Bridges

UW Health Transitions of Care

Fall/Winter 2014 Volume 4

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Frequent Flyers and Readmissions

Unlike frequent flyer airline programs that reward loyalty, there are no rewards for frequent hospital admissions or emergency department visits. To address the issue of patients who frequently readmit, UWHC developed the **Readmission Review Team**. The purpose of the team is to bring together the collective thoughts of an interdisciplinary group to recommend approaches and strategies for those patients with frequent readmissions and to establish patient-specific plans of care to reduce readmissions. An additional goal is to identify system issues for referral to the Transitions of Care Steering Committee. The team meets the 2nd and 4th Monday of each month and is comprised of physicians, social workers, nurses and case managers. Patients reviewed by the team are recommended by clinical staff.

When applicable, the team meetings include community partners and providers such as Care Wisconsin, home healthcare agencies, dialysis and skilled nursing facilities. We have a dedicated teleconference phone line to ease the burden of external care providers attending the meetings at UWHC. Collaboration with community partners has been vital as we coordinate care across the healthcare continuum.

The initial kick-off meeting was in January 2014 and since that time 48 patients have been reviewed by the team. Of the 48 patients reviewed, there were an average of 5.6 hospital admissions and 2.6 emergency department (ED) visits during the 6 months prior to initial review date. Patients remained on the team's agenda for review an average of 38 days. Seven patients have died since the final review date.

There are 11 patients who are 6 months past their final review date. Of these patients, the average number of hospital admissions 6 months prior and 6 months after final review date decreased 78% from 6.5 to 1.5. The average number of ED only visits decreased 64% from 2.0 to 0.7.

Average admissions 6 months prior to review date	6.5
Average admissions 6 months after final review date	1.5
Average ED only visits 6 months prior to review date	2.0
Average ED only visits 6 months after final review date	0.7

Recommendations and interventions from the team have been tracked. The top items include collaboration across the care continuum to develop plans of care with: Care WI care team, skilled nursing facility care team, UW Home Health staff and primary care clinic staff. Another top intervention was development of an ED management plan.

"From where we stand, the rain seems random. If we could stand somewhere else, we would see the order in it." ~Tony Hillerman

Emergency Department Frequent Utilizer Process Improvement Initiative

By Jeff Pothof MD, FACEP

Much has been written about frequent utilizers of U.S. Emergency Departments. We do know that these patients consume a disproportionate amount of healthcare resources and have worse outcomes than patients who have coordinated care through a primary care physician. By addressing this problem, we can provide higher quality care and save money.

Our first task was to identify the scope of the problem. Our initial data shows that in each of the months between Jan and May of 2014 we averaged 50-60 patients that had 3 or more visits to the UW Emergency Department. One patient had 11 visits in one month. When we looked at total healthcare charges affiliated with these visits it totaled more than *8.2 million dollars* over the 5 month period.

In response, we convened a group of ED physicians, nurses, social workers, and nurse case managers to try and come up with a way to reduce these frequent visits. The initiative is not yet complete but we have made some progress.

We have developed a real time notification page to the ED case manager whenever a high utilizer registers in the Emergency Department. This allows us to provide real time intervention, and catalog who might benefit from an individualized multi-specialty care plan.

We are currently looking to collect data that further identifies this cohort of patients. Questions like "Are they medically homed with UW?", "Do they have a primary care doctor?", "How medically complex are they?" are all questions we are looking to find answers to.

We have been developing a standardized electronic template to be used for individualized multi-specialty care plans. We are working to have a problem list diagnosis added that readily identifies these patients with a quick and seamless link to their individualized care plans. We envision an alert (BPA) that identifies high utilizers wherever they may present in the system with links back to their care plan.

We hope that this project can be spread system wide to ensure all high utilizing and complex patients have tailored health plans that ensure the high quality and safe care we want for them while also ensuring that care is provided in an efficient cost effective manner.

Introducing Heather Boehme, NP

Heather Boehme lives in Waunakee, WI with her husband, 2-year old daughter, and two dogs. She loves spending as much time outside as possible, especially during the warmer months! Her family enjoys going for walks to the park, golfing, and watching Badger, Packer, and Brewer games.

Heather graduated from the University of Wisconsin-Madison with a Bachelor of Science in Nursing in 2004. She was then hired as a nurse resident in the UW Emergency Department and worked there until obtaining her Master of Science in Nursing as a Family Nurse Practitioner from The George Washington University in 2012. After working at Associated Physicians clinic in Madison, WI as a Family Nurse Practitioner for a little over a year, Heather happily returned to the UW Hospital to join the Transitional Care team.

After meeting with the Transitional Care team, it quickly became evident to her the passion the team all shares for this program! Her role within this department will primarily include visiting recently discharged patients in their home with a focus of helping to prevent possible complications and hospital readmissions. Heather is incredibly excited and proud to be part of a team so committed to increasing patient safety, wellness, and overall satisfaction through improved communication and coordination.

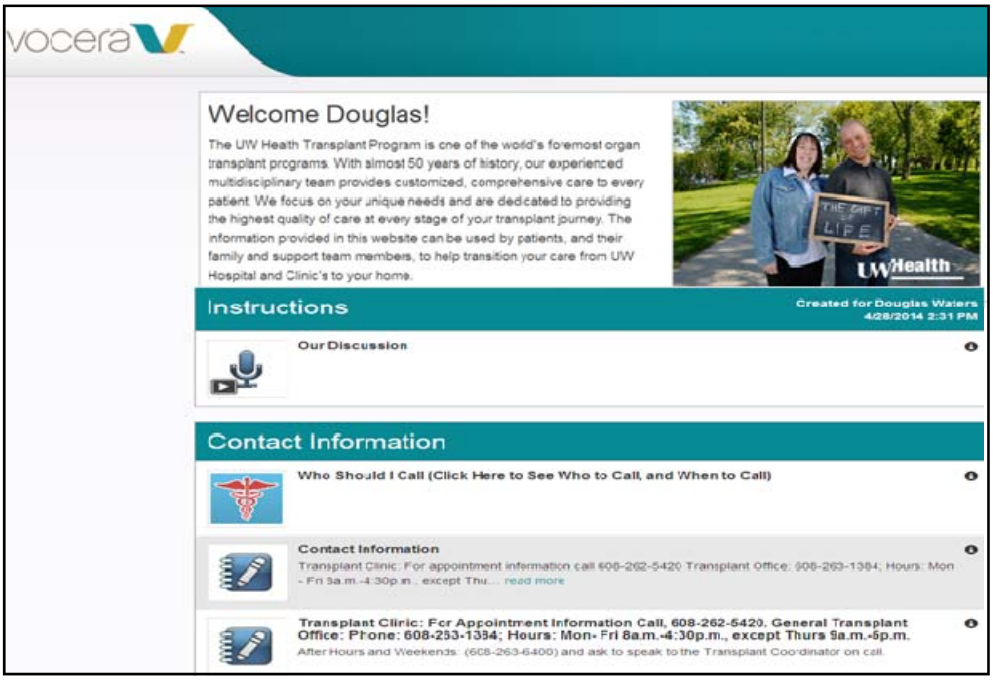
Kidney Transplant Unit is Good to Go®

Patients who understand their post-hospital care instructions are 30% less likely to be readmitted to the hospital,[1] that's why we've brought Vocera' s Good to Go Patient Discharge Communication technology to UW Hospital. This technology allows patients, family members and caregivers 24/7 access to their personalized recorded discharge, medication and dietary instructions. These instructions can be accessed via phone, computer or mobile device in the comfort of the patient's home at a time when they are more relaxed and better able to assimilate and understand their instructions. Caregivers and family members are also able to access the same information once given the access code by the patient. Good to Go technology even has the ability to send the patient automatic reminders to access their recorded discharge instructions.

Goals for the use of Good to Go technology at UW Hospital includes improving patient satisfaction, reducing the number of avoidable readmissions, increasing patient and family engagement and understanding of the discharge instructions, and ensuring a successful transition back home.

In November 2013 UW Health staff met to discuss the need for discharge teaching strategies that were patient and family centered, and had the ability to meet the different learning styles of the patients. Good to Go appeared to meet those needs.

In April 2014 the tool was implemented on the transplant unit for patients receiving kidney transplants. Nurses, pharmacists, dieticians, transplant coordinators, diabetes educators and providers have been able to record the patient's discharge instructions. An added bonus is that the various disciplines can add video recordings, audio recordings and other written materials to the library of documents that the patients can access. The plans are to expand services early fall to pancreatic transplant patients and late fall to UW surgical patients.



If you have questions regarding Good to Go Technology please contact Maria Brenny-Fitzpatrick at 608-263-6980 or mbrenny-fitzpatrick@uwhealth.org.

[1] Brian W. Jack, MD. et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial Ann Intern Med. 2009; 150(3):178-187

The Transitions Coordination Key Contacts

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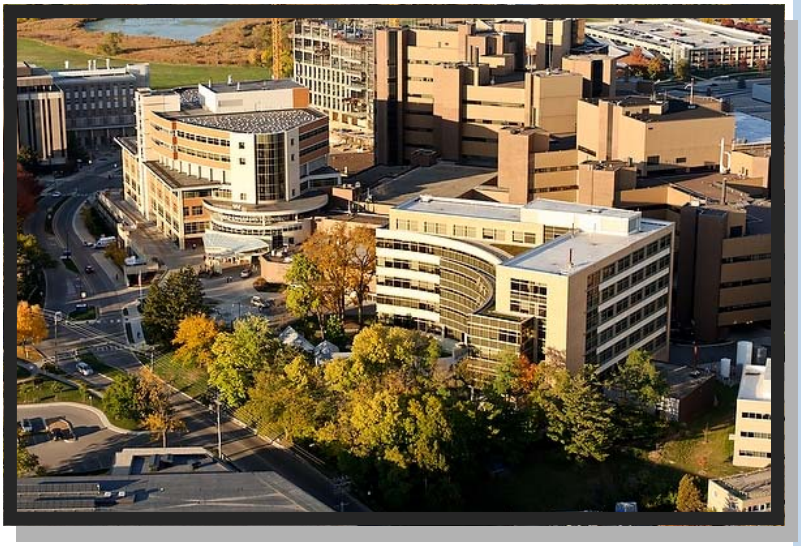
Questions or comments about Transitions of Care?

Contact Maria Brenny-Fitzpatrick, MSN Program Director of Transitional Care at mbrenny-fitzpatrick@uwhealth.org



UW Health Transitions Data

August 2013-July 2014

Did you know the Jan-Mar 2014 Adult 30 Day All-Cause Readmission Rate of 11.6% ranked us 25 of 122 of hospitals out of UHC Academic Medical Centers? Keep doing what you do!

30 Day All-Cause Readmission Rates

Overall	12.4%
Medical	14.5%
Surgical	9.5%
Pediatric	11.9%
Adult	12.5%

FY 2014 30 Day All-Cause Readmission Rates: Transitions of Care Program vs. Control Group

Enrolled in Transitions of Care Program	12.2%
Control Group[1]	14.4%

[1]Control Group is defined as UWHC patients 65 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.

New QlikView Dashboard Available!

A new, UWHC 30-Day All-Cause Readmission QlikView dashboard is now available. This data analytics tool provides a powerful set of filters that allow the user to view readmission data by a variety of demographic, provider, service and payor qualifiers. With approved user access, the dashboard can be easily accessed from the QlikView U-Connect link and puts readmission counts and rates at your finger-tips. Prerequisite training materials are available. To request access to the UWHC 30 Day All-Cause Readmission QlikView dashboard, complete a Service Now request ticket. Any other questions may be directed to QlikView@uwhealth.org.