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SUNY Upstate University Health System
Diane Nanno MS, CNS, RN
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Care Transitions

Knowing changes everything.™

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No Silver Bullet
(the what)

- Multidisciplinary team planning
- Enhanced care and support/wrap-around services at transitional points
- Improved communication and collaboration between settings
- Improved patient education and self-management support
- Patient-centered care planning, goal setting for life-limiting conditions
- Risk stratification and targeting
- Comprehensive care planning across the continuum

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Population
(the who and where)

- **Utilization**
  - ED
  - Inpatient
- **Setting**
  - Community
  - Facility
- **Risk**
  - Clinical
  - Behavioral
  - Functional
  - Resources
  - Housing/social determinants

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Evolving Strategies

- Intensive Transitions Team
- FAP Pilot
- Care Transitions Intervention

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Intensive Transitions Team

- Risk assessment upon admission
- Deployment of team
- Drill-down to root cause of risk
  - Clinical (complexity, palliative, etc.)
  - Behavioral
  - Functional
  - Supports
- Assemble cross-setting team
- Build cross-setting plan of care
- Push out plan of care to embedded care team
- Transition to next setting with warm hand-off
- Real time, two way communication post-transition

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FAP

- A person-centered ED crisis plan
- Assignment of a dedicated hospital-based social worker
- Assignment of Health Home (HH) care manager
- Real-time connectivity between social worker and HH care manager
- Cross setting plan of care
- Periodic case reviews between HH and social work

Outcomes:

54% decrease in admissions in 20 patient sample

36% decrease in ED utilization

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Care Transitions Intervention

- Patient engagement and empowerment
- Four Pillars
  - Medication Management
  - Patient Health Record
  - Red Flags
  - Timely and Meaningful follow up

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Thank you!
Questions?

- nannod@upstate.edu

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