

Building Care Transitions Coalitions in a Rural Setting

Members of Buffalo/Pepin County Coalition and Clark County Coalition

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Moderator and Coalition Chair

Two rural coalitions...

Clark County Care Transitions Coalition Clark County, Wisconsin	Upper Mississippi Valley Care Transitions Coalition Buffalo and Pepin Counties, WI
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An initiative of the Aging and Disability Resource Center of Buffalo, Clark, and Pepin Counties

Coalition building in rural areas present unique challenges but also offer unique advantages

Challenges

Large geographic area
Lack of available services
Inconsistent resources
Providers located in other counties or states

Advantages

Establish or enhance relationships with organizations out of immediate community
Opportunity to network and discover resources
Bringing entities together demonstrates different roles played in patient care

Who to have at the table?

Hospitals / Clinics

Skilled Nursing Facilities

Managed Care Organizations

County Services (ADRC, Aging)

Transportation Providers

Pharmacies

Home Care

Hospice

Assisted Living/CBRFs

Ambulance Service

How to get them there

- Contact transition care RN, hospital social worker, pharmacist, SNF administrator or social worker, MCO Service Coord. Director., etc.
- Explain reason for coalition, benefits
- Suggest two or more representatives from each facility
- Set the organizational meeting, keep to the agenda and time frame.
- Contact Metastar early on and have present at first meeting if possible

Organizational Meeting

- Convenient time and day of week.
- Email agenda ahead of meeting
- Invite Metastar staff to chair or assist first meeting
- Reiterate reason for coalition – Metastar can provide readmission data
- Discuss data sharing agreement and participation agreement

First few meetings

- Welcome, introductions, who else should be at the table
- Encourage discussion
- Don't rush the process

Determining Readmission Causes - Clark

- Hospital flow charts - admission through discharge
 - Allows all members to see steps in the process
 - Encourages discussion as each step is reviewed
- Brainstorming readmissions causes
 - Group begins to bond as they find common ground

Clark County

Narrowing down causes of readmissions

Using fishbone diagrams, we determined three causal areas of readmissions:

- medication reconciliation
- miscommunications at all levels
- patient noncompliance

Clark Intervention

- Med Reconciliation – Pharmacy Hand-off Tool

Determining Readmission Causes Buffalo/Pepin

- Examined patient readmissions from each hospital and transfers from SNFs using patient chart audit form designed for us by Metastar

Community Resource Presentations cont.

- Outside resources
 - Transportation options
 - Volunteer agencies
 - Family resources
 - Elder Benefits Specialist

Current Status

- Interventions being implemented
- 1Q 2016 data can be compared to 3Q 2015 to determine whether readmissions due to our target causes were reduced
- Overall process should run more smoothly

Western Wisconsin Cares – Kelly Miller

- Initial involvement
 - Metastar Training – 2012
 - Invitation to join Clark Co. Coalition – 2013
- Benefits of being on coalition
 - Opportunity to educate other members on the role of Family Care
 - How WWC could assist with member transition from hospital to home

Western Wisconsin Cares – Kelly Miller

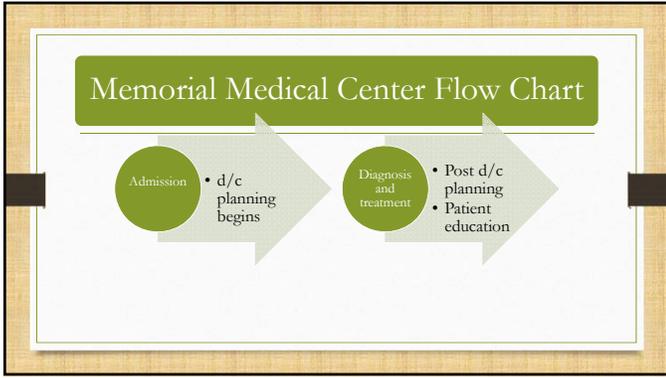
- Benefits of brainstorming (NGP) readmission causes
 - Generated good open discussion
 - allowed people/agencies to share what they could do, their limits or barriers, what their expectations were of what others could or should do
- Benefits from community resource presentations
 - Agency roles, capabilities, sharing of best practices

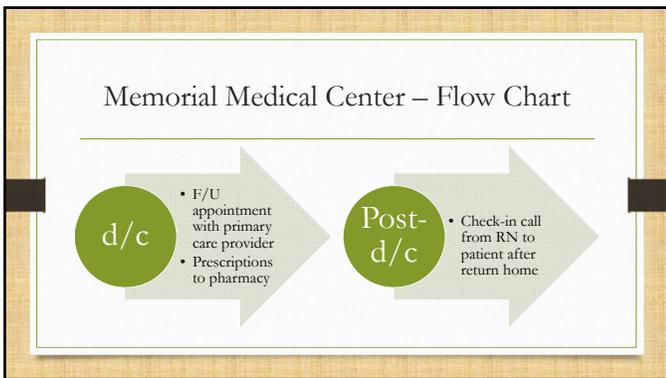
Memorial Medical Center – Rachael Buchholz

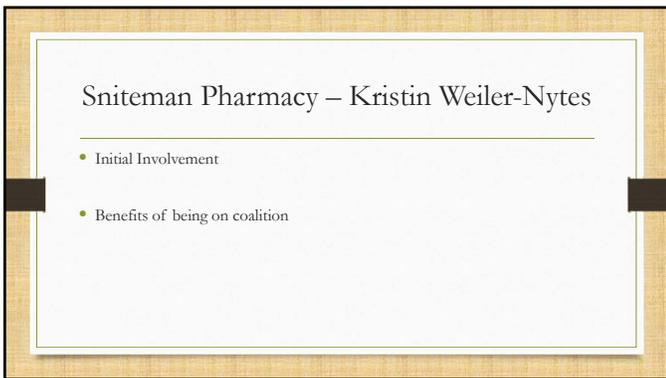
- Initial involvement
- Benefits of being on coalition
 - Discussing readmissions with members outside hospital setting assisted in gaining new perspective on reasons for readmissions

Memorial Medical Center – Rachael Buchholz

- Benefits of brainstorming and using flow charts
 - Allowed all members to generate ideas on reasons for readmissions
 - Assisted members in getting to know each other better and the processes of different agencies







Sniteman Pharmacy – Kristin Weiler-Nytes

- Why having pharmacist involved is key to successful transitions

Pharmacist Discharge Hand-off Communication

Patient Name: _____ Date: _____
 Admission Date: _____ Discharge/Member ID: _____
 Discharge Date: _____ Discharging Pharmacist: _____
 Primary Care Provider: _____ Primary Care Provider #: _____

Hospital Care Summary

Admission: _____
 Discharge: _____

Discharge Medication List

START taking these medications			
Medication	Dosage	Frequency	Last Hospital Day
CONTINUE these medications which have CHANGED			
Medication	Dosage	Frequency	Last Hospital Day
CONTINUE these medications which have NOT changed			
Medication	Dosage	Frequency	Last Hospital Day
STOP taking these medications			
Medication	Reason Stopped	Dosage	

Other Information

Allergies

Drug/Type	Reaction	Onset	Age	Site	Severity

Weight Reading & Date

Tobacco Use Status _____

Current Medical Diagnoses _____

Specialty Providers _____

Other notes: _____

Future Appointments and Labs

Date	Time	Provider	Department	Center

Prescription orders sent to _____ Pharmacy (Phone: _____ Fax: _____) on _____
 Note: Please send Rx orders to pharmacy one day prior to discharge.

Signed: _____ Date: _____

Phone Number to be Reached at: _____

American Lutheran Homes – Ken King

- Initial involvement
- Benefits to organization
- Enhance relationships with providers

American Lutheran Homes – Ken King

- Root Causes Analysis Process
 - Strengths
 - weaknesses

Patient Continuity of Care

Name: _____ Date: _____

Advance Directive Yes, send copy with pt. No Code Status: _____

Allergies: _____

Reason for transfer: _____

Mental Status: Oriented: Confused: Demented: Comatose:

Hearing: Adequate Impaired Hearing Aid (s) L R Sent

Vision: Adequate Impaired Wears glasses Yes No Sent

Dentures: Upper Lower Sent

Communication: Able to make self understood: Yes No Understands others: Yes No

Transfers: Independent Assist of 1 Assist of 2 Hoyer Lift

Uses: Walker _____ Cane _____ Wheelchair _____

Activities of Daily Living: Independent Supervision Needs Assist

Continence: Bladder: Yes No

Bowel: Yes No Last BM _____

Vaccines: Pneumonia Date: _____
Flu Date: _____

Wounds: _____

Behavior: Cooperative Agitated Combative Able to redirect

Circle # History of or Active: MRSA VRE C/Diff TB status: _____

Family/person responsible notified of transfer: Yes No

Name of person notified: _____

Phone number: _____ Relationship: _____

Include with this form:

Advance Directive/POB

Medication list (make sure last dose of medication has been documented)

Problem or Diagnosis list

Nursing notes (to explain symptoms or changes in status)

Recent Vital Signs

Recent lab reports

Last 2-3 progress notes

Last Full H&P

Blood sugars (if applicable)

Consult notes (if relevant -i.e. patient coming for GI symptoms and has had recent GI consult)

Updated physician orders]

Signature of person completing form: _____ Date: _____

Name: _____ Print Name _____ Contact #: _____

Next Steps

- Determine direction of coalition
 - ADRC phases out involvement
 - Group decision about future and format

- Transition to new coalition leadership
 - Sometimes a natural emergence
 - Sometimes more work

