The Transitions and ACE teams have had a successful 2018!

Both teams consist of real go-getters who are passionate and innovative in the care that they provide to our patients. I’m keeping my introduction here especially brief to provide adequate space to highlight some of the work that has been done over the past year. Our partnership with you and your teams enables all of us to provide remarkable care to the patients we share. A note to our surgical team colleagues, please read the beautifully written tribute to your work on page 2 by our two surgical Transitional Care Nurses.

Best,

Maria

Maria Brenny-Fitzpatrick DNP, RN, FNP-C, GNP-BC
Director, Transitional Care and Post-Acute Services
University of Wisconsin Hospital

The Conversation — Understanding the “why” Behind the Readmission by Kris Leahy-Gross, MSN, RN, CPHQ

Hospital admissions affect nearly 20% of Medicare patients costing over $17 billion annually. While some readmissions are planned and/or unavoidable, a significant number of readmissions are potentially avoidable. While we know that readmissions are multifactorial a key factor is finding out from the patient perspective what they felt led to the readmission. One way to do this, is to have a focused conversation with the patient/family. Open-ended questions focus on issues with diet, medications, transportation, social supports and post-discharge appointments. Most notably, we are focusing on those patients who had been readmitted within 7-days of discharge.

The process begins with a daily report emailed to nurse leaders and direct care staff listing which patients have been readmitted within 7 days. The nurse manager is accountable for having a focused conversation with the patient/family. Open-ended questions focus on issues with diet, medications, transportation, social supports and post-discharge appointments. Most notably, we are focusing on those patients who had been readmitted within 7-days of discharge.

These conversations have been occurring for a number of months now. The most frequent patient concerns were an inability to anticipate what was needed after discharge, particularly with diet, fluid imbalance, symptom control and medications. Findings through these conversations have led to strategies to improve patient anticipation of discharge needs such as increasing teach-back education, assuring timely post discharge appointments, discussing transportation arrangements, understanding symptom resolution and medication management.
Remarkable Surgical Care by Everyone on the Patient’s Team!
Dani Edwards, MSN, RN, PCCN and Laura Sell, MS, BSN, RN

As providers in the field of medicine, we all know that patient satisfaction and quality measures are becoming increasingly important in the everchanging healthcare system. When our focus remains on the “numbers” or the financial implication of our work, we can easily lose sight of what is truly important: our patients and the team behind their care.

UW Health is well known for their surgical services that touch the lives of thousands of patients each year. These patients may be here for a simple outpatient procedure or for a complex abdominal surgery with the hopes of prolonging their life. Without collaboration and teamwork, the remarkable care that UW provides would not be possible. While the patient may only remember a few faces during their stay, there are so many individuals that truly impact each and every patient.

The physician assistants and nurse practitioners who tirelessly help their patients, playing the role of diplomat, teacher, negotiator and caregiver – and even shed a tear at times – your patients and staff appreciate you more than you will ever know.

The residents and surgeons who are forever teaching and learning, practicing and perfecting, researching and discovering – your patients live another day, see another birthday, and welcome another child or grandchild into the world because of you.

The nurses and nursing assistants who put their patients’ needs before their own, helping them find joy in tough moments and holding their hand while they cry – your patients remember your actions and kindness for the rest of their lives.

The case managers and social workers who spend hours coordinating the impossible, and who provide hope and comfort for the anxious family member or caregiver – your patients rest assured that they have the support that they need at home to focus on their recovery.

The nutritionists who advocate for optimal nutrition, counting calories and calculating daily protein requirements – your patients heal and learn to eat again.

The pharmacists who check and double check each medication and dose, meticulously combing through charts to ensure nothing is missed – your patients are comforted knowing that you are overseeing their care.

And the ancillary staff that keep the unit running smoothly, the rooms clean, and the kitchen stocked – your patients are thankful for your attention to detail.

When it comes time to go home, Surgical Transitional Care helps ease the patient’s transition. We can rest assured that each patient has the best plan moving forward because of the amazing team that touches the lives of each of our patients. We are so proud to work with such a remarkable team.
High readmission rates exist for patients with high ileostomy output due to complications of dehydration. Patients with ileostomies need simple, objective data measures to better identify dehydration early. With the assistance of Transitional Care Case Managers (TCCMs) and an innovative practice change, hospital readmissions in these patients can be reduced.

Published literature of best practices supports the use of orthostatic blood pressures and monitoring of ileostomy output to support early identification of dehydration in ileostomy patients. As these patients are enrolled in the Transitional Care Program the TCCMs educate them on properly obtaining orthostatic blood pressures at home. Once the patient discharges, the TCCMs provide regularly scheduled follow-up phone calls to assess his/her recovery and dehydration status. Patients are guided on obtaining daily orthostatic blood pressures to assess for significant alterations. This rapid identification and treatment can decrease hospital readmissions in this patient population.

The Hearing Aid Fairy: A Low-Cost, High Impact Intervention

Peggy Troller, DNP, MSMFT, RN-BC, works as a Transitional Care Case Manager at UW Health but she’s better known as the “Hearing Aid Fairy.” Peggy helps hospitalized patients who forgot their hearing aid batteries and supplies. Peggy not only helps with the hearing aids but has made it her mission to educate the staff on correct ways to communicate with hearing impaired people.

This is a personal cause for Peggy, who has been hearing impaired since age 9 and at age 35, got hearing aids. Her passionate work has improved the lives of so many patients, and she has gently educated staff along the way (U-Connect, 2018).

Peggy’s passion has not only increased awareness across UW Health, but across the nation as she was invited to present this topic at the 2018 Magnet Conference in Colorado. In addition, Peggy was selected as one of Madison’s Top Nurses in 2018.
Readmission Risk Screening Tool Evaluation
Matthew Lakosky, MSN, RN, CMSRN

A readmission risk assessment tool assists the Transitional Care Program RN case managers to prioritize the enrollment of patients into the program who are at highest risk for readmission. The risk criteria currently used by the program include four patient conditions, 1) lives alone, 2) inadequate supports, 3) cognitive impairment, and 4) hospitalization within the past 12 months. These criteria were adapted from the C-TraC transitional care model (Kind et al., 2012). The tool has been tested to prove its validity or reliability with the Transitional Care Program medical population.

A Chi-Square analysis was done on 3,397 patients who participated in the UW Hospital Medical Transitional Care Program from 07/01/2014 to 12/31/2016. The analysis evaluated the four assessment variables (lives alone, inadequate supports, cognitive impairment and hospitalization within the past 12 months) to determine if there was a statistical relationship to 30-day hospital readmission. The findings showed 30-day hospital readmissions have a statistically significant relationship with “cognitive impairment” (P=0.005) and “hospitalized in past 12 months” (P<0.0005). The findings do not support a relationship between 30-day readmissions and “lives alone” (P=0.297) or “inadequate support” (P=0.141). However, hospital 30-day readmission rates significantly increases as the total risk assessment score increased (P<0.0005). Overall, the readmission risk assessment tool is working very well for its intended purpose to predict 30-day hospital readmissions.

Health care providers should be extra diligent when making discharge plans for patients who were hospitalized in the past 12 months and patients with cognitive impairment because these patients have the highest risk of readmission.

ACE Awarded Grant for “Tinkering” Projects—Again!

In early 2018 we reported the Acute Care for Elders (ACE) team had been awarded a grant from Friends of UW Health to provide male patients who have dementia/delirium with items to stimulate their cognitive thinking. We are pleased to announce that Friends of UW Health has approved another grant to purchase more items! Patients will be able to tinker with models and leather-working kits among other items.
An area of focus for the Transitional Care Program is assuring that our patients have the right follow-up, with the right provider, at the right time. Best practice dictates that the patient have the appointment in hand prior to discharge. This process typically goes well as long as the order to schedule the appointment is placed during clinic hours and HUCs (UH) and Administrative Operations Associates (TAC) are present to schedule the appointments. Unfortunately there are times (off-hours/holidays) that the patient goes home without an appointment in hand.

As I communicated with my patients post-discharge I came to realize that our UW messaging for how the scheduling would occur was confusing to patients and families. Working together as a team at TAC we developed a smart phrase that can be used by the HUCs and Administrative Operations Associates to place the following statement in the After Hospital Care Plan for the patient.

“Following up with a doctor after you have discharged from the hospital is an important part of your discharge plan. Appointment requests may have been ordered by your discharging doctor after the clinic has closed for the day. Our goal is to assist you with scheduling these appointments.

A team member from UW Health at The American Center may contact you directly in the next 1-2 business days to assist with scheduling appointments that have yet to be scheduled. For any questions, please contact your primary care provider directly at ***.”

I’ve enjoyed the collaboration between Transitional Care and TAC Associates! I look forward to ongoing teamwork.
Stephanie Savoie, ACE Team CNS and Luke Hallett celebrated their wedding on July 14, 2018.

Dani Edwards, Surgical Transitional Care RN, and husband Jake welcomed the birth of daughter Evie on September 4, 2018.

Check us out on the web: http://www.uwhealth.org/transitional-care/transitional-care/42062

Questions or comments about Transitions of Care?

Contact Maria Brenny-Fitzpatrick, Director of Transitions and Post-Acute Services at mbrenny-fitzpatrick@uwhealth.org or Kris Leahy-Gross, Transitional Care Program Manager at kleahy-gross@uwhealth.org.