematuria
- Suprapubic pain

Patient **with an indwelling urinary catheter** and these **SYMPTOMS:**

- New or worsening fever
- Rigors (shakes)
- Altered mental status
- Lethargy (with no other recognizable cause)
- Flank pain
- Acute hematuria
- Pelvic pain

Patient whose indwelling **urinary catheter has been removed** in the previous few days, but now has these **SYMPTOMS:**

- Dysuria (painful urination)
- Urgency
- Frequent urination
- Suprapubic pain.

Collect UA in STERILE Container

(Clean catch protocol- if no foley or protocol for urine removal through port)

Order UA with C&S, if indicated by UA results(if not collected within last 72 hours)

NOTE:

Urine C&S **should not** be ordered by itself.

If the following are **present without** any of the **SYMPTOMS** above:

- Foul smelling urine
- Cloudy urine
- On admission when the patient has no symptoms.
- Urine becomes darker in color
- Upon routine catheter insertion
- At set intervals.

Do NOT collect urine specimens for C&S. These are NOT indications for a UTI, but may indication of other issues, i.e. dehydration.

REMEMBER:

Urine usually does not smell like ROSES!

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Epidemic Plan

Table of Contents:

- C-Diff Policy
- Community Antibiotic Stewardship Policy
- Annual Flu Vaccination
- Community Epidemic Plan
- IV Therapy: IV Refresher Class Insertion, Initiation ,Maintenance Discontinuing Policy
- Guidelines for IV administration of medication utilizing IV pumps
- Implanted infusion port (mediport) access , maintenance and de-access care
- Protocol for IV lines –Flushing, Capping and Dressing change
- Community Discharge Form/ Policy
- Liberalized Medication Policy
- Sepsis Protocol

seeing sepsis

Skilled nursing facility sepsis algorithm for adults

Suspected infection *and* 2 or more SIRS criteria

Suspected infection	SIRS criteria
Fever/chills	Temp ≥100.0 or ≤96.8
Currently on antibiotics	Pulse ≥100
Cough/SOB	BP <100 or >40 mmHg from baseline
Cellulitis/wound drainage	Resp. rate >20/SpO2 <90%
Weakness	Altered mental status

SIRS = Systemic Inflammatory Response Syndrome

Early detection tool 100-100-100

NO → **Negative screen for sepsis**

YES → **Positive screen for sepsis**

Prior to calling provider

- **Educate resident/family about status**
- **Review Advance Directives and options**

Notify provider

Transfer

- Prepare transfer sheet
- Call ambulance
- Call report to hospital
- *Report positive sepsis screen*

Stay in facility

If Advance Directives and/or resident's wishes are in agreement, consider some or all of following order options:

- Labs: CBC w/Diff, lactate level (if possible), UA/UC, blood cultures if able; from 2 sites, not from lines. *Send all labs ASAP.*

Establish IV access for the following:

- IV normal saline 0.9% normal saline/sodium chloride @ 30ml/kg if BP <100
- Administer IV, IM or PO antibiotics
- Comfort care

Monitor for progression into *Multisystem Organ Dysfunction Syndrome*

Examples:

- Progression of symptoms despite treatment
- Urine output <400ml in 24 hours
- SBP <90 despite IV fluids
- Altered mental status

Consider transferring to another level of care - hospital, palliative, or hospice

Comfort care

- Pain control
- Antipyretic for fever
- Reposition every 2-3 hrs
- Oral care every 2 hrs
- Offer fluids every 2 hrs
- Keep family informed
- Adjust care plan as needed

Suspected Infection	***SIRS Criteria*** *(Systemic Inflammatory Response Syndrome)*
☐ Fever and chills	☐ Temp ≥ 100 or ≤ 96.8
☐ Currently on Antibiotics	☐ Pulse ≥ 100
☐ Cough/SOB	☐ BP < 100 mmhg (40 point drop from baseline)
☐ Cellulitis and wound drainage	☐ Resp rate > 20
☐ Weakness	☐ SPO2< 90%
	☐ Altered Mental Status

Patient has a suspected infection and meets 2 or more SIRS Criteria above (please check)?
☐ Yes - Positive Screening for Sepsis CONTINUE ☐ No STOP

1. Have all assessment information available
2. Review Advance Directives
3. Notify Provider
4. Notify POA or family members of patient status
5. ☐ Advance Directives/Patient/POA requesting acute interventions
   - ☐ Initiate IV and begin 0.9% Normal Saline @ 30cc/kg
     *(Patient weight (lbs.) ÷ 2.2 = kg) kg x 30 = rate
   - ☐ Transfer to acute hospital- “Sepsis Alert”
   - ☐ If patient remains in facility receiving acute intervention: Monitor symptoms and notify MD/NP if:
     Systolic B/P < 90 or 40 points below baseline after 1000cc NS
     Further deterioration of mental status
6. ☐ Advance Directives/Patient/POA requesting to remain in present level of care without acute interventions:
   - ☐ Encourage oral fluid.
   - ☐ Comfort care (pain control, antipyretic for fever, reposition every 2-3 hours, oral care every 2 hours, keep family informed and adjust plan of care

Objective # 4

Education of Stake Holders: Providers

- Flu/ Zika Update- Karen Buroker , Office of Public Health
- Dementia Care Seminar- Gary Joseph Leblanc, Asbury United Methodist Church
- Root Cause Analysis- Melanie Richard; Quality Manager; Our Lady of Lourdes
- IV Refresher Course- Mel Guidry , AASI; Pauline Breaux RN- Our Lady of Lourdes
- Identification and care of the Septic Patient – Dr Frank Cormier
- Introduction to Infection Prevention, Epidemiology and NHSN Definitions Workshop- Erica Washington- Office of Public Health
- Development of Community Delirium Education and Competency
- Antibiotic Stewardship Education/Program Development- Erica Washington
- MDRO Management Seminar- Dr . Retard/Erica Washington – OPH
- Education program to all providers: 'The Post –Acute Care Value Proposition- Balancing Cost with Quality" - National Home Health Analytics- Duane Blackwell , SOSO Solutions

Objective # 4

Education of Stake Holders: Providers

- Dr. Susan Nelson – LaPost education (3 different sessions) : February/March
- IV refresher course
- Changing Landscape of Infection Prevention in Nursing Facilities- Myra Foley, RN,CIC
- Quality Assurance/Performance Improvement/Root Cause Analysis
- COPD Overview- Gilbert Fontenette NP / M. Touchet, RT
- Palliative Care and Advanced Care Planning
- Sepsis in the Community: Dr Frank Cormier
- Dementia: New Updates, Non-Pharmacological Management
- Developing and Implementing Effective Infection Control- Dr. Vitalis Okechukwu
  - (Focus group of all levels of the continuum throughout the community to include Administrators, MD, Directors of Nurses, Infection Control nurses, Quality nurses and staff members)
- Antibiotic Stewardship- A Key Component for Quality and Safety"- Dr Vitalis Okechukwu (Attendance of 40 physicians, Nurse Practitioners, and Physician Assistants throughout all levels of the continuum)

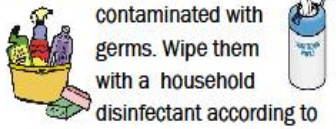
Community Coalition Statewide Education:

- Lake Charles
- New Orleans East Bank
- New Orleans West Bank
- New Orleans North Bank
- Alexandria
- Monroe
- Baton Rouge

Education of Stake Holders: Patient

Cleaning your Environment

Clean and disinfect frequently touched areas that may be contaminated with germs. Wipe them with a household disinfectant according to directions on the label.



Frequently touched areas include things such as telephones, doorknobs, light switches, remote controls, computer keyboards, toilet handles and hot & cold water knobs. Include all of those things that everyone touches often throughout the day.

If someone at home is ill, wash their linens in soapy, hot water and dry them on high heat.

Heat kills germs!

Follow these few simple steps and you'll be germ free.

For more information visit the following websites:

www.cdc.gov

www.ldh.la.gov

or call this number:

Region 4 Office of Public Health

337-262-5311

The How To's of Infection Prevention

- Hand Washing
- Covering Coughs and Sneezes
- Immunizations
- Cleaning Your Environment

Viruses

Viruses usually last 7-14 days and the symptoms can be treated with a non-prescription medicine. Antibiotics do not work to treat a virus. Sometimes the best treatment is symptom relief. Talk to your healthcare provider or pharmacist.

What can I do to feel better?

Pain relievers, fever reducers, saline nasal sprays or drops, warm compresses, liquids, and rest may be the best things to help you feel better.

Disposal of Unused Medications

Some medications could be harmful or even fatal, if accidently ingested by a child, pet, or anyone the medication is not intended for. Dispose of unused medications immediately and properly to remove the risk from the home.

Do not flush medications down the toilet or drain **unless the label or patient information instructs you to do so**. One example of a medication that should be flushed is a narcotic pain patch. For more information on what should be flushed visit : www.fda.org.

To dispose of medications not labeled to be flushed, use a community drug take-back program. Contact your city or parish government or your pharmacy to find out if a drug take-back program is available.

If a drug take-back program is not available:

- Take medications out of original containers
- Mix with undesirable substance, like used coffee grounds or cat litter
- Put the mixture in a disposable container or sealable bag
- Dispose in regular trash

For more information visit the following websites:

www.cdc.gov

www.ldh.la.gov

or call this number:

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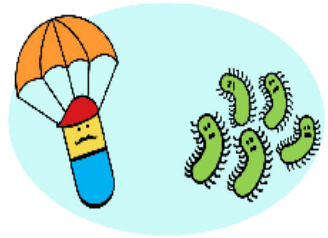
ANTIBIOTICS: Use Or Misuse?



Warning Signals for Emphysema/COPD

Green Light—Good Signs
ALL IS WELL!

- Able to do normal activities
- No changes in your symptoms
- Usual medicines are controlling your symptoms

Yellow Light—Caution Signs
TIME TO ACT!

CALL YOUR DOCTOR IF YOU HAVE:

- Increased shortness of breath with usual activity
- More than usual amount of coughing
- Increased wheezing
- Increased sputum or it has changed color
- Feeling more tired or restless

Red Light—Danger Signs
STOP!

- Severe shortness of breath
- Chest pains that don't go away
- Lips or fingernails that turn blue or gray
- Unusual sleepiness or confusion
- **CALL YOUR DOCTOR RIGHT AWAY!**

Warning Signals for

Congestive Heart Failure

Green Light—Good Signs
ALL IS WELL!

- Able to do normal activities → Continue usual activities/exercise
- Usual medications are controlling symptoms. → Take medicines as ordered

No swelling (legs,ankles,and/or feet) → Keep your scheduled doctor appointments
No weight gain or shortness of breath

Yellow Light—Caution Signs
TIME TO ACT!

- Increased shortness of breath with usual activity → Continue daily medication
- Increase shortness of breath and/ coughing → **Contact your Home Health:** _____
- Weight **GAIN** (2-3lbs. in one day) → **Contact your Doctor:** _____
- Swelling (legs, ankles, and/or feet)
- Inability to lie flat to sleep- increase # of pillows to recline/Only able to sleep in recliner
- **CHEST PAIN**

Red Light—Danger Signs
STOP!

- Severe shortness of breath → **CALL YOUR DOCTOR RIGHT AWAY!!!!!**
- Unrelieved Chest pain → **CALL 911**
- Wheezing or chest tightness at rest

Objective # 5

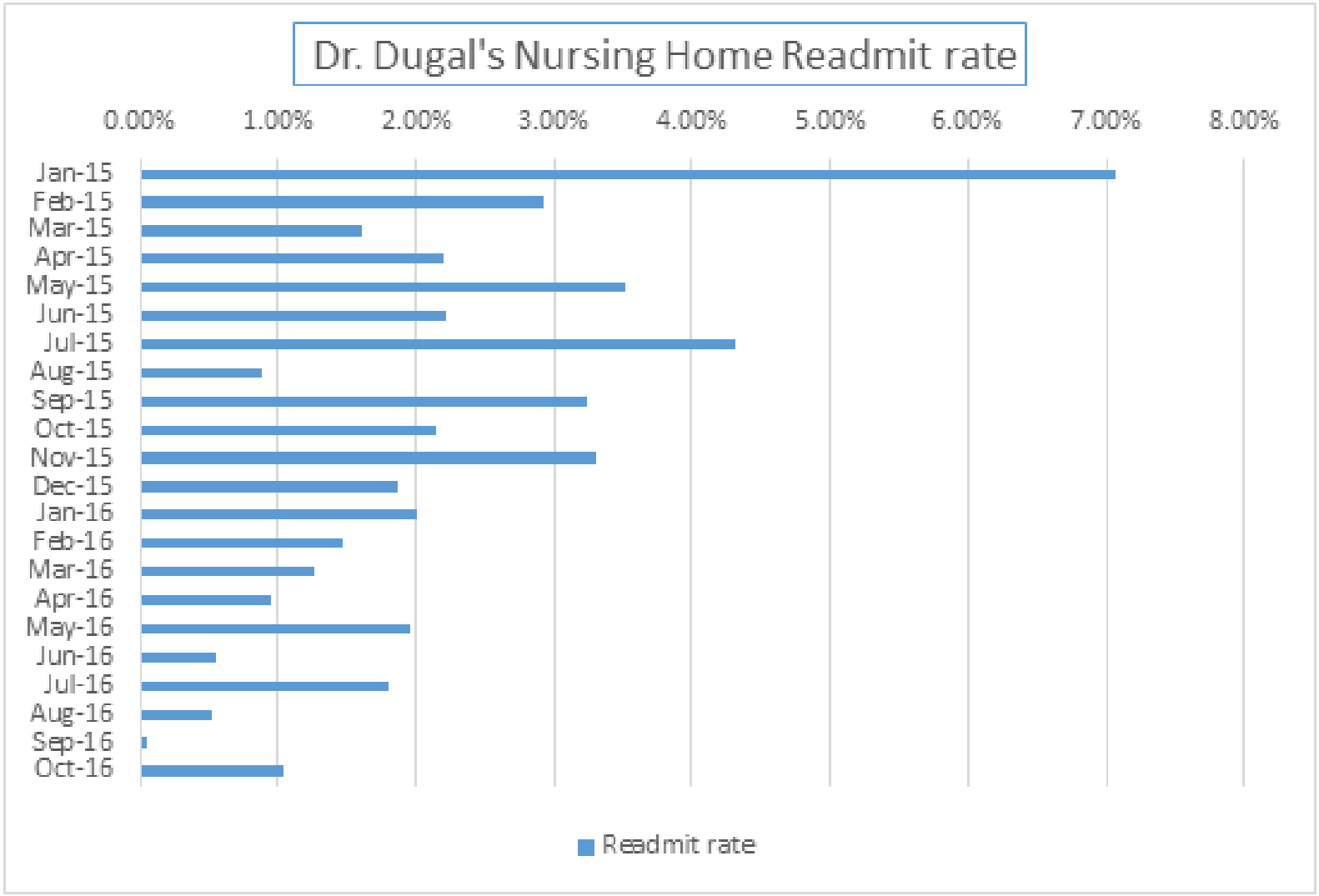
- Data Collection and Transparency
  - # 1 in the state for C- diff, UTI
  - # 1 in the state for psychotropic usage

Data collected quarterly:

- State of Louisiana Department of Epidemiology
- CMS data / Late Responder Data

** No longer highest community for C-Diff and CAUTI
** No longer highest community for psychotropic drug usage


Intended
Outcome
Just Ahead


Dr. Dugal's Nursing Home Readmit rate
0.00%
1.00%
2.00%
3.00%
4.00%
5.00%
6.00%
7.00%
8.00%
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Readmit rate

Acadiana Health Coalition
Cather-Associated Urinary Tract Infections, *Clostridium difficile*, and MRSA Progress Report
December 4, 2018

Summary
Statistical significance is set to $p < 0.05$ to determine if each of the measures are significantly higher or lower than the null/referent value. Facilities in Acadiana were subset in Infectious Disease Epidemiology Section of Louisiana Office of Public Health's National Healthcare Safety Network group to include only public health region 4. Data were compared to Louisiana's overall performance for each infection type and time period.

Catheter-Associated Urinary Tract Infections
CAUTI have been reportable since January 1, 2012 to CMS in ICU locations.

Standardized Infection Ratio

Period	2017Q3	2017Q4	2018Q1	2018Q2
Acadiana	0.794 p = 0.1367	0.996 p = 0.9941	0.804 p = 0.1546	1.120 p = 0.4090
Louisiana SIR	*0.746 p = 0.0056	0.898 p = 0.2804	0.890 p = 0.2436	1.116 p = 0.2625

**Statistically significant*

Clostridium difficile Laboratory-Identified Events
Clostridium difficile LabID events have been reportable since January 1, 2013 to CMS at the facility-wide inpatient level.

Standardized Infection Ratio

Period	2017Q3	2017Q4	2018Q1	2018Q2
Acadiana	*0.326 p < 0.0001	*0.655 p = 0.0222	*0.664 p = 0.0277	*0.621 p = 0.0145
Louisiana SIR	*0.656 p < 0.0001	*0.759 p < 0.0001	*0.837 p = 0.0018	*0.763 p < 0.0001

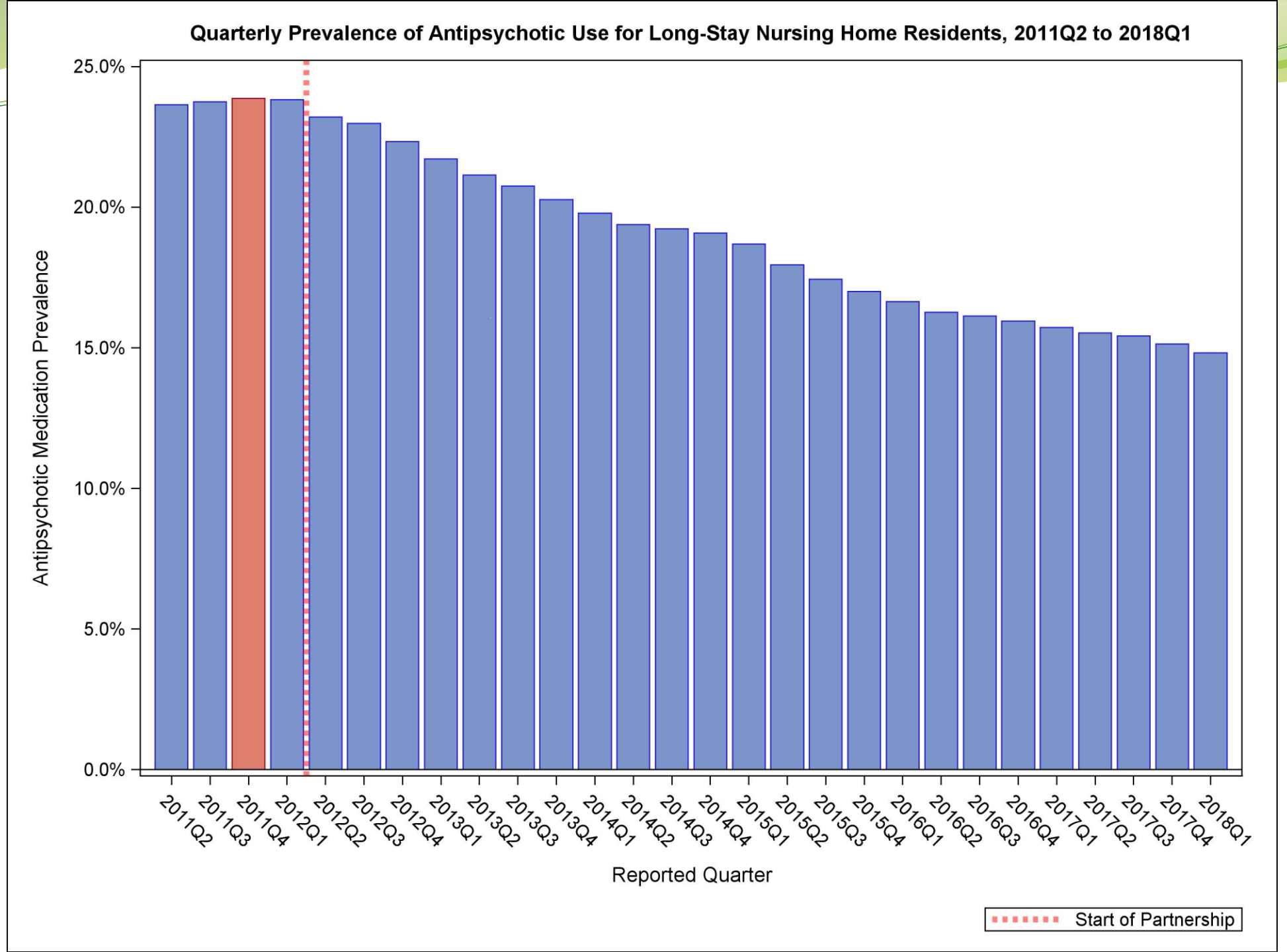
**Statistically significant*

MRSA Laboratory-Identified Events
MRSA LabID events have been reportable since January 1, 2013 to CMS at the facility-wide inpatient level.

Standardized Infection Ratio

Period	2017Q3	2017Q4	2018Q1	2018Q2
Acadiana	0.991 p = 1.000	0.429 p = 0.2094	1.591 p = 0.2351	1.138 p = 0.7268
Louisiana SIR	0.927 p = 0.6507	1.135 p = 0.3688	*1.379 p = 0.0172	1.305 p = 0.0604

**Statistically significant*


Quarterly Prevalence of Antipsychotic Use for Long-Stay Nursing Home Residents, 2011Q2 to 2018Q1
Antipsychotic Medication Prevalence
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2011Q2
2011Q3
2011Q4
2012Q1
2012Q2
2012Q3
2012Q4
2013Q1
2013Q2
2013Q3
2013Q4
2014Q1
2014Q2
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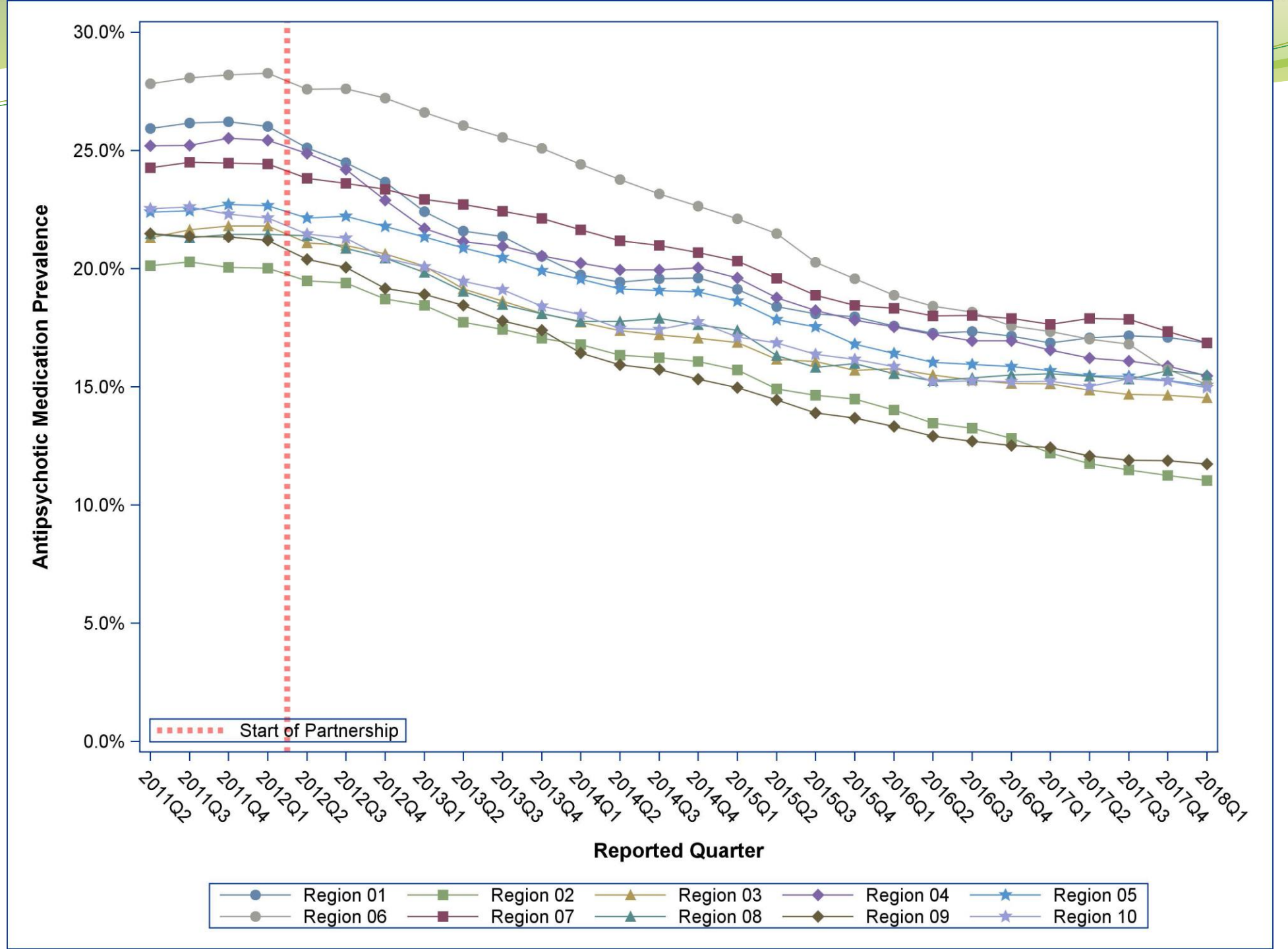
2017Q1
2017Q2
2017Q3
2017Q4
2018Q1
Reported Quarter
Start of Partnership


Antipsychotic Medication Prevalence
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Start of Partnership
2011Q2
2011Q3
2011Q4
2012Q1
2012Q2
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2015Q4
2016Q1
2016Q2
2016Q3
2016Q4
2017Q1
2017Q2
2017Q3
2017Q4
2018Q1
Reported Quarter
Region 01
Region 02
Region 03
Region 04
Region 05
Region 06
Region 07
Region 08
Region 09
Region 10

Region	2011Q4	2012Q1	2012Q4	2013Q1	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4	2015Q1	2015Q2	2015Q3	2015Q4	2016Q1	2016Q2	2016Q3	2016Q4	2017Q1	2017Q2	2017Q3	2017Q4	2018Q1	Percentage point difference (2011Q4-2018Q1)	% Change
National	23.9%	23.8%	22.3%	21.7%	20.3%	19.79	19.4%	19.2%	19.1%	18.7%	18.0%	17.4%	17.0%	16.6%	16.3%	16.1%	16.0%	15.7%	15.5%	15.4%	15.1%	14.8%	-9.05	-37.9%
Region 01	26.2%	26.0%	23.7%	22.4%	20.5%	19.74	19.4%	19.6%	19.6%	19.1%	18.4%	18.1%	18.0%	17.6%	17.3%	17.3%	17.1%	16.9%	17.1%	17.2%	17.1%	16.9%	-9.37	-35.7%
Region 02	20.1%	20.0%	18.7%	18.4%	17.1%	16.78	16.3%	16.2%	16.1%	15.7%	14.9%	14.6%	14.5%	14.0%	13.5%	13.3%	12.8%	12.2%	11.8%	11.5%	11.2%	11.0%	-9.02	-45.0%
Region 03	21.8%	21.8%	20.6%	20.1%	18.1%	17.73	17.4%	17.2%	17.1%	16.9%	16.2%	16.1%	15.7%	15.8%	15.5%	15.3%	15.1%	15.1%	14.9%	14.7%	14.6%	14.5%	-7.28	-33.4%
Region 04	25.5%	25.4%	22.9%	21.7%	20.5%	20.24	20.0%	19.9%	20.0%	19.6%	18.8%	18.2%	17.8%	17.5%	17.2%	16.9%	16.9%	16.6%	16.2%	16.1%	15.9%	15.5%	-10.04	-39.4%
Region 05	22.7%	22.7%	21.8%	21.3%	19.9%	19.55	19.1%	19.1%	19.0%	18.6%	17.8%	17.5%	16.8%	16.4%	16.0%	16.0%	15.9%	15.7%	15.5%	15.4%	15.3%	15.0%	-7.66	-33.7%
Region 06	28.2%	28.3%	27.2%	26.6%	25.1%	24.40	23.8%	23.2%	22.6%	22.1%	21.5%	20.3%	19.6%	18.9%	18.4%	18.2%	17.6%	17.3%	17.0%	16.8%	15.7%	15.1%	-13.09	-46.4%
Region 07	24.5%	24.4%	23.4%	22.9%	22.1%	21.65	21.2%	21.0%	20.7%	20.3%	19.6%	18.9%	18.4%	18.3%	18.0%	18.0%	17.9%	17.7%	17.9%	17.9%	17.3%	16.9%	-7.60	-31.1%
Region 08	21.4%	21.5%	20.4%	19.8%	18.1%	17.77	17.8%	17.9%	17.6%	17.4%	16.3%	15.8%	16.0%	15.6%	15.2%	15.4%	15.5%	15.6%	15.4%	15.3%	15.7%	15.5%	-5.94	-27.7%
Region 09	21.3%	21.2%	19.2%	18.9%	17.4%	16.44	15.9%	15.7%	15.3%	15.0%	14.5%	13.9%	13.7%	13.3%	12.9%	12.7%	12.5%	12.4%	12.1%	11.9%	11.9%	11.7%	-9.60	-45.0%
Region 10	22.3%	22.1%	20.4%	20.1%	18.4%	18.05	17.5%	17.4%	17.8%	17.1%	16.9%	16.4%	16.2%	15.9%	15.2%	15.3%	15.2%	15.2%	15.0%	15.3%	15.3%	15.0%	-7.33	-32.9%

Lafayette Nursing Homes - CMS Quarter 3 2017 State average 17.6 National Aveage 15.7	Q 3 2017	Greater than 25% 20% to 25% Less than 20%	3 5 28
Basile Care Center	N/A		
New Iberia Manor South	28.3		
Vermilion Health Care Center	26.4		
Maison du Monde	25.7		
J. Michael Morrow Memorial Nursing Home	24.3		
Senior Village Nursing and Rehab Center	23.8		
Bethany MHS Health Care Center	23.1		
Savoy Care Center	22.2		
Evangeline Oaks Guest House	21.0		
Cornerstone Village South, Inc.	19.6		
Camelot Place	18.9		
Magnolia Estates	18.8		
Eastridge Nursing Center	18.4		
River Oaks Retirement Manor	17.7		
Kaplan Healthcare Center	17.6		
Our Lady of Prompt Succor Nursing Facility	17.3		
Rayne Guest Home	16.5		
Heritage Manor of Opelousas	16.3		
Oak Lane Wellness & Rehabilitative Center	15.8		
New Iberia Manor North	15.6		
Prairie Manor Nursing Home	15.2		
Acadia St. Landry Guest Home, Inc.	15.0		
Lady of the Oaks Retirement Manor	14.9		
Southwind Nursing & Rehab Center	14.4		
Amelia Manor Nursing Home	14.3		
Heritage Manor of Ville Platte	14.3		
Gueydan Memorial Guest Home	13.7		
Maison de Lafayette	12.7		
Belle Teche Nursing & Rehab Center	12.5		
Pelican Pointe Healthcare and Rehabilitation	12.0		
Courtyard Manor Nurse Care Ctr & Asstd Livi	11.5		
Eunice Manor	10.8		
Encore Healthcare And Rehab Center	10.5		
St Agnes Healthcare and Rehab Ctr.	10.1		
Tri-Community Nursing Center	9.4		
Consolata Home	9.1		
Maison Teche Nursing Center	8.7		
Camelot of Broussard	8.1		

- Effective communication!!!!
- Transparency- Be Honest
- Set expectations and hold each other accountable
- Be there to support each other
- Non- judgmental environment
- Work together to standardize policies and processes using best practices


ACCOUNTABILITY
It is not only what we do,
but also what we do not do,
for which we are accountable.
[Moliere]

		Steering Committees			
Name/Area	Monroe/West Monroe	Central Louisiana	Acadiana Coalition	Lake Charles	Capital Region Community Coalition
Chairperson/Co-Chairperson	Not assigned but leaders are in place: Linda Southwell - linda.carter@fmolhs.org Cendy Morris - cendy.morris@uhsystem.com; Cindy Green - clgreen@iasishealthcare.com	Jamie Lucas - jlucas@commcare.com	Pauline Breaux Pauline.Breaux@fmolhs.org	Guy Davis and Dr. Manley Jordan (co-chairs) Guydavis713@gmail.com mjordan@lcmh.com	Diane Reidy and Jonathan Lyons (co-chairs) - diane.reidy@ololrmc.com jlyons@pinnaclehh.com

Northshore Readmission Coalition	BARC - Bayou Area Readmission Coalition	Westbank Health Care Coalition	CCHC (Crescent City Healthcare Coalition - East Bank)
Natalie Stolf and Dale Cooney (co-chairs) nstolf@amighm.com dcooney@gouxco.com	Courtney Carrere and Joy Martinez (co-chairs), ccareere@elderoutreach.com; joy.martinez@tgmc.com	Carol Rockwell & Carolyn Olson (Co-Chairs): crockwell@vitalhcgroup.com; carolyno@aplaceformom.com	John Miller & Matt Bourque (Co-Chairs): Jmiller@plantationmgt.com; mbourque@plantationmgt.com

References:

For more information about The Joint Commission's Sentinel Event Policy and Procedures, visit The Joint Commission's website at http://www.jointcommission.org or call the Sentinel Event Hotline at 630-792-3700.
For more information about CMS 'S Immediate Jeopardy regulations and guidelines, visit www.cms.gov/Regulations-and-Guidance, State Operational Manual , Appendix Q
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CDC NHSN **www.CDC.gov/NHSN**
AHRQ **www.ahrq.gov**
APIC website **www.apic.org**
Change Packets and Top 10 Checklists **www.HRET-HIIN.org**
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