

Kenosha County Care Transitions Coalition

Overview

What do we mean by "Care Transitions"?

The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

The Centers for Medicare and Medicaid have been tracking 30-day re-admission rates for Medicare beneficiaries for some time. On a national average 19.6% of Medicare beneficiaries are readmitted to the hospital within 30 days of discharge at a cost of \$26 billion dollars. Medicare Payment Advisory Commission (MedPAC) estimates that up to 76% of these readmissions may be preventable.

Kenosha County Care Transitions Coalition History

- The first meeting was held on November 15, 2011.
- In early 2012, coalition members signed a participation agreement with MetaStar, the Quality Improvement Organization (QIO) contracted with the Center for Medicare and Medicaid Services (CMS) for Wisconsin, to provide resources, data and support to the project.
- A Community Charter was adopted and signed in January 2012

MISSION

The mission of the Care Transitions Coalition is to improve the quality of care for Kenosha County health care consumers who transition among health care settings through a comprehensive community effort including improving cross setting communication, care coordination and patient/caregiver self-management. The Coalition is committed to the Centers for Medicare & Medicaid Services (CMS) *Partnership for Patients* goal to reduce 30 day readmission rates by 20% for Medicare beneficiaries over three years.

VISION

The Care Transitions Coalition envisions the transition of health care consumers between health care settings and practitioners in our community will be well coordinated between all institutions, practitioners and community service organizations with the patient, family and caregiver as the center of care.

PURPOSE

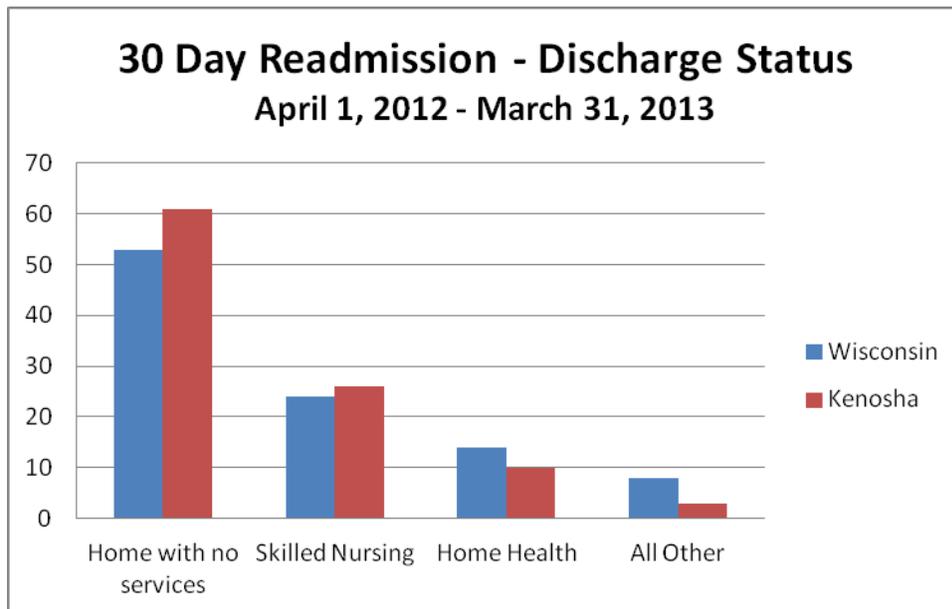
- To promote effective systems for transitions of care
- To promote the inclusion of the patient and family voice
- To encourage person-centered and person-directed models of care
- To collaborate and encourage efforts and best practices of health and human service organizations which share our vision
- To advocate for public policies that further the vision of the Kenosha County Care Transitions Coalition

- Data Sharing Agreement was signed in March 2012 to clarify the parameters needed to view and share confidential data available from the QIO.

Root Cause Analysis

Our initial root cause analysis included a cross-setting chart review and a community-wide consumer survey. The key issues identified through the RCA were:

- Patients are not going to the follow up physician visit
- Patients are going home with no services and having difficulty finding services
- Patients are having difficulty with medication issues (obtaining and managing)
- There is a need for greater provider education and understanding across settings



Member Organizations

2012:

- Aurora Medical Center – Kenosha
- Brookside Care Center
- Good Value Pharmacy
- Grande Prairie Health & Rehabilitation Center
- Hospitality Nursing and Rehabilitation Center – Extendicare
- Kenosha County Aging and Disability Resource Center
- Kenosha Visiting Nurse Association
- Manor Care
- MetaStar
- Paddock Lake Family Practice
- Right At Home
- United Hospital System

2013:

- Community Care, Inc.
- Hospice Alliance
- Kenosha Area Family and Aging Services
- Society's Assets, Inc.
- Aurora Health Center
- Consumer Representative

Work Groups

- Nursing Home Work Group (Barb Beardsley, lead)
- Heading Home Work Group (Dracey Poore, lead)
- Data Workgroup (Myra Weiss, lead)

Coalition Work History

Intervention	Description	Start Date	Outcomes (Data through August, 2013)
1. Heart Failure Referral	Home Visit Follow Up by ADRC – review discharge instructions, facilitate follow up to physician including transportation, access body weight scale, access medications, additional resources 5/1/2013: Discontinued intervention due to lack of referrals.	03/20/12	14 referrals (avg. 1.5/month) <ul style="list-style-type: none"> 7 received a home visit (ADRC provided a body weight scale for 2 individuals) 6 declined a home visit 1 was placed in a nursing home prior to visit 0 patients were readmitted to the hospital within 30 days following the ADRC home visit (1 patient was readmitted between referral and home visit); 2 patients readmitted in 30 days had declined a visit.
2. NH Discharge: 7 Day MD Follow Up	Add “physician follow up within 7 days” to discharging physician order set to expedite care when the patient is admitted to a nursing home.	05/01/12	ONE-TIME intervention. No data collected.
3. Schedule Physician Follow Up Appointment	Prior to hospital discharge, physician follow up appointments are scheduled within 7 days for Congestive Heart Failure and Pneumonia patients regardless of discharge setting (i.e. home: self care, home: home health care, or nursing home).	06/01/12	UHS has been scheduling and tracking follow up visits for CHF patients since August 2012 and for pneumonia patients since December 2012: <ul style="list-style-type: none"> The readmission rate for those CHF patients who did NOT attend appointment was 42% and for those who did attend appointment it was 2.6%. The readmission rate for those pneumonia patients who did NOT attend appointment was 33% and for those who did attend appointment it was 2.6%.
4. PACT (Patient Adherence and Competency of Therapy)	Improve medication delivery through patient education, medication reconciliation and packaging. Good Value Pharmacy: http://goodvaluerx.com/pact/	05/01/12	150 patients total. 58 people started since June 2012 and have the higher level of intervention. 48 of these patients are Medicare beneficiaries. 30 patients surveyed: <ul style="list-style-type: none"> 97% report PACT improved their medication use Rate of readmission decreased by 26% (compared to patients' actual readmission history)
5. Emergency Department (ED) Transfer	Improve communication when transferring patients between nursing home and Emergency Department and provide optimal patient information to the nursing home upon discharge (i.e. ED report, radiology and lab results, Nursing triage, meds given and ED discharge instructions).	06/29/12	ONE-TIME intervention. November 2012 survey of Nursing Homes: On average usefulness of discharge documentation has increased by 34%

Intervention	Description	Shading indicates discontinued interventions	Start Date	Outcomes (Data through August, 2013)
6. Mid-level Nursing Home Providers	Utilize mid-level providers (Nurse Practitioner or Physician's Assistant) in nursing homes to assess/treat/collaborate with the primary physician and avoid transfer to Emergency Department.		1/1/2013	SNF Care incorporated in December 2012 by Dr. Hettrick and Dr. Mata. 1 FTE PA to work with Grande Prairie, Manor Care and Kenosha Estates. Data is for Grande Prairie only: <ul style="list-style-type: none"> Unplanned Hospital Discharges (rate based on patient census): SNF Care: 2.4% Other: 5.7% Unplanned Hospital Discharges within 30 days of readmission (rate based on patient census): SNF Care: 2.4% Other: 2.9%
7. Motivational Interviewing Training	A 2-day (12 hour) MI training was provided through the ADRC. Care Transitions partner agencies were invited (3 in attendance). Monthly tips are sent by the ADRC to all participants to enhance and encourage integration.		8/29/12	Training Evaluation: On a scale of 1 – 5 where 1 = not at all and 5 = extremely Usefulness of application: 4.4 Importance of consumer choice and relevance to MI: 4.8 Investment in continued learning: 4.6
8. Care Transitions Intervention	Evidenced based coaching model including pre-discharge visit, one home visit and phone calls for one month post discharge. Focuses on medication self-management, use of a dynamic patient-centered record, primary care and specialist follow-up, and knowledge of red flags.		2013 start	ON HOLD: Aurora to hire 1 FTE Transitions Coach ADRC to hire .5 FTE Transitions Coach
9. Physician Education	Provide education related to nursing home capacity to physicians in an effort to decrease unnecessary Emergency Department transfers.		Fact finding	Pending
10. Supportive Home Care Service Package	Right at Home has developed a private pay discharge service: For a cost of \$100, patients will received a maximum of 4 hours of service which can be individualized from a service menu: transportation home or to MD follow up, pick up prescriptions, check/clean refrigerator, shop for groceries, arrange follow up appointments, personal care, other assistance as needed).		12/11/12 8/7/2013	No private pay referrals through July 2013. "Transition Home Pilot" August – December 2013: ADRC to fund 20 vouchers for hospital partners to distribute to patients they identify as high risk.
11. INTERACT II	INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. 8/26/2013: Brookside to utilize transfer sheet, copy of the SBAR, the Nursing Home Capabilities list and the hospital to post-acute care paperwork for all hospital transfers.		Rolling Implementation - 2009 to present	Brookside Data since January 2013 Transfer to ER rate: reduced by 50% Transfer to Hospital rate: reduced by 37%
12. Preparing to Go Home.	To address patient engagement and support activation, a two page patient guide was developed to help patients and their support systems think through and plan for discharge needs. Both hospitals will pilot use of this document.		4/9/2013	Data pending completion of implementation. 7/23/2013: Document revised to decrease complexity based on patient feedback.

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13. ADRC post Hospital Follow-up.	The ADRC information and assistance staff as well as those providing options counseling will review several topic areas (MD follow up appointment, medication management and discharge instructions) with every consumer who self identifies or we know to have has been hospitalized within the last 3 weeks of contact.	4/9/2013	12 contacts through July 2013 – 0 readmissions known: 50% had NOT had or scheduled a follow up appointment with their physician. 67% had changes in medication and 25% had difficulty getting prescriptions filled. 25% were NOT confident following their discharge plan.
14. Nutrition Support Pilot	Kenosha residents age 60+ upon discharge from a hospital or nursing home will receive: 1. In home consultation with a Nutrition Coach to help patients clarify recommendations from their health care providers, identify their own objectives, explore options, identify challenges and available supports and take action. 2. 7-day post-hospitalization home delivered meal package.	8/15/2013	Pilot: August-December, 2013. Services will begin 9/1/2013. Desired Outcomes: 1. Participants will express increased confidence in managing their nutritional well-being 2. 80% of participants will maintain or reduce their nutrition risk scores 3. 90% of program participants will remain in the community for a minimum of 30 days post discharge.