Bridges

UW Health Transitions of Care

Fall 2013 Volume 3

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Coordinated –Transitional Care Program (C-TraC) Rolls out at UWHC

You might have noticed a few new staff members roaming through the halls. We would like to introduce you to our Transitional Care staff Peggy Troller RN, Hilary Krieger RN, Magda Bertalan MSW, Amanda Deniger NP and Kris Leahy-Gross, Transitional Program Specialist (photos on page 2). The team members are now working together with our staff to improve how patients are transitioning out of the hospital back into the community.

In July 2013, UWHC officially rolled-out the Coordinated Transitional Care (C-TraC) model on a number of medical units. The C-TraC program, designed by Dr. Amy Kind was originally designed to improve care transitions and outcomes among veterans with high-risk conditions at the William S. Middleton Veterans Hospital here in Madison. Patients who received the C-TraC protocol experienced one-third fewer re-hospitalizations than those in a comparison group, producing an estimated savings of $1,225 per patient net of programmatic costs.

Dr. Kind worked with our UW transitions team to adapt the program to fit the specific needs of our UW patients. The program is a telephonic program which consists of the Transitional RN's rounding with the inpatient teams, meeting with patients/families shortly before discharge, and then following them telephonically for 30 days post-discharge with scripted phone calls. In cases where the patient is considered to be very high risk for readmission or complications the Transitional NP will perform a home visit. The transitions team works closely with the inpatient primary nurses, coordinated care staff and medical teams to assure coordination of care and target interventions before the patient leaves our doors. After discharge the RN's and NP stay in close contact with the patient's Primary Care and other community providers assuring smooth communications and transitions.

The goals of the C-TraC program are to (1) educate and empower the patient/caregiver in medication management (2) ensure the patient has medical follow-up (3) educate the patient/ caregiver regarding red flags and (4) ensure the patient/caregiver knows whom to contact if questions arise. Eligibility criteria includes medical patients age 65+ discharged home or to an assisted living facility who have poor social support, previous hospitalizations in the past year and are at high risk for readmission.

Consults for a Transitional Care screening can be ordered through Health Link.

The program has been extremely well received by patients. The following statements are quotes from patients enrolled in the program.

"I didn't feel left out on a limb with no one to call."

"Good program to be checking up on people, especially with the medications. "

"I was not enthusiastic at first, but it was nice to have Amanda come out and talk to me about my health because I didn't think I needed it."

"Program definitely helped. Felt Amanda was very knowledgeable. Hospital staff was wonderful, top of the line. Very pleased with all the people I came in contact with. Only use UW doctors and have always been very pleased."

In Her Own Words: Introducing the Geriatrics Transitional Care Medical Director, Elizabeth Chapman, MD

On August 1, 2013, I had the pleasure of joining the Geriatric Transitional Care program as medical director. The University of Wisconsin Hospital and Clinics are truly my medical home, so to speak, as I have spent the entirety of my training here, from undergraduate to medical school, from Internal Medicine residency to a chief resident year, and finally fellowship training in Geriatric Medicine. During my fellowship, I was able to witness firsthand the benefits that the transitional care program provides for vulnerable elderly patients as they discharge from the hospital, including the promotion of safety, empowerment of patients in disease self-management, prevention of readmissions, and – most importantly – improvement in patient satisfaction. I am thrilled now to be a part of this team that so positively impacts the lives of our patients and that focuses so directly on patient-centered care.

As medical director, I work with the other members of the transitional care team to address complex clinical situations and also to help monitor and improve the quality of the care we provide. Within the past year, we have begun using the Coordinated Transitional Care (C-TraC) model developed by Dr. Amy Kind, which consists of protocol-based inpatient and post-discharge contact between patients and trained nurses to reconcile medications, educate patients about important symptoms that should prompt evaluation, and ensure follow-up with primary care or specialty providers. When indicated, our team social worker can help connect recently discharged patients with needed community resources, and our team nurse practitioner is able to see some patients in their home for rapid assessment. Currently, we are expanding our service to reach more of our elderly hospitalized patients and plan to continue to grow. Going forward, I hope to help build on the program my colleagues and predecessors have established and find ways to evolve our services to best meet the needs of our patients.

Elizabeth Chapman, MD
Assistant Clinical Professor-Geriatrics
Geriatrics Transitional Care Medical Director

Introducing the Transitional Care Team

The Transitional Care Team works hard every day to make sure that programs are in place and tools are available so that patients receive the education and information that they need to make a safe transition out of the hospital—whether it's to a skilled nursing facility or back home. The team continues to grow as the need for more transitions resources intensifies.

Who is on the Transitional Care Team?
Amanda Deniger, NP: Geriatric NP
Hilary Krieger, RN: Transitional Care RN
Peggy Troller, RN: Transitional Care RN
Kris Leahy-Gross: Transitional Care Program Specialist
Magda Bertalan: ACE/Transitional Care Social Worker
Elizabeth Chapman, MD: Medical Director ACE/Transitions (photo above)
Maria Brenny-Fitzpatrick: Program Director Transitions






Partners in Care and Transitions…Acute Care-Skilled Nursing Facility (SNF)

What happens when representatives from 20+ Skilled Nursing Facilities gather in a room with UWHC staff? Good communication, relationship building, a better understanding of each other's workplace and great outcomes.

In early 2012 UWHC Coordinated Care and Transitional Care staff invited area SNFs to an informal gathering to dialog on how we could work together to improve communication and transitions for patients whose care we share. After a few fun ice-breakers and refreshments the group got down to business and identified key strengths and barriers in the transitions process. One topic that rose to the top was the need for a revised discharge order set and discharge packet. What followed was a series of focus groups and monthly meetings dedicated to the revision of these items with an end product that was acceptable to all. The SNF participants of the group were so pleased with the process that they requested that the group meet monthly to discuss issues, complete blinded readmission reviews and hear expert UW clinicians speak on topics of interest to them. The group continues to meet monthly here at UWHC on the second Thursday of the month. If you are interested in joining the group for one or more sessions please contact Maria Brenny-Fitzpatrick, Program Director for Transitions at mbrenny-fitzpatrick@uwhealth.org.

"Coming together is a beginning; keeping together is progress; working together is success."
Henry Ford

BOOSTing Care Transitions

Friday, November 22nd the UW School of Medicine and Public Health's Department of Medicine brought in a national leader in transitions of care to speak at Medicine Grand Rounds, Mark V. Williams, MD. FHM. Dr. Williams is the Chief of the Division of Hospital Medicine at Northwestern University in Chicago, IL. He is a leader and active member of the Society of Hospital Medicine's (SHM) BOOST program, which stands for Better Outcomes by Optimizing Safe Transitions.

The BOOST program was funded in 2007, where a dedicated committee developed a toolkit for care transitions. They rolled out the toolkit to 6 hospitals as a pilot and then to 24 more hospitals. The toolkit includes many different resources including, but not limited to, a discharge patient education tool, a discharge knowledge assessment tool, medication reconciliations for both admissions and discharges, and teach back training resources. He shared with the group why readmissions are a big focus in Medicare regulations. Roughly 1 in 5 Medicare patients are re-hospitalized within 30 days and these readmissions cost Medicare billions of dollars. Dr. Williams talked about what the BOOST committee learned in the initial rollouts. He stressed the importance of physician mentors when implementing change, that change is slow and it requires defined committed resources from leadership. Additionally, he stated that teamwork was critical and that patient centered care is everyone's best ally. Dr. Williams also reminded the group that we all use medical jargon, even when we don't realize it, and emphasized the importance of using teach back to assess a patient's level of understanding.

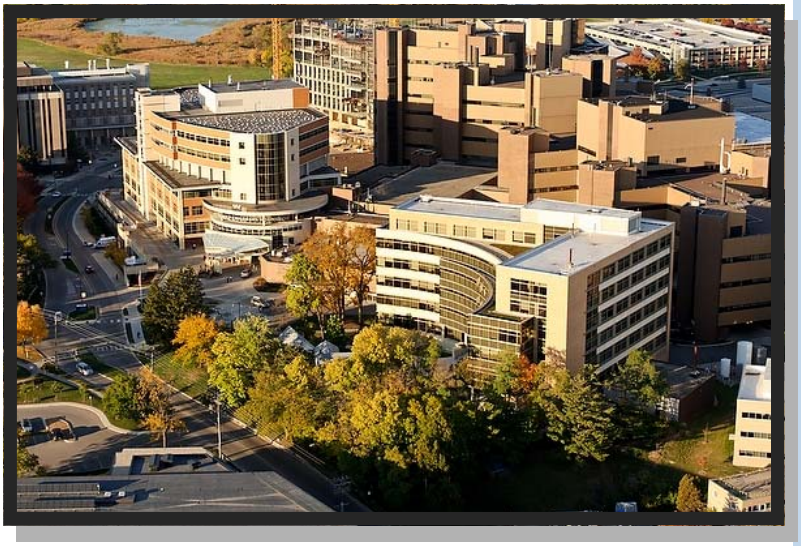
For more information and toolkit resources regarding BOOST go to http://www.hospitalmedicine.org/resourceroomredesign/rr_caretransitions/ct_home.cfm. If you would like to see Dr. William's presentation, you can view it in its entirety at http://www2.medicine.wisc.edu/home/videolibrary.

Mark V. Williams, MD FHM
Chief of the Division of Hospital Medicine
Northwestern University, Chicago, IL

The Transitions Coordination Team

Maria Brenny-Fitzpatrick, MSN, Program Director
Mark Juckett, MD, Physician Co-Lead
Pete Newcomer, MD, Physician Co-Lead
Elizabeth Chapman, MD, Geriatric Transitional Care Medical Director
Jennifer Hendricks, Project Manager
Mark Sanderfoot, Business Planning & Development
Michelle Thoma, PharmD, Pharmacy Administration

UW Health Transitions of Care Vision:
UW Health provides a holistic, patient and family centered transition of care experience that seamlessly spans across the continuum of care. Through proactive planning, looking at all aspects of the patient situation and utilizing strong community partnerships, UW Health delivers safe, timely, efficient, effective transitions of care while optimizing the use of resources.



UW Health Transitions Tidbits

Average number of days between discharge and readmission at UWHC:

12.3 days

Average UWHC adult discharges that are readmitted to UWHC in 30 days:

12.5%

Surgical complications and infection are the two most frequent diagnosis of readmissions at UWHC.

After climbing a great hill, one only finds that there are many more hills to climb.
~Nelson Mandela