# Kenosha County Care Transitions Coalition

## Overview

### *What do we mean by "Care Transitions"?*

The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

*The Centers for Medicare and Medicaid have been tracking 30-day re-admission rates for Medicare beneficiaries for some time. On a national average 19.6% of Medicare beneficiaries are readmitted to the hospital within 30 days of discharge at a cost of $26 billion dollars. Medicare Payment Advisory Commission (MedPAC) estimates that up to 76% of these readmissions may be preventable.*

Kenosha County Care Transitions Coalition History

- The first meeting was held on November 15, 2011.
- In early 2012, coalition members signed a participation agreement with MetaStar, the Quality Improvement Organization (QIO) contracted with the Center for Medicare and Medicaid Services (CMS) for Wisconsin, to provide resources, data and support to the project.
- A Community Charter was adopted and signed in January 2012, revised in December 2014 and again in February 2019

**MISSION**

The mission of the Care Transitions Coalition is to improve the quality of care for Kenosha County health care consumers who transition among health care settings through a comprehensive community effort including improving cross setting communication, care coordination and patient/caregiver self-management. The Coalition is committed to:

- Providing Coalition education up to 3 times a year
- Provide community education 1 time a year
- Increase enrollment in PACT, Home Delivered Meals at least 10% each year of the charter period
- Pilot at least one new intervention within the next charter period (Tele-monitoring and 72 hour follow up for nursing home discharges)
- Maintain negative slope in 30 day readmission rates (relative improvement rate per 1,000 Medicare FFS beneficiaries) over time compared to the state rate.

**VISION**

The Care Transitions Coalition envisions the transition of health care consumers between health care settings and practitioners in our community will be well coordinated between all institutions, practitioners and community service organizations with the patient, family and caregiver as the center of care.

**PURPOSE**

- To promote effective systems for transitions of care
- To promote the inclusion of the patient and family voice
- To encourage person-centered and person-directed models of care
- To collaborate and encourage efforts and best practices of health and human service organizations which share our vision
- To advocate for public policies that further the vision of the Kenosha County Care Transitions Coalition

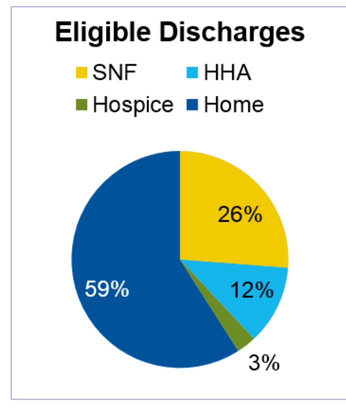
- Data Sharing Agreement was signed in March 2012 to clarify the parameters needed to view and share confidential data available from the QIO.

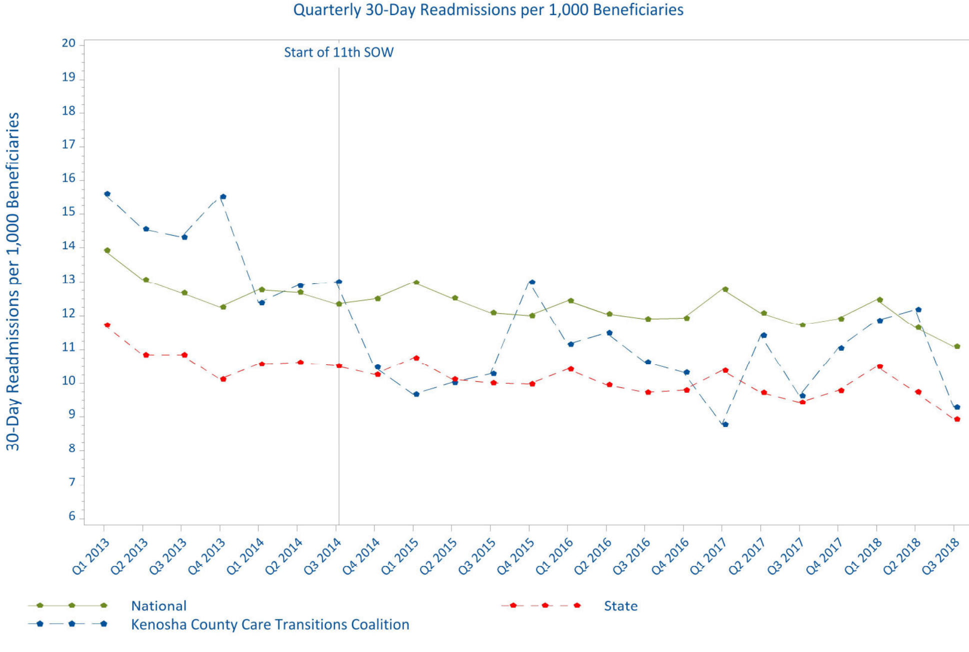
## Root Cause Analysis

Our initial root cause analysis included a cross-setting chart review and a community-wide consumer survey. The key issues identified through the RCA were:

- Patients are not going to the follow up physician visit
- Patients are going home with no services and having difficulty finding services
- Patients are having difficulty with medication issues (obtaining and managing)
- There is a need for greater provider education and understanding across settings

Discharges by Discharge Disposition (data as of Qtr. 1 2016)




## Member Organizations

2012:

- Aurora Medical Center – Kenosha
- Brookside Care Center
- Good Value Pharmacy
- Grande Prairie Health & Rehab Center
- Crossroads Care Center of Kenosha (previously Hospitality Nursing and Rehabilitation Center – Extendicare)
- Kenosha County Aging and Disability Resource Center
- Kenosha Visiting Nurse Association
- Manor Care
- MetaStar
- Paddock Lake Family Practice
- Right At Home
- Froedtert South (previously United Hospital System)

2013:

- Community Care, Inc.
- Hospice Alliance
- Kenosha Area Family and Aging Services
- Society's Assets, Inc.
- Aurora Health Center
- Consumer Representative

2018:

- The Bay at Sheridan

## Work Groups

- Nursing Home Work Group (Lynda Bogdala, lead)
- Heading Home Work Group (Amy Mlot and Mike Callahan, lead)
- Data Workgroup (Ross Gatzke, lead)
- Advanced Care Planning (Rita Hagen, lead)

## Coalition Work History

| Intervention | Description | Start Date | Outcomes |
|---|---|---|---|
| | Shading indicates one-time or discontinued interventions | | |
| 1. Heart Failure Referral | Home Visit Follow Up by ADRC – review discharge instructions, facilitate follow up to physician including transportation, access body weight scale, access medications, additional resources<br>**5/1/2013: Discontinued intervention due to lack of referrals.** | 03/20/12 | 14 referrals (avg. 1.5/month)<br>• 7 received a home visit (ADRC provided a body weight scale for 2 individuals)<br>• 6 declined a home visit<br>• 1 was placed in a nursing home prior to visit<br>0 patients were readmitted to the hospital within 30 days following the ADRC home visit (1 patient was readmitted between referral and home visit); 2 patients readmitted in 30 days had declined a visit. |
| 2. Physician Follow Up Appointment | Prior to hospital discharge, physician follow up appointments are scheduled within 7 days for Congestive Heart Failure regardless of discharge setting (i.e. home: self care, home: home health care, or nursing home).<br>Due to the success of the intervention, the practice has been expanded to all diagnoses at UHS. | 06/01/12 – ongoing practice | UHS has been scheduling and tracking follow up visits for CHF patients since August 2012. Data collection ended 12/31/2014:<br>• The readmission rate for those patients who did NOT attend appointment was 59.3% and for those who DID attend appointment it was 5.5%. |
| 3. PACT (Patient Adherence and Competency of Therapy) | Improve medication delivery through patient education, medication reconciliation and packaging.<br>Good Value Pharmacy: [http://goodvaluerx.com/pact/](http://goodvaluerx.com/pact/) | **Intervention Duration:**<br>January 2013 – present | **Report Duration:** September 2015 – June 2018 (claims used for analysis)<br>Of the 206 PACT Medicare patients 95 had Part A data available for hospitalizations (compared to the individuals' actual admission history) and readmissions:<br>• Admission pre-PACT were 59 and post-PACT were 33 – Statistically Significant reduction in admission<br>• 30-day readmissions pre-PACT were 17 and post-PACT were 7 |
| 4. Emergency Department (ED) Transfer | Improve communication when transferring patients between nursing home and Emergency Department and provide optimal patient information to the nursing home upon discharge (i.e. ED report, radiology and lab results, Nursing triage, meds given and ED discharge instructions). | 06/29/12 | ONE-TIME intervention. November 2012 survey of Nursing Homes:<br>On average usefulness of discharge documentation has increased by 34% |
| 5. Mid-level Nursing Home Providers | Utilize mid-level providers (Nurse Practitioner or Physician's Assistant) in nursing homes to assess/treat/collaborate with the primary physician and avoid transfer to Emergency Department. | 1/1/2013<br>Project ended April 2014 | SNF Care incorporated in December 2012 by Dr. Hettrick and Dr. Mata. 1 FTE PA to work with Grande Prairie, Manor Care and Kenosha Estates. Data from GP only:<br>• Unplanned Hospital Discharges (rate based on patient census): SNF Care: 2.4% Other: 5.7%<br>• Unplanned Hospital Discharges within 30 days of readmission (rate based on patient census):<br>SNF Care: 2.4% Other: 2.9 |
| 6. Motivational Interviewing | A 2-day (12-hour) MI training was provided through the ADRC. Care Transitions partner agencies were invited (3 in | 8/29/12 | Training Evaluation: On a scale of 1 – 5 where 1 = not at all and 5 = extremely |

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| Training | attendance). Monthly tips are sent by the ADRC to all participants to enhance and encourage integration.<br>MI has been integrated to varying degrees across settings. | | Usefulness of application: 4.4<br>Importance of consumer choice and relevance to MI: 4.8<br>Investment in continued learning: 4.6 |
| 7. Care Transitions Intervention | Evidenced based coaching model including pre-discharge visit, one home visit and phone calls for one month post discharge. Focuses on medication self-management, use of a dynamic patient-centered record, primary care and specialist follow-up, and knowledge of red flags. Aurora to hire 1 FTE Transitions Coach and ADRC to hire .5 FTE Transitions Coach | 2013 start | Funding unavailable |
| 8. Physician Education | Provide education related to nursing home capacity to physicians in an effort to decrease unnecessary Emergency Department transfers. | Fact finding | No further action |
| 9. Supportive Home Care Service Package | Right at Home has developed a private pay discharge service: For a cost of $100, patients will received a maximum of 4 hours of service which can be individualized from a service menu: transportation home or to MD follow up, pick up prescriptions, check/clean refrigerator, shop for groceries, arrange follow up appointments, personal care, other assistance as needed). | 12/11/12<br>8/7/2013 | No private pay referrals through December 2013.<br>"Transition Home Pilot" August – December 2013: ADRC to fund 20 vouchers for hospital partners to distribute to patients they identify as high risk.<br>Out of 18 referrals, 9 accepted service and of those 9, 4 were readmitted. Of the 9 that refused service, 3 were readmitted. |
| 10. INTERACT II | INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital.<br>8/26/2013: Brookside to utilize transfer sheet, copy of the SBAR, the Nursing Home Capabilities list and the hospital to post-acute care paperwork for all hospital transfers. | Rolling Implementation - 2009 to present | Brookside Data as of 6/30/2015 (Goal: <10%)<br>Transfer to ER rate: 1.4%<br>Transfer to Hospital rate: 4.1%<br>Overall transfer rate (hospital and ER): 5.5% |
| 11. Preparing to Go Home. | To address patient engagement and support activation, a two page patient guide was developed to help patients and their support systems think through and plan for discharge needs.<br>**UHS** implemented the document with CHF patients who are going home with no services. The social worker completes the document with the patient and provides a follow up phone call within 72 hours.<br>**Aurora** implemented use of the document in February 2014 to all patients. There is no phone call follow up. | 4/9/2013 | UHS:<br>August 2013 – June 2015: **238 patients received the intervention, 30 were readmitted (12.6%)**<br><br>Aurora:<br>Started February 2014 – June 2015: **2013 patients received the intervention, 27 were readmitted (13.3%)** |
| 12. Post Hospital Follow-up Questions. | PHASE I: The ADRC information and assistance staff as well as those providing options counseling will review several topic areas (MD follow up appointment, medication management and discharge instructions) with every consumer who self identifies or we know to | 4/9/2013 – 12/31/2014 | PHASE I: 21 contacts since July 2013<br>48% had NOT had a follow up appointment with their physician. |

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| | have has been hospitalized within the last 3 weeks of contact. | | 67% had changes in medication and 24% had difficulty getting prescriptions filled.<br>14% were not confident following their discharge plan. |
| | PHASE II: To integrate best practice related to physician follow up and medication management with community based data collection, ADRC, Right At Home, Kenosha Visiting Nurse Service and Society's Assets are all asking the same follow up questions and providing support as needed and appropriate for their scope of practice. | 1/1/2015 | PHASE II: 860 Completed through April, 2019<br>69% had a physician follow up appointment (or was scheduled)<br>70% had no concern related to medications<br>83% were confident about their discharge instructions |
| 13. (Nutrition Support Pilot) **At Home Coach** | Kenosha residents age 60+ upon discharge from a hospital or nursing home will receive:<br>1. In home consultation with a Nutrition Coach to help patients clarify recommendations from their health care providers, identify their own objectives, explore options, identify challenges and available supports and take action.<br>2. 7-day post-hospitalization home delivered meal package.<br><br>April 2014 program restructured: At Home Coach<br>• Referrals within 14 days of discharge from hospital or nursing home for any adult with a chronic illness or risk of readmission regardless of insurance coverage.<br>• 30 days of coaching with a focus on nutrition, access to food, transportation to physician follow up visit and medication management | 8/15/2013 | Pilot: Services began 9/1/2013. Data through December, 2013<br>Desired Outcomes:<br>1. Participants will express increased confidence in managing their nutritional well-being<br>2. 80% of participants will maintain or reduce their nutrition risk scores<br>3. 90% of program participants will remain in the community for a minimum of 30 days post discharge.<br><br>Data from 4/1/2014 – 11/31/2014: 86 referrals have resulted in 66 active participants.<br>1. 44 of the active participants were referred post hospitalization and 22 post nursing home discharge<br>2. 95% of participants, who are 30 days post hospital discharge, have ***not*** been readmitted.<br>3. 92% of all participants who are 30 days post discharge (nursing home and hospital, have ***not*** been readmitted.<br><br>Pilot discontinued 12/31/14 due to loss of funding. |

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| 14. Advanced Care Planning | In 2016 – 3 educational events were offered in the community prior to National Healthcare Decision Day. These events had a combined total of 19 people. Two locations were offered for “Sign Your Document Day” and collaboratively staffed by Coalition members.<br><br>In 2017 and 2018 the event changed to include community member “celebrities” who spoke about their experience with advance directives:<br><br>NATIONAL HEALTHCARE DECISION DAY<br>★ your decisions matter ★<br>April 16, 2019, 2 - 4 p.m.<br>Brookside Care Center, Southport Room<br>3506 Washington Road, Kenosha<br>Video Introduction by Legendary<br>GRAHAM NASH<br>★ Join Sheriff Beth, Principal Kaufmann, Reverend Lowe, Miss Kenosha 2018, Maria Salerno, Nancy Salerno, Mayor Antaramian, Cameron Swallow, and complete YOUR Power of Attorney. From ROCK STAR to PUBLIC SERVANT, everyone can benefit from this community conversation!<br>★ National Healthcare Decision Day ENCOURAGES & EMPOWERS all of us to express our wishes regarding healthcare, and for providers to respect those wishes, whatever they may be.<br>RSVP appreciated: ADRC 262-605-6646<br>Sponsored by the: Kenosha County Care Transitions Coalition<br>FREE event! Refreshments! | 4/16/2014<br>4/16/2015<br>5/15/2016<br>4/25/2017<br>4/16/2018<br>4/16/2019 | National Healthcare Decision Day EVENT Attendance<br>(Bar chart, Total: 2016 – 20; 2017 – 43; 2018 – 50; 2019 – 57)<br>60, 40, 20, 0<br>Total<br>2016 2017 2018 2019 |
| | Honoring Choices Wisconsin, an Initiative of the Wisconsin Medical Society. | 9/30/2014<br><br>6/29/16 | Facilitator Training completed for 3 coalition membership organizations.<br><br>Design and Implementation Training |
| | A series of 3 advance directive class for Kenosha County Employees to earn Humana Go 365 points. The final class is signing the document. | February, August, October 2018 | 57 in attendance and approximately 45 completed their document. |
| 15. Coalition Google Site | Provides a means for housing and sharing information and resources with our community partners and consumers. | 9/1/2014 | https://sites.google.com/site/kenoshacocaretransitions/home |
| 16. Home Delivered Meals | Home Delivered Meals: Individuals who begin (or continue with) home delivered meals within 2 weeks of discharge from a hospital will be tracked for potential impact on 30-day readmission.<br><br>MEALS on WHEELS KENOSHA COUNTY | 1/1/2015 | **Report Duration:** September 2015 – June 2018 (claims used for analysis)<br>Of the 180 Meal participants who provided their Medicare number, 65 had Part A data available from which to analyze confidently hospitalizations (compared to the individuals’ actual admission history) and readmissions:<br>• Admission pre-meals were 55 and post-meals were 34 – Statistically Significant reduction in admission<br>• 30-day readmissions pre-meals were 7 and post-meals were 8 |

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| 17. Options Counseling | Measuring the impact of “options counseling” offered by the ADRC which includes at least one face-to-face meeting to discuss needs and resources/options (does not include those individuals who enroll in a long term care program).<br>Number of RDMs<br>0.30 0.25 0.20 0.15 0.10 0.05 0.00<br>RDM PRIOR 6MO: 0.26<br>RDM POST 6MO: 0.07 | January 2017 | **Report Duration:** September 2015 – June 2018 (claims used for analysis)<br>Of the 166 options counseling participants who provided their Medicare number, 76 had Part A data available from which to analyze confidently hospitalizations (compared to the individuals’ actual admission history) and readmissions:<br>• Admission pre-options counseling were 67 and post-options counseling were 37 – Statistically Significant reduction in admission<br>• Re-admission pre-options counseling were 20 and post-options counseling were 5 – Statistically Significant reduction in re-admission |