

Jefferson County Care Transitions

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Focus 2015



Why focus on Care Transitions?

The Revolving Door: A Report on U.S. Hospital Readmissions
Source: Dartmouth Atlas, February 2013

- 1 in 5 Medicare patients (nearly 2.6 million seniors) are readmitted to a hospital within 30 days of a discharge;
- 3 out of 4 readmissions are **preventable**;
- The Centers for Medicare & Medicaid Services (CMS) estimates that readmissions cost \$17 billion annually.

Reasons for Readmissions

- Health Literacy
- No Caregivers
- Access to Transportation
- Medication Interactions
- Cognitive Issues
- Poor Coordination



Impetus for Project

2011-2013 Department of Health Services: Long Term Care Sustainability Proposal

Living Well at Home and in the Community – The Care Transition Initiative

Goal: To assist seniors and persons with disabilities leaving hospitals and making a successful transition to home.

Aging and Disability Resource Centers (ADRC's) were encouraged to be at the table to strengthen relationships between ADRC's and hospital discharge units to improve information and assistance about community resources.



Jefferson County Care Transitions Coalition



Our Root Cause Analysis Data

Nationally, CHF –congestive heart failure, AMI-acute myocardial infarction (heart attack) and Pneumonia are the leading readmission diagnosis

30 day all cause readmission rates for Local Community vs. State of Wisconsin

Clinical Diagnosis	# of Patients		Jefferson County	Wisconsin
	2013	2014	30 day, all cause Readmission Rate	30 day, all cause Readmission Rate
	7/1/2013-6/30/2014			
All Jefferson County Residents CHF	152	106	19.81% (under)	21.54%
All Jefferson County Residents Dementia	224	131	13.74% (less than 1%)	12.76%
All Jefferson County Residents Pneumonia	160	87	17.24% (1.24% more than State)	16%
All Patient Types	2471	2137	13.66%	15.89

Baseline information: Admissions & Readmissions

Local Data from November 2013 through March 2014: 20 Readmissions

- Admission Diagnosis: **35%** admitted due to **Pneumonia**
- Readmission Diagnosis: **45%**, or every other readmission was re-admitted due to **Aspiration Pneumonia**
- Mental Status: 65% of the patients appeared alert, 35% had a cognitive impairments
- Residence: 50% lived at home, 25% in SNF, 25% Assisted Living

Level of Independence

The KATZ Index of Independence in Activities of Daily Living was used to measure level of independence.

RESULTS:

Half of the patients were highly independent and the other half was very dependent.

Katz Index of Independence in Activities of Daily Living

Activities (1 or 0)	Independence (1 Point)	Dependence (0 Points)
BATHING	(1 POINT) Bathes self completely or with help bathing only a single part of the body such as the neck, genital area or distal extremity	(0 POINTS) Needs help with bathing other than one part of the body, getting in or out of the tub or shower. Requires some help getting in or out of the tub.
DRESSING	(1 POINT) Gets clothes from closet and dresses and puts on shoes and outer garments completely with freedom. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING	(1 POINT) Goes to toilet, gets in and out, averages clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERING	(1 POINT) Moves in and out of bed or chair unassisted. Manual transfer aids are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires complete transfer.
CONTINENCE	(1 POINT) Exercises complete self-control over urination and defecation.	(0 POINTS) Incontinence or needs assistance of bed or bladder.
FEEDING	(1 POINT) Gets food from plate into mouth without help. Manipulation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires complete feeding.

Total Points: _____

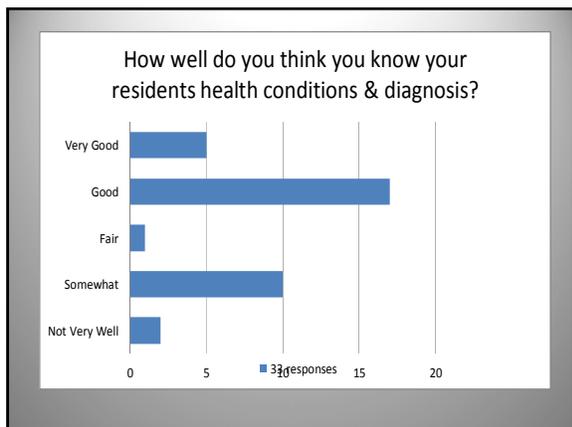
Score of 6 = High, Patient is Independent.
Score of 0 = Low, patient is very dependent.

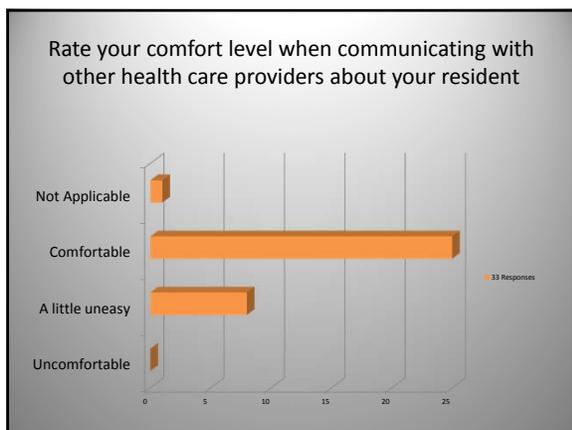
**Slightly adapted. Katz, S., Downs, T.C., Clark, H.R., et al. (1970) progress in the development of the index of ADL. Gerontologist 10:20-30. Copyright The Gerontological Society of America. Reproduced by permission of the publisher.

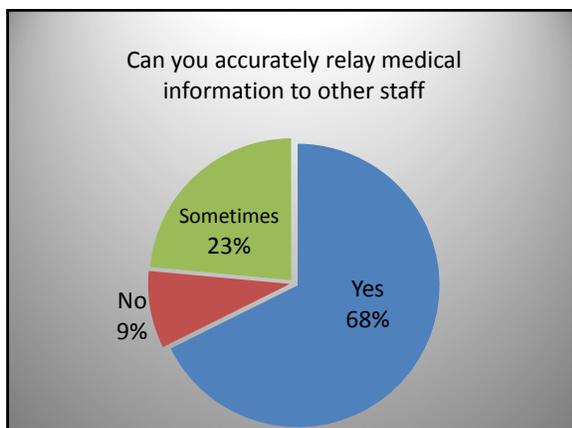
Facility Staff Response to the Care Transitions Survey

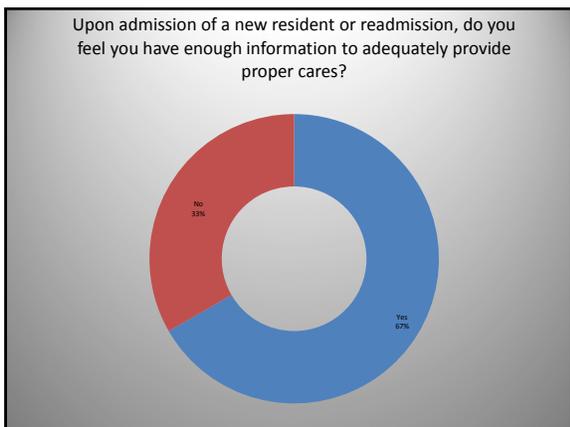


33 responses were collected between 06/23/2014 to 08/25/2014









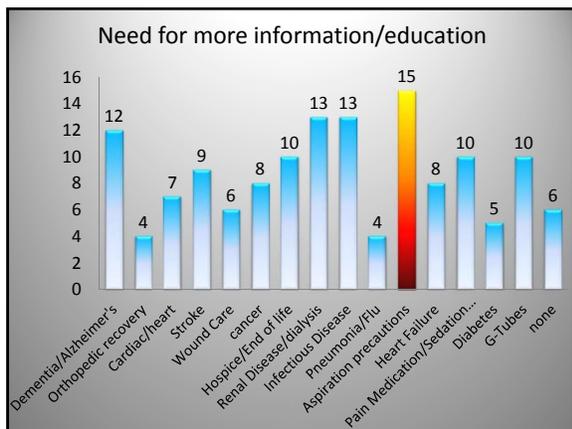
In your opinion, when a resident transitions from the hospital to your facility, what areas need to be improved? For example: Discharge paperwork, nurse to nurse report, physician cooperation, equipment or medication issues, terminology etc.

Medication issues & better communication was most often mentioned



Survey Comments from Staff:

- ▣ Everybody can use more tools for learning and help in doing their job better.
- ▣ I feel a survey like this one can be informative in obtaining a tool to better care for my residents cares and needs.



As a coalition, we thought we had enough information to start a project.

So we **brainstormed**, met with speech therapists for some insight, reviewed some other practice tools, and came up with a few ideas.

Our first step was to develop an educational focus on Aspiration and Precautions

For Example: **What is Dysphagia?**

Project Roll Out

Steps taken:

- Developed a second survey regarding facility training/needs
- Provider Meeting
- Tool Development
- "Train the Trainer"

Training Needs Survey for SNF's, CBRF's & Adult Family Homes

Please help us by answering the following questions for your facility.

1. Who does the training?
2. What staff should be included in the safe swallowing education?
3. Does this include Staff who fix the dysphagia diet meals too?
4. Do you have required yearly education hours? Yes No
If so, how many hours? _____
5. Would your staff use online resources and videos for ongoing training or reference? Yes No
Other _____
6. Type of training most useful to get to all shifts and staff:
 - a. Train the trainer? Yes No
 - b. Who would that be? _____
 - c. Mini classes at your facilities? Yes No
 - d. A larger presentation in the auditorium at the hospital? Yes No
 - e. Other _____
7. Would you include this in your orientation? Yes No
8. Is there something additional on aspiration precautions that would be helpful to your facility?
May we contact you after the pilot period to implement and train? Yes No

Highlights from Care Provider meeting

- Most nursing homes and assisted living providers provide training for their staff
- Many times the staff preparing meals provide cares on the 2nd and 3rd shifts, some larger facilities have cooks
- Providers shared that everyone should be cross trained – direct care staff, cooks and volunteers

Coalition Project: **Safe Swallowing to Avoid Aspiration Pneumonia**



Goal: Decrease readmissions to under 20%.

Pilot Project: St. Coletta of WI

Pilot Time Period June 18 thru August 1, 2015

- Findings:
 - 29 staff were trained : 12 Direct Support and 17 Leaders in various positions
 - 19 residents: 5 of those residents have a formal diagnosis of dysphagia
 - 3 residents with a pureed diet
 - 2 residents with a prescribed mechanical soft diet
- Feedback
 - Everyone liked the charts and thought they were very helpful
 - Materials are easy to use and training is in an easy to learn format

During this time period, there were no admissions to the hospital for aspiration pneumonia but there was one choking incident. The person was seen in ER and diagnosis now includes dysphagia.

One easy location to access the training and informational tools at the [ADRC of Jefferson County Website](#)



QUESTIONS ?
