San Francisco Transitional Care Program

A presentation for “Make History” at California Readmissions Summit
Avoid Readmissions through Collaboration
May 6, 2014 at Oakland Scottish Rite Center

Presenters

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Agenda

- Why is Transitional Care Important?
- Background
- Description of the San Francisco Transitional Care Program
- Hospital Perspectives in Transitional Care –

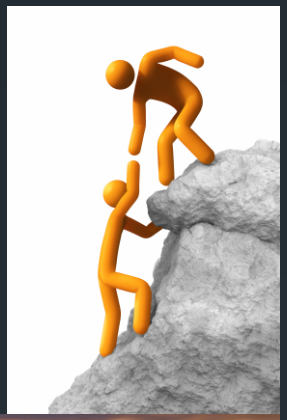
  California Pacific Medical Center
- Outcomes and Next Steps

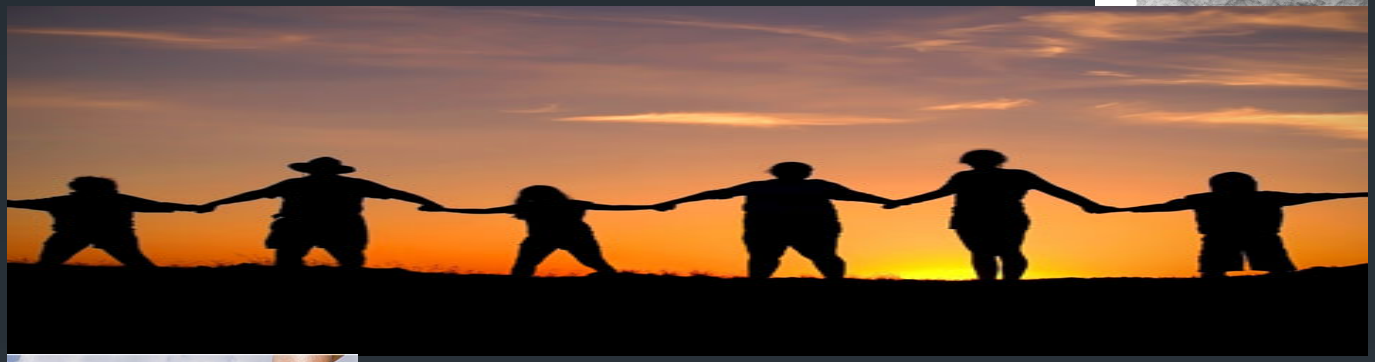
It’s a “numbers game” with a “human cost”

Better Access, Better Care for More Patients

Collaboration

Why is Transitional Care important?



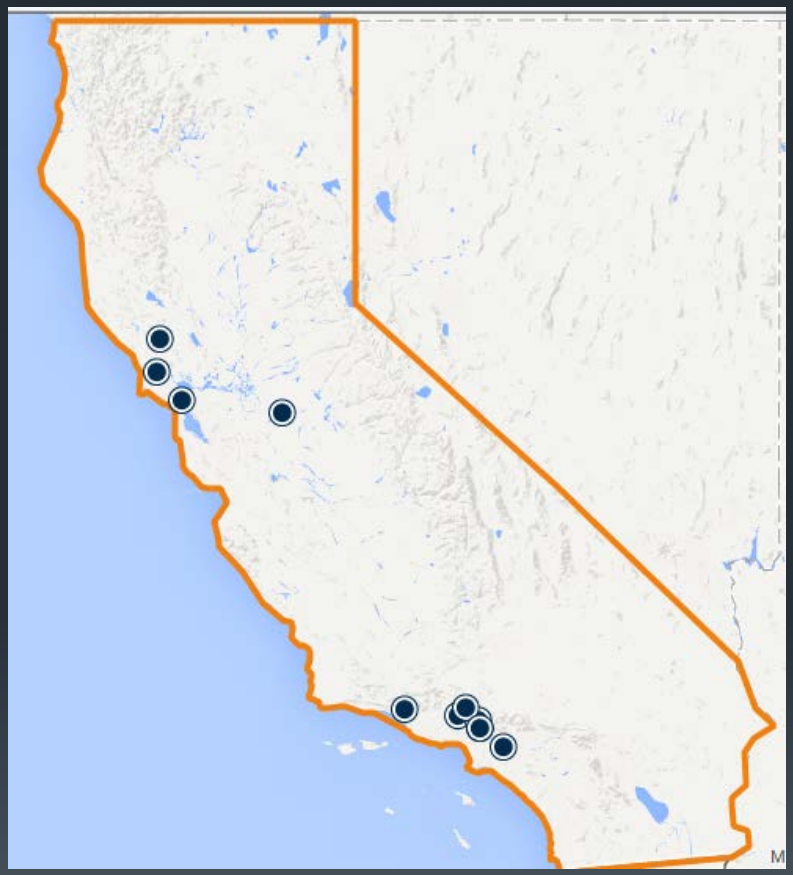


Making it personal…


experiment
creativity
inspiration
science
analysis
alteration
idea
Innovation
technology
research
development
concept
invention

The Community-based Care Transitions Program (CCTP)

- Created by Section 3026 of the Affordable Care Act
- Launched in 2011
- Test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- Also a part of the Partnership for Patients which is a nationwide public-private partnership that aims
  - to eliminate harm in hospitals by 40% and
  - to reduce hospital readmissions by 20%



CCTP Participants

- 102 participants nationwide
- California has 11 CCTP Teams
- Northern California
  - San Francisco
  - Sonoma
  - Marin
- Southern California
  - Anaheim
  - Glendale
  - Los Angeles
  - Reseda
  - San Diego
  - San Fernando
  - Ventura

For more information contact the
San Francisco Transitional Care Program
415- 923-4491
For referrals contact the SF Department
of Aging and Adult Services Intake Line
415-355-6700

Hospital Partners

CPMC Davies Campus
CPMC Pacific Campus
CPMC St. Luke's Hospital
Chinese Hospital
Saint Francis Memorial Hospital
Saint Mary's Medical Center
San Francisco General Hospital
UCSF

Community Organization Partners

Bernal Heights Neighborhood Center
Episcopal Community Services-
Canon Kip Senior Center
Catholic Charities CYO
Curry Senior Center
Institute on Aging
Kimochi
Northern California Presbyterian
Homes & Services
On Lok 30th Street Senior Center
San Francisco Senior Center
Self-Help for the Elderly

San Francisco Transitional Care Program

A hospital-to-home transitional care service for older adults and people with disabilities

Infrastructure

- Collaboration of county, 8 hospitals, and 8 community-based organizations – each with representation at Governance and Steering Committees to guide program aspects
- Centralized Intake System at Department of Aging and Adult Services for SF Transitional Care Program referrals and other county services such as In-Home Supportive Services, Adult Protective Services, home-delivered meals, Community Living Fund, and Information & Referral.
- Web-based electronic client database for data management and reporting

Target Population

- Older adults (age 60 or older)
- Adults with disabilities (age 18 to 59)
- Cognitive impairment
- Little or no formal or informal supports and/or lives alone
- Chronic illness and/or more than three medical co-morbidities
- Two or more readmissions within the last 6 months
- Difficulty managing medications and/or taking 8 or more routine medications
- Needs assistance with 2 or more activities of daily living
- Demonstrated need for service/resource to avoid readmissions

Eligibility Criteria

- Payor source:

  MediCare fee-for-service and MediCare/MediCal (eventual expansion to uninsured and MediCal only)
- Seniors age 60 & older or adults with disabilities age 18-59
- A resident of San Francisco
- In stable housing
- Referred by hospital during acute medical hospitalization
- Client, family or friends are able to benefit from coaching or care coordination services
- Willing to accept services

Main Roles

- Hospital Liaison with Department of Aging & Adult Services Intake
  - Assist hospital staff/units with program information and referrals
  - Initiate patient intervention during initial hospital visit
  - Collectively cover all 7 hospital campuses every weekday
- Transitional Care Specialist
  - Provide transitional care services in the 5 focus areas
  - Complete home visits and appropriate follow up
  - Arrange for service packages (transportation, meals, or homecare)
  - Stabilize and refer to long term resources
  - Complete Patient Experience Survey

Client Areas of Focus

- Set a recovery goal
- Understand one's health issues and role of medications
- Recognize symptoms and have a plan of action if they occur
- Develop “My Wellness Plan” – a tool to organize health information
- Secure/prepare for the first PCP appointment including questions and concerns
- Establish services/resources with emphasis on nutrition, transportation, care at home

Hospital Perspectives in Transitional Care…

California Pacific Medical Center

Mary Ann Calles,RN BSN MSN-c

Melinda Mata, RN, MSN, MBA

Why is it important to CPMC…

- It's the right thing to do
- 47% of our patients are Medicare recipients
- Majority of patients are residents of San Francisco
- Focus on readmission rates

Sutter Health
CPMC
We Plus You

Readmission Rates

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

All-Cause Readmission Rates

Table 1 depicts the all-cause 30-day readmission rates by discharge setting for Quarter 4 2011 through Quarter 3 2012. Results for the State of California and your hospital's region are provided for comparison.

Table 1: All-Cause 30-Day Readmission Rates—October 1, 2011 - September 30, 2012

Group	Setting Discharged To	Number of Discharges	Number of Discharges Readmitted within 30 Days	30-Day Readmit Rate	Number of 30-Day Readmits to the same hospital	Percentage of 30-Day Readmits to the same hospital	Number of 30-Day Readmits to another hospital	Percentage of 30-Day Readmits to another hospital
Your Hospital	Home	3,036	573	18.9%	424	74.0%	149	26.0%
	Skilled Nursing Facility	613	106	17.3%	73	68.9%	33	31.1%
	Home Health Agency	1,081	213	19.7%	165	77.5%	48	22.5%
	Hospice	117	6	5.1%	3	50.0%	3	50.0%
	Other	490	105	21.4%	56	53.3%	49	46.7%
	All	**5,337**	**1,003**	**18.8%**	**721**	**71.9%**	**282**	**28.1%**
Region	Home	11,193	1,992	17.8%	1,433	71.9%	559	28.1%
	Skilled Nursing Facility	3,597	717	19.9%	477	66.5%	240	33.5%
	Home Health Agency	3,934	793	20.2%	545	68.7%	248	31.3%
	Hospice	333	24	7.2%	13	54.2%	11	45.8%
	Other	1,880	405	21.5%	230	56.8%	175	43.2%
	All	**20,937**	**3,931**	**18.8%**	**2,698**	**68.6%**	**1,233**	**31.4%**
California	Home	387,477	67,039	17.3%	49,265	73.5%	17,774	26.5%
	Skilled Nursing Facility	174,996	39,063	22.3%	28,555	73.1%	10,508	26.9%
	Home Health Agency	123,904	25,359	20.5%	19,802	78.1%	5,557	21.9%
	Hospice	15,916	555	3.5%	357	64.3%	198	35.7%
	Other	52,933	10,717	20.2%	6,198	57.8%	4,519	42.2%
	All	**755,226**	**142,733**	**18.9%**	**104,177**	**73.0%**	**38,556**	**27.0%**

Table 2 depicts distinct beneficiaries with at least one all-cause 30-day readmission. The rate is calculated as the percentage of beneficiaries who had at least one readmission within 30 days of a previous admission. Each beneficiary is counted only once in this rate calculation (e.g., a beneficiary with four 30-day readmissions in the measurement period counts as one distinct beneficiary readmission). The table provides information on beneficiaries that were readmitted, rather than readmissions.

Table 2: All-Cause 30-Day Readmission Rates for Distinct Beneficiaries—October 1, 2011 - September 30, 2012

Group	Number of Discharges (Distinct Beneficiaries)	Number of Discharges Readmitted within 30 Days (Distinct Beneficiaries)	30-Day Readmit Rate (Distinct Beneficiaries)
Your Hospital	3,965	722	18.2%

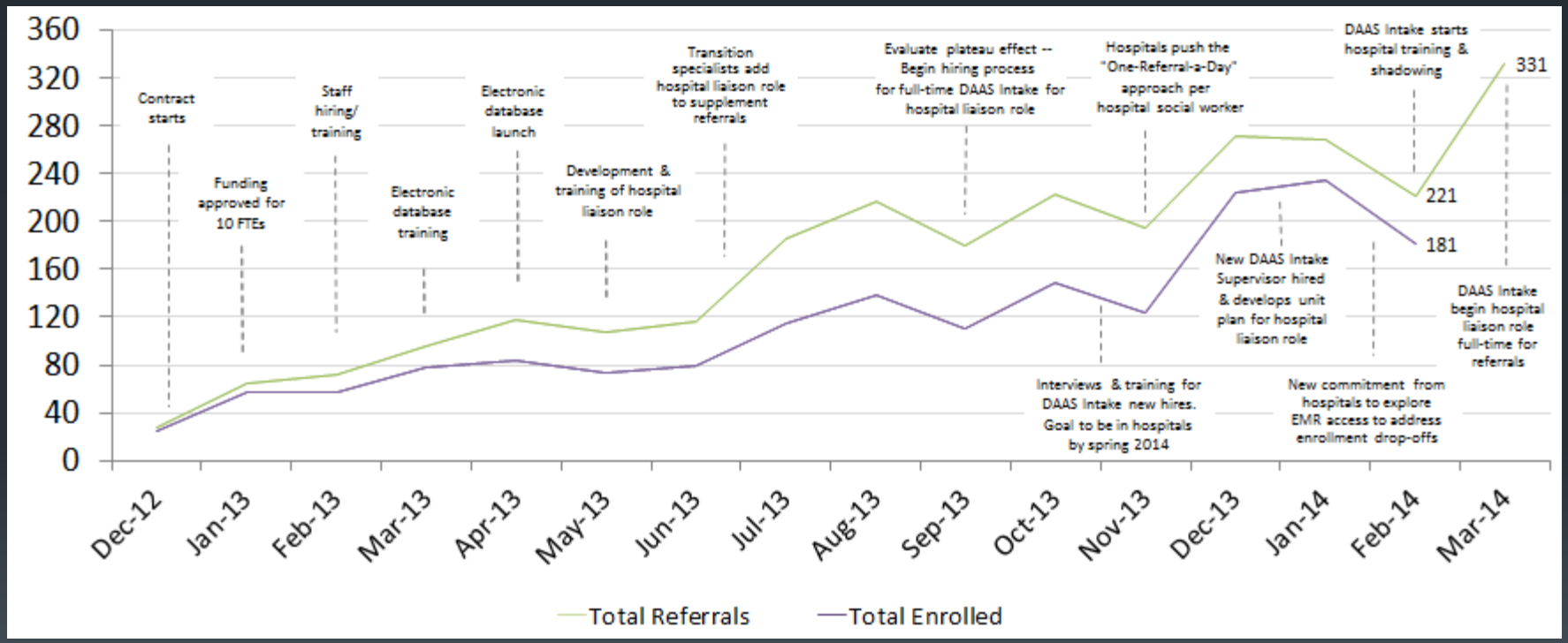
California Pacific Medical Center San Francisco Transitional Program

- Set mutual goals to assure maximizing efforts for referrals
- Daily oversight and support provided
- Facilitation of an interdisciplinary approach through regular engagement meetings
- Equipped both teams with tools and resources
- Measuring and celebrating successes measured by volume of patients referred

Changes made with program experience

- Increased presence of Department of Aging & Adult Services Intake every Monday-Friday 8:30-5:00pm
- Provided electronic medical record access for intake staff
- Celebrated successes - measured by volume of patients referred
- Closer look at why patients say “NO”?
- Early identification at discharge

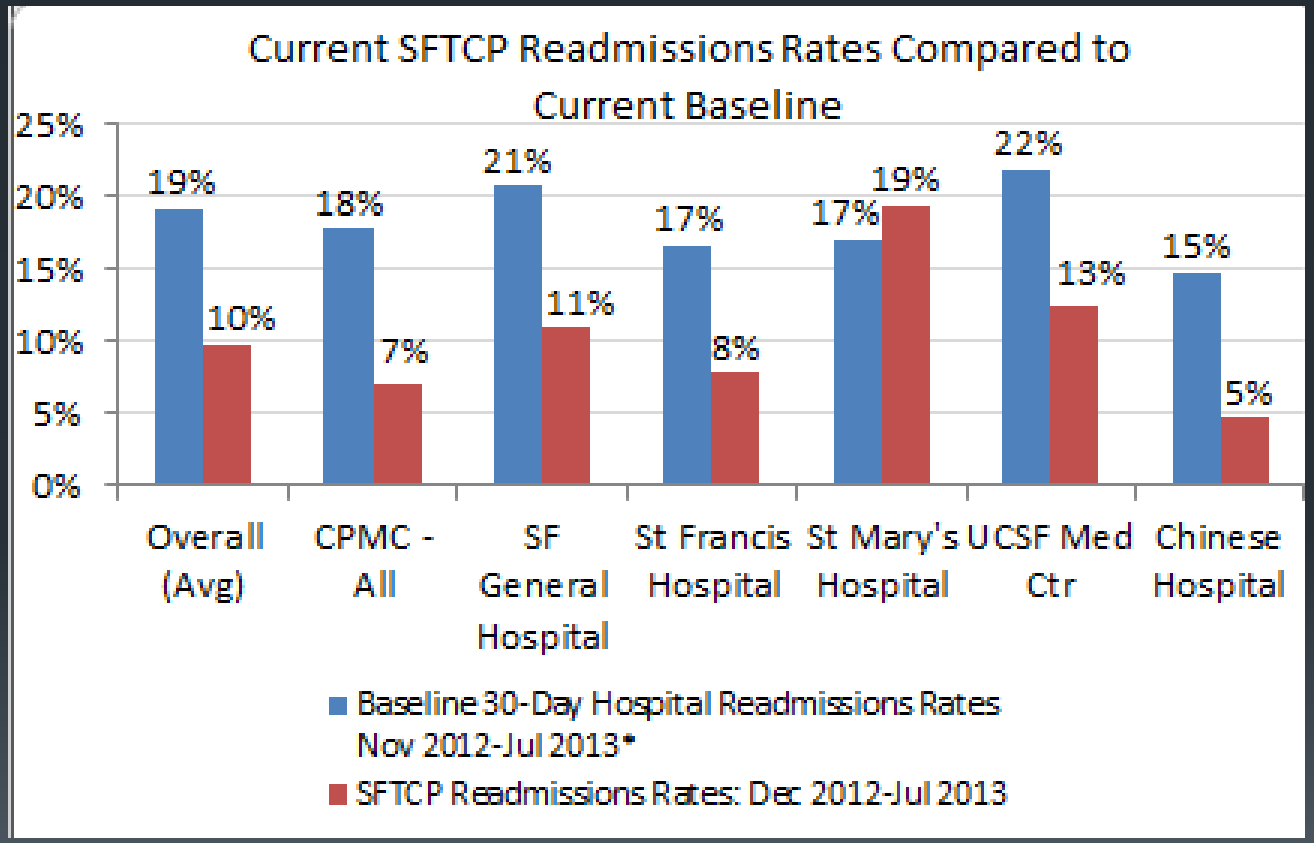
Program-to-Date Referrals & Enrollments



Readmissions for SF Transitional Care Program Clients

Preliminary Data for SFTCP Clients: Hospital Readmissions between Dec 2012 - Nov 2013	Number of Readmissions		Number of SFTCP Clients Served		Percent Readmissions
Chinese Hospital		6		127	4.7%
CA Pacific Medical Center		26		419	6.2%
Pacific Campus	10		133		7.5%
Davies Campus	0		14		0%
St. Luke's Campus	0		45		0%
SF General Hospital		19		187	10.1%
St Francis Hospital		14		157	8.9%
St Mary's Hospital		29		199	14.6%
UCSF Medical Center		19		103	18.4%
TOTAL		**113**		**1192**	**10.5%**

Comparison Readmissions: SFTCP Clients vs City-wide Data (All-Cause, All Condition)



Next Steps...

- Continue to enhance CPMC and SFTCP Partnership
  - Feedback Loop
  - Readmission Case Review

Collaboration

Contact

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