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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California Pacific Medical Center

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San Francisco Department of Aging and Adult Services
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...
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
### 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>
<thead>
<tr>
<th>Group</th>
<th>Setting Discharged To</th>
<th>Number of Discharges</th>
<th>Number of Discharges Readmitted within 30 Days</th>
<th>30-Day Readmit Rate</th>
<th>Number of 30-Day Readmits to the same hospital</th>
<th>Percentage of 30-Day Readmits to the same hospital</th>
<th>Number of 30-Day Readmits to another hospital</th>
<th>Percentage of 30-Day Readmits to another hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Hospital</td>
<td>Home</td>
<td>3,096</td>
<td>573</td>
<td>18.9%</td>
<td>424</td>
<td>74.0%</td>
<td>149</td>
<td>26.0%</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing facility</td>
<td>613</td>
<td>106</td>
<td>17.3%</td>
<td>73</td>
<td>68.9%</td>
<td>33</td>
<td>31.1%</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency</td>
<td>1,081</td>
<td>213</td>
<td>15.7%</td>
<td>165</td>
<td>77.5%</td>
<td>48</td>
<td>22.5%</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>117</td>
<td>8</td>
<td>7.1%</td>
<td>3</td>
<td>50.0%</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>490</td>
<td>105</td>
<td>21.4%</td>
<td>56</td>
<td>53.3%</td>
<td>49</td>
<td>46.7%</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>5,337</td>
<td>1,093</td>
<td>18.8%</td>
<td>721</td>
<td>71.9%</td>
<td>212</td>
<td>28.1%</td>
</tr>
<tr>
<td>Region</td>
<td>Home</td>
<td>11,393</td>
<td>1,992</td>
<td>17.8%</td>
<td>1,433</td>
<td>71.9%</td>
<td>519</td>
<td>28.1%</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing facility</td>
<td>3,597</td>
<td>717</td>
<td>19.9%</td>
<td>477</td>
<td>66.5%</td>
<td>240</td>
<td>33.5%</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency</td>
<td>3,594</td>
<td>713</td>
<td>20.2%</td>
<td>545</td>
<td>68.7%</td>
<td>248</td>
<td>31.3%</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>333</td>
<td>24</td>
<td>7.2%</td>
<td>13</td>
<td>54.2%</td>
<td>11</td>
<td>45.8%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,880</td>
<td>405</td>
<td>21.5%</td>
<td>230</td>
<td>56.8%</td>
<td>175</td>
<td>43.2%</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>20,937</td>
<td>3,331</td>
<td>11.8%</td>
<td>2,598</td>
<td>68.6%</td>
<td>1,133</td>
<td>31.4%</td>
</tr>
<tr>
<td>California</td>
<td>Home</td>
<td>387,777</td>
<td>67,039</td>
<td>17.3%</td>
<td>49,265</td>
<td>73.5%</td>
<td>17,774</td>
<td>26.5%</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing facility</td>
<td>174,996</td>
<td>39,063</td>
<td>21.3%</td>
<td>28,555</td>
<td>73.1%</td>
<td>10,508</td>
<td>26.9%</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency</td>
<td>123,904</td>
<td>25,359</td>
<td>20.5%</td>
<td>19,802</td>
<td>78.1%</td>
<td>5,557</td>
<td>21.9%</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>15,916</td>
<td>515</td>
<td>3.9%</td>
<td>357</td>
<td>64.3%</td>
<td>198</td>
<td>35.7%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>52,533</td>
<td>10,717</td>
<td>20.2%</td>
<td>6,198</td>
<td>57.8%</td>
<td>4,519</td>
<td>42.2%</td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>755,226</td>
<td>142,733</td>
<td>11.9%</td>
<td>104,177</td>
<td>73.0%</td>
<td>38,556</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Group</th>
<th>Number of Discharges (Distinct Beneficiaries)</th>
<th>Number of Discharges Readmitted within 30 Days (Distinct Beneficiaries)</th>
<th>30-Day Readmit Rate (Distinct Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Hospital</td>
<td>3,965</td>
<td>722</td>
<td>18.2%</td>
</tr>
<tr>
<td>California</td>
<td>174,996</td>
<td>39,063</td>
<td>21.3%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Clinical Center</th>
<th>Number of Readmissions</th>
<th>Number of SFTCP Clients Served</th>
<th>Percent Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese Hospital</td>
<td>6</td>
<td>127</td>
<td>4.7%</td>
</tr>
<tr>
<td>CA Pacific Medical Center</td>
<td>26</td>
<td>419</td>
<td>6.2%</td>
</tr>
<tr>
<td>Pacific Campus</td>
<td>10</td>
<td>133</td>
<td>7.5%</td>
</tr>
<tr>
<td>Davies Campus</td>
<td>0</td>
<td>14</td>
<td>0%</td>
</tr>
<tr>
<td>St. Luke's Campus</td>
<td>0</td>
<td>45</td>
<td>0%</td>
</tr>
<tr>
<td>SF General Hospital</td>
<td>19</td>
<td>187</td>
<td>10.1%</td>
</tr>
<tr>
<td>St Francis Hospital</td>
<td>14</td>
<td>157</td>
<td>8.9%</td>
</tr>
<tr>
<td>St Mary's Hospital</td>
<td>29</td>
<td>199</td>
<td>14.6%</td>
</tr>
<tr>
<td>UCSF Medical Center</td>
<td>19</td>
<td>103</td>
<td>18.4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>113</strong></td>
<td><strong>1192</strong></td>
<td><strong>10.5%</strong></td>
</tr>
</tbody>
</table>
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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