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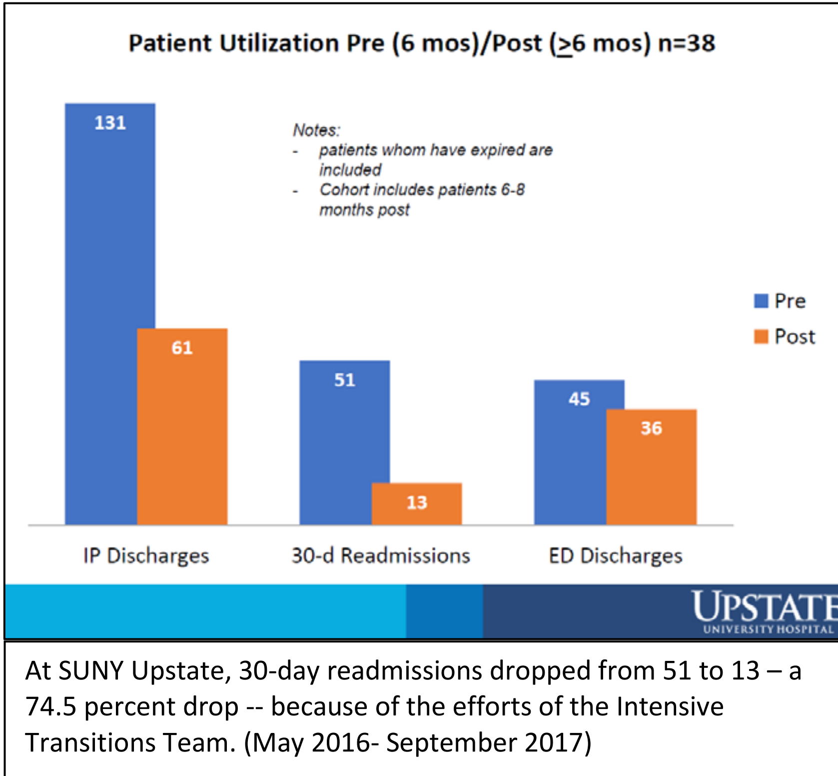
HOSPITAL SPOTLIGHT

30-day Readmissions Drop 74.5 Percent Due to Intensive Transitions Work

State University of New York (SUNY) Upstate University Hospital (two campuses – downtown and community), Syracuse, New York. 735 beds. Part of SUNY Upstate Medical University.



At SUNY Upstate, 30-day readmissions dropped from 51 to 13 – a 74.5 percent drop -- because of the efforts of the Intensive Transitions Team. (May 2016- September 2017)

The intensive transitions team at **SUNY Upstate University Hospital** has reduced the hospital's 30-day readmissions rate by deploying a range of tactics which address the varied and underlying reasons identified why "high-utilizer" patients had been landing in the hospital so frequently. Considering the social, logistical and behavioral causes of readmissions is central to their work; going past the admitting diagnosis to the root cause has allowed them to help patients in a significant way.

Director of Transitional Care **Diane Nanno**, MS, CNS, RN, CCCTM, leads this initiative. On her team are Nurse Practitioner **Barbara Eckhard**, MSN, FNP-C; Program Coordinator **Samadhi Moreno**, MPH; Clinical Case Manager **Toni Heer**, MS, CNS, RN, CCTM; Social Worker **Lisa Lioto**, LMSW; Social Worker **Taisa Jenkins**, LMSW; DSRIP Coordinator **Kari Burke** and Clinical Case Manager, **Elaine Green**, RN, BSN, BCCM.

The Intensive Transitions Team (ITT) is a hospital-based, multidisciplinary team designed to facilitate safe and effective transitions for patients at greatest risk of readmission. The team employs a whole-person approach to transitional care, to better identify not only the risk of readmission, but also the services and supports needed to address the patient's needs. At SUNY Upstate, patients are enrolled in the Intensive Transitions Team if they have had two unplanned admissions including the current admission with an additional emergent hospital encounter in the past six months and a diagnosis of chronic cardiac, renal, diabetic, respiratory and/or mental health concern. SUNY Upstate is part of the Vizient Transformation Network on Readmissions. The work of the ITT is well worth replicating at other hospitals. Nanno and her team described some lessons they learned along the way, which could benefit other hospitals seeking to improve their readmissions rates.

Lesson 1 — Bring case managers, social workers and nurse practitioners on to your team – ones who are passionate about their work.

When forming the team, "We really looked at what population we have that are at high risk of readmission due to their utilization," Nanno said. "We knew that there were certain disciplines we needed to involve – case management, social work and nurse practitioners. We wanted to put a hospital-based team together, then extend that team throughout the community and wrap around services that we knew these folks would need as we developed the intervention," Nanno explained. In the hiring process, "there was a real focus on engagement and passion in this type of work," Nanno said. "These patients have some unique challenges and can be challenging to attend to. We asked candidates, 'what does patient-centered mean to you?' "

Lesson 2 — Connect patients with community resources for long-term help.

When Nanno and her team were developing their program, they knew community resources would be a key part of their work. Before they even started, they had three community-based sessions where they met with and asked for feedback from home health workers, primary care physicians, specialists, rehab and housing experts – "anybody we identified who would be key in taking care of these folks," Nanno said. Working with Health Home is an important part of their patient care. Health Home is a program in New York State that helps Medicaid patients who have complex chronic diseases and behavioral health conditions. Patients are assigned a care coordinator to help them manage their conditions. Health Home "is more of a long-term support," Lioto said. "It's really helpful when patients are eligible for care managers. That's usually one of our first phone calls."

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Lesson 3 — Focus on helping patients rebuild bridges they have "burned."

Many of the patients the ITT team works with are isolated physically and emotionally. "These are patients that really are pretty disenfranchised," Nanno said. "They have burned bridges behind them in many cases. They have been labeled as 'non-compliant,' but we don't use that word on our team. Much of what this team does is really re-engage them in not only clinical care but also behavioral health, housing and services that attend to social determinants."

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>
> *"These goals are really important because it helps to get people engaged with their own care."*
>
> *– Toni Heer*

Lioto explained that their first focus "is building a trusting relationship with that person. We can have some honest communication with them. What has worked and why or why not? In our experience, we build that relationship and that trust when we are making those connections in the community." For example, if the patient is no longer on speaking terms with a physician or social worker who has worked with them in the past, an ITT team member can go with the patient to meet with the physician or social worker, and help to re-establish that relationship. Sometimes, a connection has been severed because the patient no longer had transportation to see that provider, and the team member can help the patient make arrangements for transportation.

Lesson 4 — Set patient-centered goals and help your patients work to meet them.

One of the ITT team's innovations is asking each patient, "What is something you would really like to do, that you have not been able to do?" One woman wanted to be able to live at home again with her cat. One man hoped to be able to work in his garden again. A grandmother wished to be well enough to attend her granddaughter's piano recital. Several patients have said they wanted to go fishing again. "These goals are really important because it helps to get people engaged with their own care," Heer said.

Sometimes the barrier to what the patient wishes for is simple – one woman needed her electric wheelchair fixed, for example. Other times, it's more complicated and the patient needs to get healthier to meet their goal. But when patients see their personal goal and are motivated to reach it, it can help them meet their clinical goals as well, Heer explained.

Members of the Intensive Transitions Team: Left to right (back row), Samadhi Moreno, Taisa Jenkins, Diane Nanno. Left to right (front row) Barbara Eckhard, Elaine Green, Toni Heer, Lisa Lioto.

Lesson 5 —Emphasize Patient and Family Engagement.

ITT team members work hard to include families in the treatment process, not just immediate family living in the home but also extended family, Lioto said. Friends are also important. "Sometimes 'family' to patients means friends, it doesn't necessarily mean blood relations," Lioto said. In one case, a patient and her adult son were estranged, and team members were able to reunite mother and son. After they were reconciled, the son was able to help his mother hire someone to help care for her in her home. Team members are also wary – they ask many questions of their patients and through those questions have discovered instances of abusive relationships with family members. They've been able to help a patient move from an abusive situation with a family member to another, safer housing arrangement.

With all of their work, the team keeps in mind that they frequently work with some patients "everyone has given up on," Nanno said. "Having a passion to make it better is huge."

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