Jefferson County Care Transitions

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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

<table>
<thead>
<tr>
<th>Clinical Diagnosis</th>
<th># of Patients</th>
<th>Jefferson County 30 day, all cause Readmission Rate</th>
<th>Wisconsin 30 day, all cause Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Jan 1/2013-Jan 30/2014</td>
<td></td>
</tr>
<tr>
<td>All Jefferson County Residents CHF</td>
<td>152</td>
<td>19.81% (under)</td>
<td>21.54%</td>
</tr>
<tr>
<td>All Jefferson County Residents Dementia</td>
<td>224</td>
<td>13.74% (less then 1%)</td>
<td>12.76%</td>
</tr>
<tr>
<td>All Jefferson County Residents Pneumonia</td>
<td>160</td>
<td>17.24% (1.24% more then State)</td>
<td>16%</td>
</tr>
<tr>
<td>All Patient Types</td>
<td>247</td>
<td>13.86%</td>
<td>15.89</td>
</tr>
</tbody>
</table>
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

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**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.

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**Facility Staff Response to the Care Transitions Survey**

33 responses were collected between 06/23/2014 to 08/25/2014
How well do you think you know your residents health conditions & diagnosis?

- Very Good: 5 responses
- Good: 10 responses
- Fair: 3 responses
- Somewhat: 6 responses
- Not Very Well: 1 response

Rate your comfort level when communicating with other health care providers about your resident

- Comfortable: 20 responses
- A little uneasy: 4 responses
- Uncomfortable: 1 response
- Not Applicable: 9 responses

Can you accurately relay medical information to other staff

- Yes: 68% (23 responses)
- Sometimes: 23% (7 responses)
- No: 9% (3 responses)
Upon admission of a new resident or readmission, do you feel you have enough information to adequately provide proper cares?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>67%</td>
<td>33%</td>
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</table>

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?

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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
    - 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?