The UW Health Transitions Program Continues to Grow

Welcome to the Fall 2015 Bridges Newsletter. This newsletter is meant to keep you informed of what is happening with Transitions of Care across UW Health. As you will see in the following pages, we have a lot going on! Multiple individuals and teams are working together across the continuum of care to assure safe transitions for our patients. This includes work both in-house and externally with our community partners.

There are multiple large scale transitional care initiatives currently happening at UW Health. Two of the newest and most notable are the ED/Post-Acute Care Communications Workgroup and the expansion of our in-house Coordinated Transitional Care (C-TraC) program to the surgical services. The ED/Post-Acute Care Communications Workgroup is a UW Health interdisciplinary group which also includes seven community Skilled Nursing Facilities and Assisted Living Facilities, Madison Fire EMTs and Ryan Brothers Ambulance. Improved bi-directional written and verbal communication processes are being piloted and will be disseminated to the larger post-acute population later this fall. Interestingly, we have already received requests for the information from a few national Transitions groups.

The long-awaited expansion of our C-TraC program to the surgical services has begun and we are excited to see what results the program will bring in improving transitions for our surgical patients and decreasing avoidable readmissions. C-TraC is a nurse-led telephonic post discharge follow up program that has had amazing and statistically significant results with the medical services currently being served. We hope to have the same results with our surgical services. Emily Osterhaus, BSN, RN, CMSRN is the first of two surgical transitional nurses to join the team.

Lastly, we have two system-wide Transitional Care committees that meet monthly here at UW Health. Briefly, the Transitions Steering Committee helps to coordinate UW Transitional Care efforts at the 10,000 foot level and the Transitions Coordination Committee is what I like to call the “boots on the ground” committee that assures the coordination of the more day to day details of what is happening across the continuum. I certainly welcome your involvement in any of these committees and look forward to continued work and success of each group.

Please feel free to call me or email me if you have any questions, comments or thoughts regarding our transitional care work both internally at UW Health and across the entire continuum of care with our community partners.

Maria

Maria Brenny-Fitzpatrick MSN, FNP-C, GNP-BC, APNP
Director Transitional Care
University of Wisconsin Hospital

“If we knew what it was we were doing, it would not be called research, would it?” ~ Albert Einstein
In the UW Health Transitional Care (TC) program, we pride ourselves in becoming partners with our patients. However, forming a successful post-discharge plan for our complex patient population not only involves partnering with patients themselves, but also with community resources as well. Often times community resources are offered prior to discharge but for various reasons the patient may refuse services that would truly be helpful at home. What makes the TC program unique from other outpatient case management services is the ability to meet and establish relationships with patients before they ever leave the hospital; this is quite helpful in building a trusting relationship and partnership with the patient prior to discharge.

Although home health services and the TC program both provide outpatient follow-up for patients, we have found that by combining efforts and working together we can further improve the patient experience by increasing communication and eliminating patient care silos. We recognize that by forming a close alliance with good communication between our organizations, we can provide our mutual patients with the best possible chance for success in staying healthy and at home.

Let's meet Sam. Sam had been readmitted to UW Hospital twice in the last few months. Sam was adamant that he and his daughter were managing well, despite two recent hospital admissions for Congestive Heart Failure (CHF) exacerbation and increased weakness. Soon after returning home Sam had gained a significant amount of water weight and developed difficulty breathing, which ultimately brought him back to the hospital. Sam was offered home health services during both hospitalizations but refused due to bad experiences he had with similar services in the past. He also initially refused a home visit from the TC NP because he thought it was unnecessary.

After about a week at home Sam was still very weak. Sam’s daughter reported to the TC nurse that Sam had a difficult time even walking down a short hallway. Sam and his daughter knew that they could use some extra help but still
were not willing to sign on with home health services. However, Sam did agree to a home visit by the TC Nurse Practitioner (NP). Through this home visit, the TC NP established that one of Sam’s goals was to be able to walk out to his mailbox at the end of his driveway and get his mail. Sam was unable to currently meet this goal due to painful swelling in his legs from his poorly managed CHF and significant physical deconditioning related to recent hospitalizations. In discussing these goals the NP also recognized that his daily sodium intake was far too high. Sam’s high sodium intake played an active role in the worsening of his CHF symptoms, which in turn was further decreasing his mobility. The TC NP reviewed actual cans and boxes from Sam’s food pantry. She then was able to provide education on sodium restriction recommendations and how to properly read food labels to both the patient and his daughter.

Through motivational interviewing, therapeutic listening, and good communication, the NP was able to pick out what was most important to Sam and do so in the comfort of his living room. After this visit Sam finally agreed to home health services and was set up to work with home nursing and physical therapy services. The nurse was able to provide additional education and reinforcement of the importance of a low-sodium diet, which Sam and his daughter found helpful. Additionally, through continued visits by the physical therapist, Sam was able to achieve his goal and walk down the driveway to the mailbox. Sam’s story could have ended in a readmission but because of a good partnership between the patient, Transitional Care, and home health services, Sam’s story had a much happier ending.

The Transitional Care Program from the Patient Perspective

In July 2013, UWHC officially rolled-out the Coordinated Transitional Care (C-TraC) model to patients 65 and older. The model is known by our patients as the Transitional Care Program. The program’s goal is to successfully transition patients from UW Hospital back to their place of residence and to reduce their chance of readmission.

UW Transitional Care nurses meet the patient and family in the hospital and then follow the patient for up to 30 days making phone calls to check on their health, review medications, follow-up with the physician and answer questions. The team also consists of a nurse practitioner who can visit the patient in their home and a social worker who can assist patients and families in finding additional support.

The Benefits of Transitional Care

- Help patients understand and follow their discharge instructions
- Help patients understand and manage their medications
- Assist patients in communicating with their PCP about any problems or changes in their condition

What our patients have to say about the Transitional Care Program

- “Very happy customer. Glad to know I have a support system in place.”
- “Excellent! Extraordinary program.”
- “Program was really, really helpful. Loved being fussed over.”
- “Very reassuring to have someone come check on me and answer my questions.”
- “Positively impressed with the whole program.”
- “Great for people who have holes in their thinking.”
Transitions of care occur each time the patient moves from one health care provider or health care setting to another. These care transitions are the highest risk phases of care for patients and may result in poor patient care and preventable readmissions. In fact, nearly one in five Medicare patients readmits to the hospital within 30 days (Jencks et al., 2009). Bi-directional communication and information transfer deficits during changes in facility level of care are common and may affect patient care.

At University of Wisconsin Hospital and Clinics, we determined that there were no standardized communication processes for transferring a patient to and from post-acute care facilities, i.e. skilled nursing and assisted living facilities. This had resulted in missed communications and a lack of pertinent clinical data necessary to care for the patient. As a result, a work group formed along with 4 skilled nursing and 3 assisted living facilities in the area to arrive at a consistent process to improve communication with handoffs. The processes are aimed to improve the quality of patient care at the time of the patient transfer, whether it is from a post-acute care facility to the emergency department or from the emergency department/inpatient unit back to a post-acute care facility.

While spending time understanding the current process, we developed a detailed process map of what was currently happening. Based upon our process map analysis we arrived at the need for a standardized transfer packet. On June 15, 2015, we implemented the new transfer packet process with select post-acute care facilities.

**What was implemented?**
- Participating skilled nursing and assisted living facilities complete a standardized transfer label. The label includes important information for clinicians and the receiving facility such as: reason for transfer, level of care the resident is being transferred from, direct dial number, and other pertinent information (see example below).
- A standard blue 9x11” envelope is used to package the transfer documents, and the completed label are adhered to the outside of the envelope.
- Upon arrival to the UW Emergency Department, EMS hands the transfer packet to the Emergency Department Coordinator (EDC) for immediate scanning into the electronic medical record.

**What is the goal?**
- To improve the quality and safety of patient transfers.
- To improve communication between facilities and EMS.
- To test a standardized transfer process and tool with a plan to eventually implement this process in all post-acute care facilities.

**Which facilities are participating?**
- UW Hospital Emergency Department
- Capitol Lakes Skilled Nursing Facility
- Nazareth in Stoughton Skilled Nursing Facility
- The Village of Middleton Village Skilled Nursing Facility
- Lighthouse of Sun Prairie Assisted Living Facility
- Oak Park Place Assisted Living Facility
- Sylvan Crossings Assisted Living Facility
- Karmenta Care Center

We identified several other opportunities for improvement and prioritized these opportunities. Other improvements the workgroup will be working on include creating Discharge Summaries specific for the needs of post-acute care facilities, creating a capabilities list template, and creating an Emergency Department Discharge to Post-Acute Care Facilities Checklist.

**References**


**UW Health Transitional Care Patient Satisfaction Survey**

January 2015-August 2015
176 pts contacted since Jan 1, 2015 / 155 completed the telephone survey (88%)
- 100% of the pts stated they were satisfied with the Transitional Care Program
- 100% of the pts stated the Transitional Care Program was helpful
- 100% of the pts who had social work involvement stated it was helpful
- 100% of the pts stated they would recommend the Transitional Care Program to others
CONGRATULATIONS!
Matt Lakosky, BSN, RN on winning the Transitional Care Team Zinnia Growing Contest!

Transitional Care Readmission Statistics

<table>
<thead>
<tr>
<th>Clinical Service</th>
<th>TCP Readmissions</th>
<th>Control Group Readmissions</th>
<th>TCP Discharges</th>
<th>Control Group Discharges</th>
<th>TCP Readmission Rate</th>
<th>Control Group Readmission Rate</th>
<th>Difference: TCP-UWHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PRACTICE</td>
<td>16</td>
<td>41</td>
<td>162</td>
<td>179</td>
<td>9.9%</td>
<td>22.9%</td>
<td>-13.0%</td>
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<tr>
<td>HOSPITALIST</td>
<td>61</td>
<td>120</td>
<td>538</td>
<td>659</td>
<td>11.3%</td>
<td>18.2%</td>
<td>-6.9%</td>
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<td>CARDIOLOGY</td>
<td>19</td>
<td>40</td>
<td>297</td>
<td>294</td>
<td>6.4%</td>
<td>13.6%</td>
<td>-7.2%</td>
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<tr>
<td>GENERAL MEDICINE</td>
<td>58</td>
<td>63</td>
<td>423</td>
<td>337</td>
<td>13.7%</td>
<td>18.7%</td>
<td>-5.0%</td>
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<tr>
<td>TOTAL</td>
<td>154</td>
<td>264</td>
<td>1,420</td>
<td>1,469</td>
<td>10.8%</td>
<td>18.0%</td>
<td>-7.1%</td>
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</table>

Statistically significant difference: p<.10  p<.05  p<.01

Control Group is defined as UWHC patients 60 and older, discharged to home or an assisted living facility, in the family practice, hospitalist, cardiology, or family medicine service lines and NOT enrolled in the Transitions of Care Program.

Questions or comments about Transitions of Care?
Contact Maria Brenny-Fitzpatrick, MSN, Director, Transitional Care at mbrenny-fitzpatrick@uwhealth.org