ON THE ROAD…

With the Kenosha County Care Transitions Coalition

2013 Focus Conference

WHY…

*Are so many people **WALKING** around my office?*

Humana Vitality Points reduce health insurance premium!

Ok, I'll admit it, ***MONEY MOTIVATES!***

WHY…

- *What the heck are people "shaking"?*
- It is **Principle, Purpose and Core Value** that guide and sustain the direction of change.
- What's your "why"?
  Take a moment and reflect.
- What's our "why"?

WHY…

Just so you know I'm not making this stuff up…

TED TALK: Simon Sinek - How great leaders inspire action

- People don't buy what you do, they buy why you do it.
- "Why" can change the course of the world.

WHO (CLOSELY RELATED TO WHY)…

- Start the conversation with the hospitals – our soup to nuts tale
- Expand the conversation – who can contribute? Remember the conversation leads directly to rolling up your sleeves.

> *"Ask not what your coalition can do for you, ask what you can do for your coalition."*

- Data driven decision making: Social Network Analysis
- Welcoming and respecting diversity (Organizers, Advocates, Pot Stirrers and Boat Rockers, Questioners, Peace Keepers, Analyzers (AKA Data Geeks), Listeners, Talkers, Persisters, Storytellers, Critical Thinkers, Digressers, Darers and Doers) while putting principles (the why) above personality.

HOW (ALSO CLOSELY RELATED TO WHY)…

Structure	Underlying Value, Principle, WHY
Keep it small	*If we can be safe, we can be honest and vulnerable which will lead us to greater understanding and real risk taking. No one gets to hide.*
Have a map	*We hold the complexity of this issue and acknowledge that it could be easy to get lost – the Charter, Data Sharing and Participation Agreements provide a good North Star.*
Keep at it – Meet regularly	*This is challenging work and requires that we work at it. Every agenda…* **VII. WRAP UP** Review Task List: Who is doing what?
Write it all down	*We believe in what we're doing and we are accountable to each other. It all matters.*
Check In	*We're willing to be wrong and make course correction – revising our map, our structure, our direction, our thinking and testing our assumptions.*
Do Something	*Opportunities are meant to be taken and all solutions are local – even if they are not evidence based or perfect. Try it and learn.*
Measure	*We have to be able to see, prove and share our story.*
Keep it Positive Be Patient	*Expectations are the key to happiness.*

DATA IS DELIGHTFUL

- Data is important for understanding the problem ***and*** acknowledging the successes
- End of 2011 early 2012 a Root Cause Analysis Work Group was formed as a subgroup.
- Root Cause Analysis Work Group included representation from Hospitals, Home Health and Nursing Homes
- The group was charged with choosing a collaborative data collection tool
- Final tool consisted of 23 questions that could be used by Hospitals, Home Health and Nursing Homes

QUESTION		ANSWER	
1.	Reviewer	☐ UHS ☐ Aurora ☐ KVNA ☐ Hospitality	☐ Brookside ☐ Grand Prairie ☐ Manor Care
2.	Patient ID		
3.	Number of days between the last discharge and this readmission date? (Count days from when patient left the hospital to when they went back into the hospital)	_____	
4.	Initial discharge level of care RECOMMENDATION (what did the physician/provider recommend happen)	☐ HHC ☐ SNF ☐ ALF ☐ Hospice	☐ Private Caregiver ☐ Other Community Resources ☐ Home No Services ☐ Unknown
5.	ACTUAL level of care following initial discharge (what really happened when the patient went home)	☐ HHC ☐ SNF ☐ ALF	☐ Hospice ☐ Private Caregiver ☐ Other Community Resources
6.	Was the follow-up physician visit (primary or diagnosis related physician only) scheduled prior to discharge?	☐ Yes ☐ No ☐ Unknown	
7.	Date of follow up appointment	____/____/____	
8.	Were there difficulties in scheduling the follow up appointment? Comment if yes.	Yes ☐ No ☐ Unknown Comment: _____	
9.	Did the patient GO to the follow up appointment?	Yes ☐ No ☐ Unknown	
10.	Comment on physician follow up		
11.	Was the patient readmitted prior to follow visit	Yes ☐ No ☐ Unknown	
12.	Did the patient call the doctor prior to readmission? If yes, instructions given	Yes ☐ No ☐ Unknown	
13.	Was the readmission direct or ED	Direct ☐ ED ☐ Planned ☐ Unknown	
14.	Were there any urgent clinic/ED visits before readmission? If yes, how many?	Yes ☐ No ☐ Unknown # _____	
15.	Were there medication discrepancies on the discharge plan?	Yes ☐ No ☐ Unknown	
16.	Primary medication problem	☐ Handoff off facility communication ☐ Did not obtain due to comprehension ☐ Did not obtain due to cost	☐ Medication shortage ☐ Unable to pick up ☐ Global comprehension issue ☐ Did not obtain due to compliance ☐ Other
17.	Medication problem comment		
18.	Did any social conditions contribute to the readmission? (select as many as needed)	☐ Transportation ☐ Lack of money ☐ Lack of housing	☐ Lack of caregiver ☐ Other
19.	Social conditions comment		
20.	Caregiver problems (select as many as needed)	☐ Overwhelmed ☐ Comprehension ☐ Willingness	☐ Other ☐ Unknown
21.	Caregiver comment		
22.	Reviewer's General Comments		
23.	Describe any communication problems indentified		

RCA

- Hospitals, Home Health and Nursing Homes then utilized the Data Collection Tool to complete chart reviews
- The following criteria was selected:
  - 30-day readmission between July 1, 2011 and March 31, 2012
  - Preference for CMS Dx: Heart Failure, Pneumonia and Acute MI, or (in the absence of CMS Dx) CVA, or Multiple Chronic conditions were chosen
  - Hospitals selected charts representing readmission from home (66%) SNF (17%) and HHC (17%)
  - SNF selected one readmission chart from each hospital
  - HHC selected 2 readmission charts from each hospital

RCA – An Unexpected Opportunity

- The ADRC was in the process of completing a county-wide needs assessment and included a question on hospital discharges giving patients and caregivers an opportunity to contribute to the data story

3. How many times in the past year were you (or your relative) admitted to the hospital or taken to the emergency room?
Check one:
☐ 0 ☐ 1 ☐ 2 to 4 ☐ 5+

If you checked 1 or more times, please answer question 3a.

3a. After leaving the hospital did you (or your relative) have any of the following difficulties?
Check all that apply.
☐ Obtaining medications
☐ Managing medications: ☐ New ☐ Ongoing
☐ Following up with my doctor
☐ Falls or concerns about safety
☐ Understanding how to manage my condition
☐ Finding needed services or support such as:
_____
☐ Other: _____

3. How many times in the past year were you (or your relative) admitted to the hospital or taken to the emergency room?		
0	202	44%
1	115	25%
2 to 4	99	22%
5+	21	5%
Blank	19	4%
TOTAL	**456**	**100%**

3a. After leaving the hospital did you (or your relative) have any of the following difficulties? (140 respondents)		
Obtaining medications	20	9%
Managing medications	11	5%
Managing medications: New	12	6%
Managing medications: Ongoing	7	3%
Following up with my doctor	29	14%
Falls or concerns about safety	30	14%
Understanding how to manage my condition	33	16%
Finding needed services or support such as	26	12%
Other	44	21%
TOTAL	**212**	**100%**

A FEW OBSERVATIONS…

- Chart Review tool was limited in clarity and ability to provide info sought (i.e. medication discrepancies, what happened after discharge)
- Real time data is the most valuable
- Patient readmission interviews provide greater clarity than retrospective chart reviews
- Workgroup consensus was that a consistent patient readmission interview would provide ongoing cross-setting data and support monitoring of any intervention

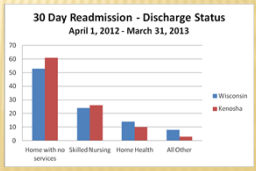
SO… WHAT'D WE LEARN?

- Patients were **NOT** going to follow-up physician visit after leaving the hospital
- Patients were going home with **NO** services and having difficulty finding services
- Patients were having **DIFFICULTY** with medication issues (obtaining and managing)
- **NEED** for greater provider education and understanding across settings

MORE LEARNING

- Over 60% of 30 day readmissions were from patients who went home with no services
- 25% were from skilled nursing facilities
- Approximately 10% were patients who had home health in place when initially discharged from hospital to home

NOTE: Home with No Services means **Home with No Medicare Funded Services** (i.e. home health). Individual patients may in fact have other community-based services in place.



THEN WHAT?

- The "Heading Home" work group was formed as a result of the root cause analysis finding.
- Case reviews are brought to the Coalition meetings as another opportunity for learning.
- METASTAR initially provided hospital readmission rates for hospital systems after data sharing agreement was signed by the entire coalition (***Medicare FFS patients only***).
- METASTAR compiles data for some interventions and other data is managed locally. The data is reviewed regularly by the Coalition to monitor progress and continue RCA for ongoing improvement across our healthcare settings.

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IT'S THE JOURNEY (and the of course destination)

- Root cause analysis is a ongoing process in the quest to continually identify problems, eliminate the causes, and prevent reoccurrence.
- Each problem identified is an OPPORTUNITY to discover why and how a problem is occurring.
- Ideally, the TRUE problem has to be thoroughly understood before action can be taken…

  AND you have to start somewhere - it's important to avoid **analysis paralysis**.

MORE ON RCA (Really Careful Assessment?)

- To complete a good RCA you must be focused, open minded, patient and most of all relentless.
- If you do a poor job of completing the RCA, you may end up with a band aid on the symptoms, not a cure for the problem.
- You could "miss the forest for the trees" if rush to identify "THE" problem.
- Many tools are available for use in RCA (i.e. Brainstorming, Flowchart, Fishbone Diagram etc.)
- The National Coordinating Center: http://www.cfmc.org/integratingcare/toolkit_rca.htm

BACK WHERE WE BEGAN: WHY?

- RCA is asking WHY the problem is occurring and then continuing to ask WHY until we reach the actual process failure
- Asking the question WHY in an RCA can sometimes be simple or sometimes complex
- RCA, if performed correctly, is not only an opportunity to identify a problem but also eliminate it by asking WHY over and over (5 Whys)

*"I'll tell you why she went to the hospital – the physician told her to!" **WHY?** "She was impacted." **WHY?** "She wasn't taking her meds." **WHY?** "Her daughter was not giving them regularly." **WHY?** "She was overwhelmed and burned out." **WHY?** "She had no support."*

FINDING VALUE ALL OVER THE PLACE

Knowledge is like money: to be of value it must circulate, and in circulating it can increase in quantity and, hopefully, in value. - Louis L'Amour

Connecting the dots is a process - Understanding who we are, what we do, our points of view and perspectives.

FINDING VALUE ALL OVER THE PLACE

- Interaction between all care settings is invaluable.
- By sharing "stories" we found common ground
- Learning priorities and current practices
- How we "Interact"

FINDING VALUE ALL OVER THE PLACE

- Cross Training

  UHS teaches ADRC about Heart Failure; Brookside teaches the hospitals about INTERACT; KVNA teaches everyone about health care in the home (i.e. does the patient even own a scale?!)

- Resource Sharing

  ADRC shares Motivational Interviewing Training with the Coalition

Coming together is a beginning; keeping together is progress; working together is success. - Henry Ford

SUCCESSES AND NEAR MISSES

- Relied on RCA, experience, brainstorming, and data
- An organized approach: **PDSA** Plan-Do-Study-Act
  - Supportive Discharge Home care Service Package

Phase I: **P**LAN (61% of readmission are going home with little or no services)
DO (Supportive Home Care provider develops flexible package)
STUDY (no referrals, cost is a barrier)
ACT – adopt, **adapt**, abandon

Phase II: 20 vouchers for hospitals to distribute

  - Heart Failure Referral- ADRC home visit follow up

PLAN (61% of readmission are going home with no Medicare funded services (*does the patient even own a scale?*), readmission prevalence for CHF diagnosis
DO (ADRC goes to the home, focuses on post discharge concerns and provides options counseling)
STUDY (low referrals - need? referral uptake?) **A**CT – adopt, adapt, **abandon**

WORK IN PROGRESS

- Examples of interventions
  - Scheduling Physician follow up appointments
  - PACT

WORK IN PROGRESS

- Examples of interventions
  - ED transfer information
  - Motivational Interviewing training
  - Care Transitions Intervention
  - Physician Education
  - Mid-Level Provider

WORK IN PROGRESS

- Examples of interventions
  - INTERACT 3
  - ADRC post hospital follow up
    - What are the issues: medication, MD follow up, discharge instructions
    - How can we help you?

Have you had a follow up appointment with your physician?		
Yes	6	50%
No	6	50%
NA	0	0%
Unknown	0	0%
Blank	0	0%
Total	**12**	**100%**

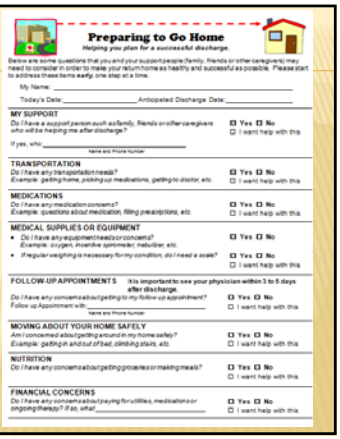
Do you feel confident about following your discharge instructions?		
Yes	6	50%
No	3	25%
NA	2	17%
Unknown	1	8%
Blank	0	0%
Total	**12**	**100%**

Have you had changes in your medication?		
Yes	8	67%
No	2	17%
NA	1	8%
Unknown	0	0%
Blank	1	8%
Total	**12**	**100%**

  - Nutrition Coach

A SAMPLE…

- Preparing to Go Home - Patient Guide



Preparing to Go Home

Helping you plan for a successful discharge.

Below are some questions that you and your support people (family, friends or other caregivers) may need to consider in order to make your return home as healthy and successful as possible. Please start to address these items early, one step at a time.

My Name: _____

Today's Date: _____ Anticipated Discharge Date: _____

MY SUPPORT

Do I have a support person such as family, friends or other caregivers who will be helping me after discharge? ☐ Yes ☐ No ☐ I want help with this

If yes, who: _____ (Name and Phone Number)

TRANSPORTATION

Do I have any transportation needs? ☐ Yes ☐ No ☐ I want help with this

Example: getting home, picking up medications, getting to doctor, etc.

MEDICATIONS

Do I have any medication concerns? ☐ Yes ☐ No ☐ I want help with this

Example: questions about medication, filling prescriptions, etc.

MEDICAL SUPPLIES OR EQUIPMENT

- *Do I have any equipment needs or concerns?* ☐ Yes ☐ No
  Example: oxygen, incentive spirometer, nebulizer, etc.
- *If regular weighing is necessary for my condition, do I need a scale?* ☐ Yes ☐ No ☐ I want help with this

FOLLOW-UP APPOINTMENTS It is important to see your physician within 3 to 5 days after discharge.

Do I have any concerns about getting to my follow up appointment? ☐ Yes ☐ No ☐ I want help with this

Follow up Appointment with: _____ (Name and Phone Number)

MOVING ABOUT YOUR HOME SAFELY

Am I concerned about getting around in my home safely? ☐ Yes ☐ No ☐ I want help with this

Example: getting in and out of bed, climbing stairs, etc.

NUTRITION

Do I have any concerns about getting groceries or making meals? ☐ Yes ☐ No ☐ I want help with this

FINANCIAL CONCERNS

Do I have any concerns about paying for utilities, medications or ongoing therapy? If so, what _____ ☐ Yes ☐ No ☐ I want help with this

MORAL OF THE STORY

- Use GPS as a guide, but don't follow it into the cornfield
- Data: be willing to ask for directions when the GPS is broken
- Communication is key
- If you don't succeed, try, try again!
- *Half the fun is the journey…*

Success is not final, failure is not fatal: it is the courage to continue that counts.
- Winston Churchill

CONTACT US…

- **Barb Beardsley**, Director of Nurses
  Brookside Care Center
  3506 Washington Road, Kenosha, WI 53144
  Email: Barbara.Beardsley@kenoshacounty.org
  Tel: 262-653-3819
- **Jody Sadlon**, Nursing Home Administrator
  Hospitality Nursing and Rehabilitation Center - Extendicare
  8633 32nd Avenue, Kenosha, WI 53142
  Email: jsadlon@extendicare.com
  Tel: 262-694-8300
- **Helen Sampson**, Quality Specialist
  Kenosha County Aging and Disability Resource Center
  8600 Sheridan Road, Suite 500, Kenosha, WI 0
  Email: Helen.Sampson@kenoshacounty.org
  Tel: 262-605-6614