Wisconsin Hospitals: National Leaders in Discharge Planning & Care Transitions

Governor's Task Force on Caregiving – Family Caregiver Workgroup

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Introductions

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Why We Are Here

- Wisconsin hospitals are national leaders in care transitions, patient/caregiver education and patient satisfaction.
- Discuss how the Wisconsin way of improvement benefits patients, caregivers and providers.
- Discuss how hospitals have engaged with local partners to customize discharge options. Not a one-size fits all solution.
- Discuss challenges that hospitals and health care providers face in successful care transition.
- Discuss recommendations to strengthen our already strong position.

Data Drives Collaborative Improvement

- WI health providers use transparent and reliable data to drive improvement – it's our culture!
- WHA's CheckPoint – over 50 measures of hospital quality since 2004
  - Identified hospital results compared to each other, state, and national rates
- Hospital Improvement Innovation Network
  - Innovated new strategies for readmission reductions for target populations
- Superior Health Quality Alliance
  - Person-centered community coalitions to improve care transitions

GREAT LAKES PARTNERS FOR PATIENTS
Illinois | Michigan | Wisconsin
Powered by the MHA Keystone Center
Accelerating Improvement at the Point of Care

SUPERIOR HEALTH Quality Alliance

CHECK POINT | WHA FOR QUALITY

WI's Patients Rank Us High!

- WI hospitals tied for 1st in the nation for care transitions:
  - Patient preferences were taken into account when planning post-acute care
  - Patients had a good understanding of management of health needs
  - Clearly understood the purpose of each medication
- WI hospitals ranked 1st in the nation for discharge instructions:
  - Staff discussed post-acute care that was needed with the patient
  - Patients were given written discharge instructions
- WI hospitals ranked 4th in the nation for patients who would be likely to recommend the hospital
- WI hospitals rank 1st in the nation for average overall star ratings in satisfaction survey results

CMS's Hospital Compare HCAHPs data from April 2020 Release: 7/2018 – 6/2019

WI Hospital Transition Teams Go Above and Beyond

- Complex patient transition examples:

  - 66-year-old admitted with early onset and rapidly progressing dementia, most likely Lewy Body Dementia. Was living with husband prior to admission and he could no longer care for her. No SNF would accept due to needing frequent/constant supervision for safety so we assisted family to find a CBRF that had a locked unit.

  - Admitted with no contact with doctor for many years with what appeared to be widespread cancer. Patient refused work-up or treatment for cancer and did not want us to call any family\friends. Patient was unsafe to discharge home and needed SNF for rehab. No SNF would accept our referral of this patient based on Medicaid-only payer, social issues and inconsistent therapy participation. Hospital provided rehab for patient at hospital and was eventually discharged home when rehab was complete.

Thank you…

- We are proud to share your priority in achieving the best health care outcomes for Wisconsin residents
- We are very interested in the continued progress of this task force
- We are ready to supply additional information about how Wisconsin hospitals are collaborating and innovating in creating and sustaining models for safe care transitions
- Please contact Kyle O'Brien at WHA with follow-up questions

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