



ONE GOAL, FOUR APPROACHES

Kenosha County's Strategies to Improve
Care Transitions and Reduce Re-hospitalizations

2015 Focus Conference

THE PLAN FOR TODAY...

1. Coalition Building and Collaboration
- Helen Sampson
2. Intervention: Advanced Practice Nurse
- Jodi Sadlon
3. Intervention: PACT (*Patient Adherence and Competency of Therapy*)
- Dani Kroll
4. Intervention: INTERACT
- Barb Beardsley
5. Final Thoughts and Questions

PART ONE

WHY DO WE CARE ABOUT CARE TRANSITIONS?

- ✦ On average, 19.6% of Medicare fee-for-service beneficiaries who have been discharged from the hospital were readmitted within 30 days and 34% were readmitted within 90 days¹
- ✦ According to MEDPAC (Medicare Payment Advisory Commission), hospital readmissions within 30 days accounted for \$15 billion of Medicare spending²

CARE ABOUT YOUR CARE

Launched in 2011, *Care About Your Care* focuses attention on what people can do to provide and receive better health care. This Robert Wood Johnson Foundation national initiative focuses on improving care transitions to reduce avoidable hospital readmissions, and how nurses, care coordinators, doctors, consumers, caregivers, patients, and others can work together to achieve this.³

- 1. Hospital readmissions are a real problem.
- 2. Hospitals are paying the price for readmissions.
- 3. Patients and providers are both overwhelmed.
- 4. Hospitals and doctors' offices need to talk to each other.
- 5. For patients, knowledge about their health = power.
- 6. Patients need to continue care outside the hospital.
- 7. Discharge plans should come standard.
- 8. Medications are a major issue.
- 9. Caregivers are a crucial part of the equation.
- 10. Hospitals and other providers are making improvements.

5 (more) WHY'S

- * Sakichi Toyoda, one of the fathers of the Japanese industrial revolution, developed the technique in the 1930s. He was an industrialist, inventor and founder of Toyota Industries. His technique became popular in the 1970s and Toyota still uses it to solve problems today.
- * "I'll tell you why the patient was readmitted... Because the doctor said 'send her to the hospital!'"



WHY 1...

Why did Kenosha County start a Care Transitions Coalition?

Kenosha has 2 hospital systems that were both on CMS's high readmission list. The Aging and Disability Resource Center initiated the early discussions because this "problem" looked a lot like an **opportunity**.

- * Initial conversations were started with each hospital separately.
- * The first meeting was held on November 15, 2011.
- * In early 2012, coalition members signed a participation agreement with MetaStar.
- * A Community Charter was adopted and signed in January 2012 and revised in December 2014 → The Coalition is committed to the goal of reducing 30 day readmission rates by 5% for Medicare beneficiaries per year over the next three years (2015 - 2017).

WHY 2...

Why did it look like an opportunity?

- ✗ Because there was motivation (financial carrot and stick)
- ✗ Because silos work best for storing grain (we are all taking care of the same people) and this work really gave us permission to rethink our silos.
- ✗ Because there was a willingness to start
- ✗ Because once we started, **we kept going** and along the way we developed authentic collaboration, greater trust (forged in action) and understanding of each other's practice strengths and limitations.

WHY 3...

Why did the Coalition keep going?

- ✗ We had a consistent facilitator (ADRC – unbiased) who continues to serve “at the pleasure of the coalition.”
- ✗ We made a decision to keep the Coalition small. Others interested in participating were asked to send the facilitator a statement of how they could contribute or strengthen the Coalition’s mission and who would represent their organization (clinical or administrative staff only – no marketing people) and from there the Coalition would make a decision. Other members were sought out when we saw a particular need (i.e. Hospice as end of life issues were identified as a significant concern).
- ✗ We were accountable to each other – and everyone matters. Because we were small, it was impossible to hide and because we developed a commitment to using **data to make decisions** and test interventions, we could really see our impact.

WHY 4...

Why is data so important?

- ✗ It holds our feet to the fire and guides the use of scarce resources – we maintained interventions that demonstrated an impact, we stopped those that did not

Intervention	Description	Start Date	Outcomes
1. Sleep Apnea Referral	Starting with the use of an educational intervention, Home Visit (HV) by ADRC – patient education intervention. Screened newly admitted patients, identified patients at risk for readmission due to lack of referrals, and referred patients to ADRC for readmission prevention.	03/20/12	14 (70%) sleep apnea referrals were identified and referred to ADRC. 10 (50%) patients were referred to ADRC for readmission prevention. 10 (50%) patients were referred to ADRC for readmission prevention. 10 (50%) patients were referred to ADRC for readmission prevention.
2. Hospice Referral	Plan to increase discharge planning follow-up and enrollment in hospice care. A plan to increase enrollment in hospice care. A plan to increase enrollment in hospice care. A plan to increase enrollment in hospice care.	04/01/12	100% of patients were referred to hospice care.

- ✗ Data makes us curious and encourages exploration and new thinking.
- ✗ Data maintains morale – there’s nothing like being able to **SEE success** (it is also important to have individuals at the table who carry an internal sense of optimism and possibility).

WHY 5...

Why have we had success?

- ✘ Because we were committed to learning – ongoing Root Cause Analysis, what are other’s doing?
- ✘ Because we kept on testing and adjusting
 - + Work Groups (Data, Heading Home, Nursing Home, Advanced Care Planning) – to organize work and reach out to others in the community
 - + Transparency whenever possible - <https://sites.google.com/site/kenoshacocaretransitions/home>
 - + Interventions – Follow up physician appointments, “Preparing to Go Home” worksheets, Follow up questions (across settings), Mid-level provider, Medication packaging, INTERACT, etc.
- ✘ **Because we are patient and persistent**

HOW (CLOSELY RELATED TO WHY)...

Structure	Underlying Value, Principle, WHY
Keep it small	<i>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.</i>
Have a map	<i>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.</i>
Keep at it – Meet regularly	<i>This is challenging work and requires that we work at it. Every agenda...</i> <ul style="list-style-type: none"> • Review Task List: Who is doing what? • Work Groups
Write it all down	<i>We believe in what we’re doing and we are accountable to each other. It all matters.</i>
Check In	<i>We’re willing to be wrong and make course correction – revising our map, our structure, our direction, our thinking and testing our assumptions.</i>
Do Something	<i>Opportunities are meant to be taken and all solutions are local – even if they are not evidence based or perfect. Try it and learn.</i>
Measure	<i>We have to be able to see, prove and share our story.</i>
Keep it Positive Be Patient	<i>Expectations are the key to happiness.</i>

PART TWO HOSPITALITY Midlevel Provider

An Overview of Successes and Barriers

- ✘ At the end of 2012 our facility began discussing options to decrease hospital readmissions and unnecessary ER visits. **What could we do as an intervention?**
- ✘ Partnership to enhance our focus on care transitions community-wide
- ✘ Met with one of the local Hospital systems regarding the idea of sharing a Nurse Practitioner
- ✘ In Sept 2013 after completing the interview process with the hospital system a contract was signed and the Nurse Practitioner (NP) began in October 2013

DETAILS OF AGREEMENT

- ✦ The NP was in Hospitality 20 hours per week - Monday thru Friday afternoon.
- ✦ 10 hours per week were spent as an employee of our center
- ✦ Those hours were utilized in teaching, attending QAPI and Medicare meetings, reviewing lab work, writing orders, etc.
- ✦ The other 10 hours were spent seeing residents as billable hours

SUCCESES

- ✦ Families and residents immediately embraced having the NP in the center five afternoons per week
- ✦ Families and residents became familiar with his schedule and were able to speak with him in person to ask questions and address concerns
- ✦ Number of phone calls to physicians decreased as non-emergency issues were able to be addressed by the NP

SUCCESES

- ✦ Increased satisfaction of staff
- ✦ Orders obtained quicker
- ✦ Lab results were able to be addressed in a more timely manner
- ✦ Increased timeliness of interventions, orders and order changes

WHAT GOES UP?...

Time to Talk About Barriers

- ✘ Due to multiple changes in upper management of hospital and clinic in late 2013 marketing of the program fell through the cracks
- ✘ Presentations to the physicians may not have occurred as originally agreed upon
- ✘ Legwork on the nursing home side only was completed prior to initiation of the program
- ✘ Physicians just were not agreeable to the NP seeing their patients related to revenue and trust issues
- ✘ In the end only 4 physicians agreed to participate
- ✘ Overall readmission rate did not show improvement due to the number of physicians unwilling to allow the NP to see their patients

GREAT MINDS THINK ALIKE

- ✘ Two local Independent Physicians during the same time period had the same concept.
- ✘ A NP was hired initially to visit the nursing homes where these 2 physicians are Medical Directors
- ✘ These Physician approached both hospital systems to discuss the potential of other physicians allowing the NP to see their residents residing in local nursing homes
- ✘ Neither hospital system was willing to participate at that time
- ✘ Despite it's initial success, the program was unable to sustain itself

LESSONS LEARNED

“Though nobody can go back and make a new beginning... Anyone can start over and make a new ending.” — Chico Xavier

- ✘ Ensure that education and marketing of program is mutual and thorough early on in the process
- ✘ Complete work upfront including surveying Physicians to ensure cooperation and buy in to program before proceeding
- ✘ Some physicians are not ready to take that next step in transitions of care mainly as it involves the Mid Level Provider
- ✘ Stop when it's not working - program and contract was terminated on 7/1/15

PART THREE
THE PHARMACY PERSPECTIVE

A little about me...

- ✘ 2009 BS in Biology at UW-Parkside
- ✘ 2014 Doctor of Pharmacy at Concordia University Wisconsin
- ✘ Started with Good Value as technician in 2004, transitioned to pharmacist role in 2014
- ✘ Clinical pharmacist for Aurora Medical Center Kenosha

GOOD VALUE PHARMACY

- ✘ Locally owned and family operated pharmacy
- ✘ 3 retail locations
 - + Festival Foods
 - + MedCare West
 - + Larsen Mayer
- ✘ 1 long term care location
- ✘ All located in Kenosha, WI



SO WHAT?

- ✘ Medication errors harm an estimated 1.5 million people each year⁴
- ✘ Costing at least \$3.5 billion annually⁴
- ✘ On discharge from the hospital, one study found that 30% of patients have at least one medication discrepancy⁵
- ✘ One in five patients discharged to their home from the hospital experienced an adverse event within three weeks of discharge⁶
60% were medication related and could have been avoided

PACT GOALS

PATIENT ADHERENCE AND COMPETENCY OF THERAPY

- ✦ Enhance the quality of life for enrolled patients
- ✦ Reduce readmissions and emergency department visits
- ✦ Promote health competence and patient responsibility

PACT SERVICES

- ✦ Basic PACT
 - + Therapy Management
 - + Monthly Profile Reviews
 - + Home Delivery
 - + Specialized Packaging
- ✦ Intensive PACT
 - + All Basic PACT features
 - + Medical History Review
 - + Frequent Phone Consults
 - + Pharmacist Home Visit

MAIN FEATURES

- ✦ Patient-friendly packaging
- ✦ Monthly profile reviews
- ✦ Free home delivery

PATIENT ADHERENCE STRIP SYSTEM (PASS)

- ✗ Roll of perforated plastic baggies
- ✗ Each baggie contains:
 - + Patient name
 - + Date and time of medication administration
 - + Medication name, strength and directions of use
 - + Pill descriptions



MEDICINE-ON-TIME (MOT)

- ✗ Bubble packs
- ✗ Color-coded based on time of medication administration
- ✗ Each bubble contains:
 - + Patient name
 - + Medication name and strength
 - + Date and time of administration



WHAT HAPPENS ON A TRANSITION OF CARE?

- ✗ Pharmacy receives discharge medication list
- ✗ Compare prior to admission medications to the medications listed on the discharge med list
- ✗ Contact prescriber regarding any discrepancies

A PICTURE IS WORTH A THOUSAND WORDS...

Example of a discharge med list



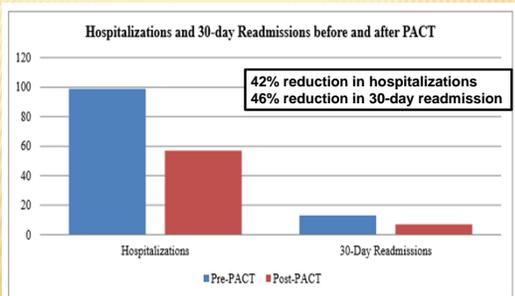
BARRIERS WITH TRANSITION OF CARE

- ✘ Incorrect medication list reported by patient on admission to hospital/facility
- ✘ Timing is everything in life → receiving discharge medication list after patient has been discharged and is home without medication
- ✘ Difficulty clarifying medication orders with physicians
- ✘ Medications prescribed for patient that are not covered under the patient's insurance

PHARMACIST IN-HOME VISIT BARRIERS

- ✘ Not cost effective
- ✘ Created unrealistic expectations
 - + Could not start medications when patient wanted due to multiple factors:
 - ✘ Difficulty getting medication orders
 - ✘ Medications too soon to fill (Insurance rejection)
- ✘ Do not have access to patient's complete medical chart

MOST RECENT DATA



HOW CAN WE KEEP IMPROVING?

- ✦ Improve communication during transitions between providers, patients and family caregivers
- ✦ Implement electronic health records that include standardized medication reconciliation elements
- ✦ Expand the role of pharmacists in transitions of care in respect to medication reconciliation
- ✦ Establish points of accountability for sending and receiving care, particularly for hospitalists, Skilled Nursing Facilities, primary care physicians and specialists
- ✦ Increase the use of case management and professional care coordination
- ✦ Implement payment systems that align incentives
- ✦ Develop performance measures to encourage better transitions of care

PART FOUR BROOKSIDE CARE CENTER'S JOURNEY

- ✦ Became charter member of Care Transitions Coalition in 2011
- ✦ Took part in discussion on various methods to reduce hospital readmissions, i.e. RED, Boost, INTERACT, etc.
- ✦ All member nursing homes began collecting data on 30 day readmissions
- ✦ Started exploring INTERACT as an intervention

YOU HAVE TO KNOW WHERE YOU STARTED

	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	AVERAGE
Average Daily Census	147	150	149	146	147	149	149	150	149	148	148	147	148.25
# of Admissions	24	28	26	25	35	24	24	24	28	33	30	32	27.75
30-Day All Cause, All Insurers hospital readmissions	6	4	5	3	4	8	6	5	4	5	10	4	5.33
% of Readmission based on Admissions	25.00 %	14.29 %	19.23 %	12.00 %	11.43 %	33.33 %	25.00 %	20.83 %	14.29 %	15.15 %	33.33 %	12.50 %	19.70%
% of Readmission based on Average Daily Census	4.08%	2.67%	3.36%	2.05%	2.72%	5.37%	4.03%	3.33%	2.68%	3.38%	6.76%	2.72%	3.60%

WHAT IS THIS "INTERACT" I KEEP HEARING ABOUT?

Let's go to the source:

www.interact2.net ⁷

- ✘ 2013-Volunteered to participate in the INTERACT Program Evaluation
- ✘ Chosen as part of initial study group
- ✘ Started education, data collection and implementation in March of 2013

KEY POINTS FOR IMPLEMENTATION

- ✘ Facility wide effort
- ✘ Important to have Champion and Co-champion to coach and encourage staff
- ✘ Start small (one unit, one hall)

THE JOURNEY CONTINUES

- ✘ Completed year long program evaluation in May 2014
- ✘ Implemented Stop and Watch, SBAR, Care Paths, Change in Condition File cards, Transfer Checklist, Acute Care Transfer form, Advanced Care Planning tools and Nursing Home Capabilities Checklist
- ✘ It's a work in progress - need to continually coach and reinforce use of tools

DATA DO'S

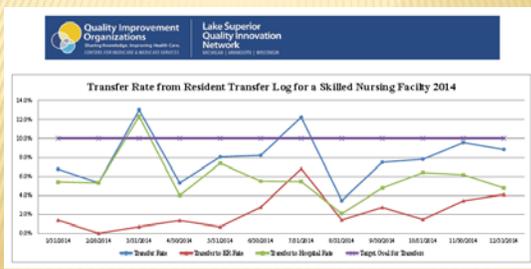
Advancing Excellence ⁸

- ✘ Business Office enters admission data
- ✘ Supervisors complete Q.I. tool with each transfer
- ✘ D.O.N. enters transfer data on spreadsheet and enters data on Advancing Excellence website
- ✘ Goal: rate of 30- day readmissions less than 10%

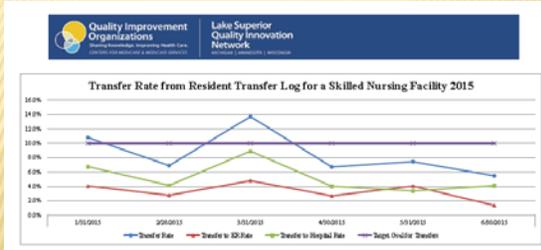
DATA STORY (Look how far we have come!)

Remember 5 slides back?

- ✘ 25% readmission rate in Nov 2011



MORE...



NOW WHAT?

- ✘ Continuing to reinforce use of INTERACT tools with staff
- ✘ Tools integrated with EMR
- ✘ Educate and re-educate
- ✘ Improve use of data, sharing with hospital partners
- ✘ Focus on improving formulating Advance Directives

THE MORAL OF THE STORY...

Quality is not an act, it is a habit. - Aristotle

*Even if you fall on your face,
you're still moving forward.*

- Victor Kiam



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