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HEALTH

Tallahassee Memorial HealthCare celebrates 10th anniversary of Transition Center

Lauren Faison-Clark Tallahassee Memorial HealthCare

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The Tallahassee Memorial Transition Center is one of the community's best-kept secrets. Created by Tallahassee Memorial HealthCare, in partnership with Capital Health Plan and the Florida State University College of Medicine, this facility provides follow-up care to patients after they've been discharged from TMH.

February 2021 marked the 10th anniversary of this innovative multidisciplinary clinic.

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The Centers for Medicare and Medicaid Services (CMS) reports that approximately one in five patients discharged from an acute care hospital will be readmitted within the first 30 days following the initial admission. Patients with congestive heart failure, pneumonia, COPD and other chronic illnesses predominately require readmission.

These readmissions are often preventable and are sometimes a result of confusion over medications and how to take them, a lack of education about the cause of the initial admission, and awareness of what could cause readmission or a lack of timely follow up with a primary care provider or specialist in the community. CMS believes lowering the incidences of hospital readmissions can dramatically reduce the overall cost of healthcare.

The Transition Center's goal is to improve our community's health, enhance the patient care experience, including quality, access and reliability, and reduce the demand for hospital services, visits to emergency centers and readmissions to the hospital. The healthcare system is complex, and patients often face challenges getting the care they need.

The team's focus at the Transition Center is to help patients access care when and where they need it.

Patients seen at the Transition Center include adults previously hospitalized at TMH and who meet any of the following criteria when discharged.

- Patients without a primary care provider
- Patients without health insurance
- Patients who are not able to obtain a follow-up appointment with a provider within seven days of discharge
- Patients who have been hospitalized three or more times over the last 12 months

The availability of a compassionate, multidisciplinary care team is one of the main reasons the Transition Center is so successful and capable of caring for the most vulnerable patients.

Dean Watson, MD, Vice President & Chief Integration Officer of TMH and CHP and Transition Center Medical Director, oversees a diverse clinical team. They offer services including filling prescriptions, medication education, coordination of follow-up services and follow-up visits as needed both in the clinic and through telemedicine. The team also guides patients to local resources and community agencies that can provide them with the care and support they need to help them continue on the road to recovery.

"What started as a simple idea focusing on providing clinical care in a multidisciplinary clinic setting for the most vulnerable patients has become an overwhelming success due to the hard work and dedication of clinicians, researchers and students. The Transition Center has helped thousands of high-risk patients gain access to medical care and psychosocial support, as well as obtain medications that would have otherwise been unobtainable," said Dr. Watson.

On average, the Transition Center assists over 1,200 unique patients per year. Since opening the doors on Feb. 11, 2011, the center has seen more than 14,000 patients. It has a successful track record of reducing hospital readmissions by over 90 percent in the first 30 days following discharge from TMH.

The Transition Center team has successfully helped over 75 percent of patients obtain a primary care provider and attend their initial appointment. These results can be attributed to the strong working relationships with local Federally Qualified Health Centers (FQHCs) such as Bond Community Health Center and Neighborhood Medical Center, and community

providers such as Care Point Health & Wellness Center and the Kearney Center, which provide services to the homeless.

When asked about his experience with the Transition Center, a patient had this to say, "Your assistance with my situation has been life-changing. I appreciate you so much. You make me feel like there is hope. I haven't felt this much love except from my mom. You are just awesome! My morale has improved since the social worker helped me apply for food stamps and Medicaid."

In 2018, the Transition Center expanded their services to assist patients with congestive heart failure. This concerted effort resulted in reducing hospital readmissions by 50 percent. The Transition Center recently provided COVID-19 testing to over 600 patients without a primary care provider and assisted with post-hospitalization support for patients with COVID-19.

The Transition Center has become a model for other programs and has hosted visits from several different healthcare systems wanting to implement a similar model. The team also shares its model with students through educational partnerships with Florida State University, Florida A&M University and other clinical training programs.

"We have had the honor to serve our community with medical care and guidance for a decade and through some of the most complex healthcare situations. I have witnessed first-hand how patients can feel empowered and knowledgeable while experiencing relief knowing that there are clinical colleagues who can assist them after being discharged from TMH," said Judy Griffin, APRN.

For more information about the Tallahassee Memorial Transition Center, visit TMH.ORG/TransitionCenter.

Lauren Faison-Clark is Administrator for Regional Development, Population Health and Telemedicine at Tallahassee Memorial HealthCare.

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