VITAL2015
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Care Transitions: From Silos to Bridges

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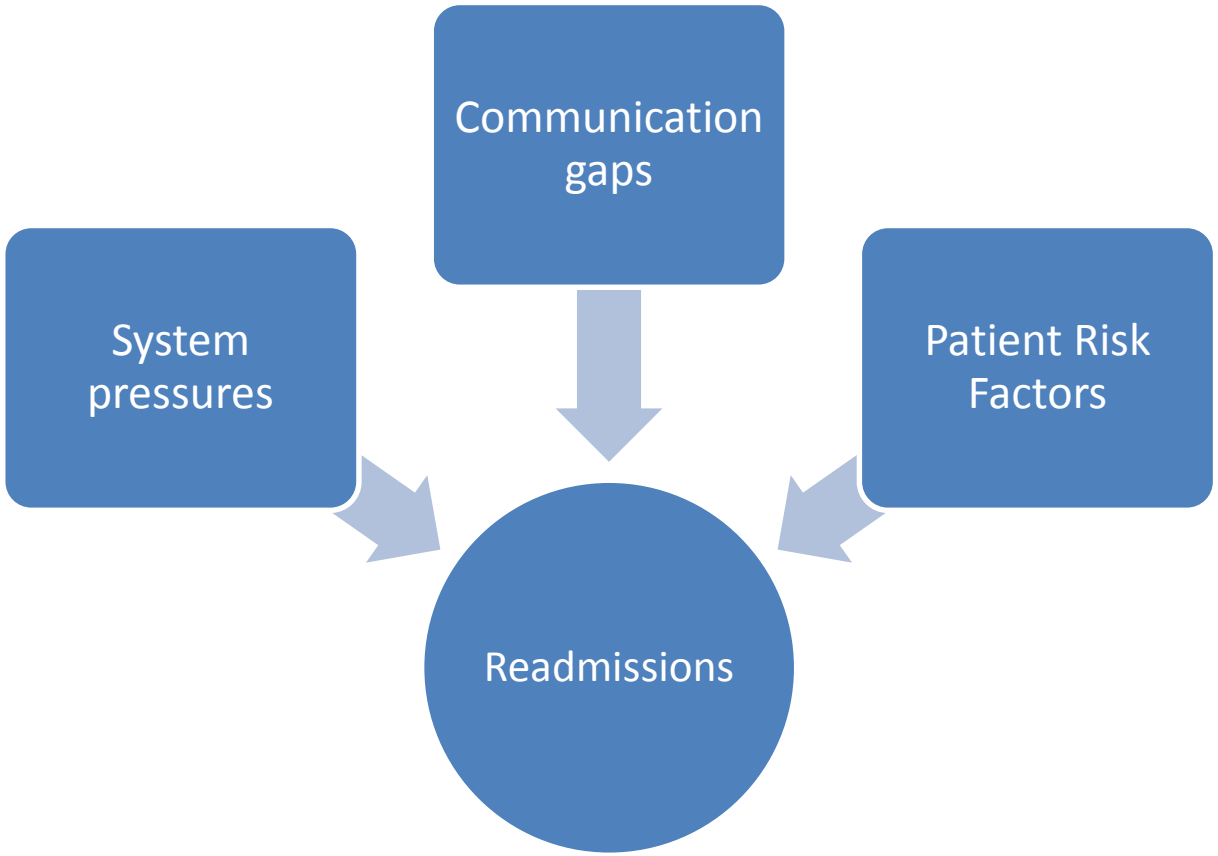
AMERICA'S ESSENTIAL HOSPITALS

Why do readmissions occur?




LOST
CONFUSED
UNSURE
UNCLEAR
PERPLEXED
DISORIENTED
BEWILDERED

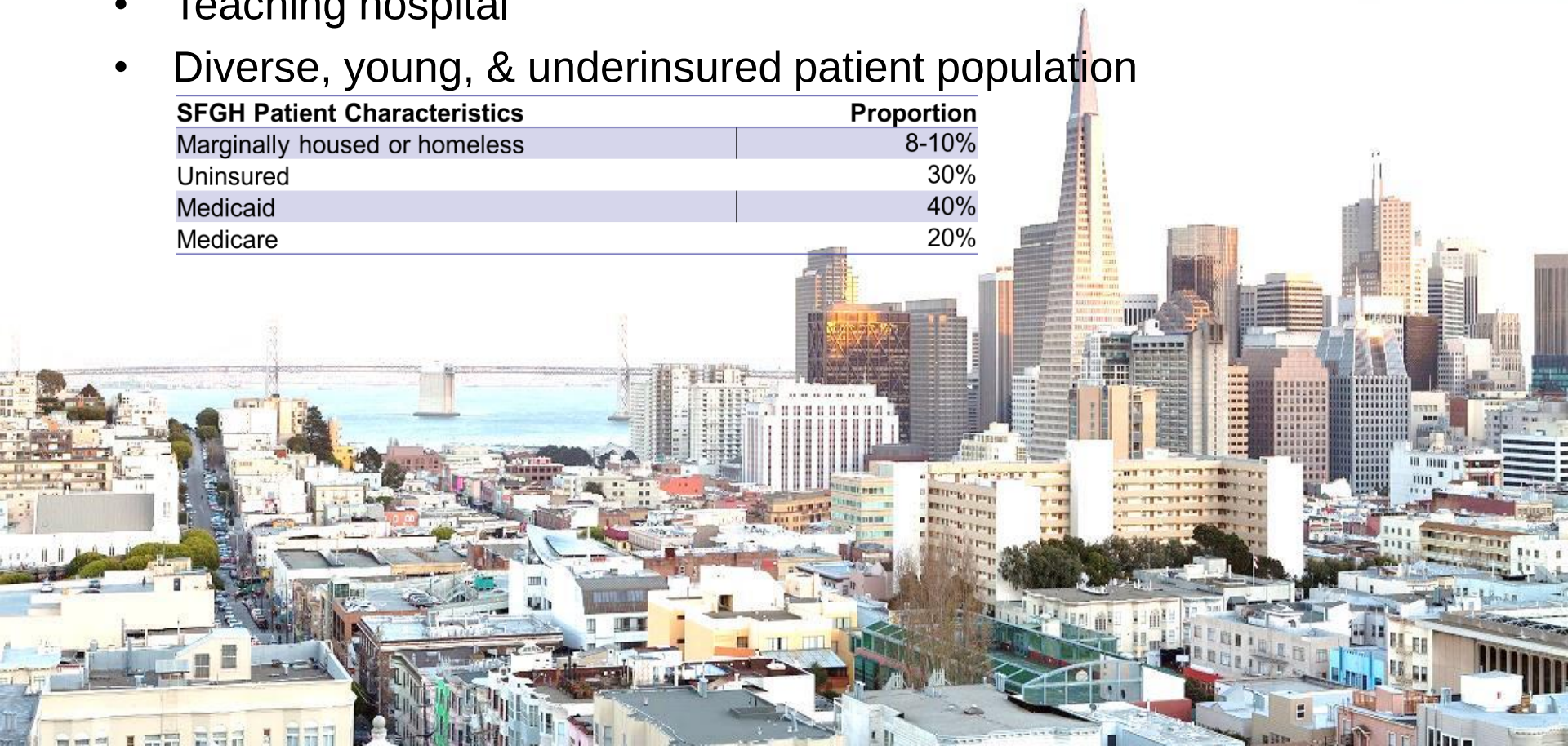
THE SF HEALTH NETWORK (SFHN) EXPERIENCE

SFHN: Integrated clinical enterprise of the SF Dept of Public Health

San Francisco General Hospital

- Only public safety net hospital, trauma center in San Francisco
- Teaching hospital
- Diverse, young, & underinsured patient population

SFGH Patient Characteristics	Proportion
Marginally housed or homeless	8-10%
Uninsured	30%
Medicaid	40%
Medicare	20%



CHALLENGES

2012 Unmet Operational Goals:

- Provide patients with tools to stay out of hospital
- Bridge silos across Network
- Provide a centralized access point of information
- Standardize and improve processes of care

- Reduce readmissions by 15 percent

SUPPORT FROM HOSPITAL TO HOME (SHHE) TRIAL

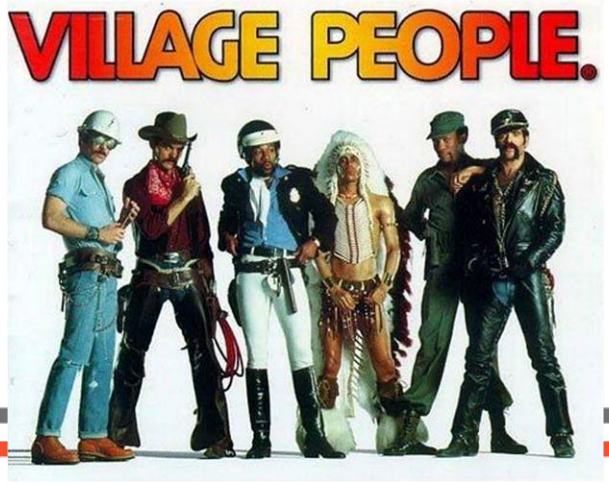
- Randomized trial of usual care vs RN-based self-management education with follow-up coaching phone calls.
  - » Built on best practices of RED and Coleman models
- 699 patients age >55, linguistically and ethnically diverse, discharged to community.
- No difference in readmission or ED visits, with trend towards increase in ED visits.
- Conclusion: Cannot assume successful interventions studied in other populations will be effective in the safety net.

Goldman LE et al. *Ann Intern Med.* 2014; 161(7).

EARLY IMPROVEMENT WORK

SFGH Care Transitions Taskforce

- Established Fall 2012
  - » Grassroots group from across SFHN with interest in care transitions
  - » Initial goal: Bring all relevant stakeholders to the table to develop mission, charter, and deliverables

it takes a 

to improve the quality & safety of care transitions

Considerations and components	
Shared mission	Goal and aim statement
Stakeholders	Cross-continuum Interdisciplinary
Schedule	Established with group input
Statistics	At least one target metric
Sponsorship	Required at executive level
Staff	Dedicated point person/organizer

SFGH Care Transitions Taskforce

Shared mission	Reduce readmissions at SFGH by 15% and improve processes or care.
Stakeholders	• Inpatient: MD, RN, Rx, PT, SW • Outpatient: MD, RN, Rx, CM
Schedule	• Biweekly meetings • Working group meetings
Statistics	• 30 day readmission rate • 7 day post discharge follow-up
Sponsorship	Past chief of staff
Staff	Care transitions analyst and two physician coordinators

CARE TRANSITIONS TASKFORCE: FIRST STEPS

- Initial Taskforce goals:
  - » Conduct inventory of transitions initiatives across Health Network
  - » Do gap analysis/needs assessment
  - » Gather data
  - » Strategize around initiating improvement work

INVENTORY?

Post-discharge Bridge Clinic

Medical Respite & Sobering Center

ED High User Case Management Program

Complex Care Management Teams

Primary Care

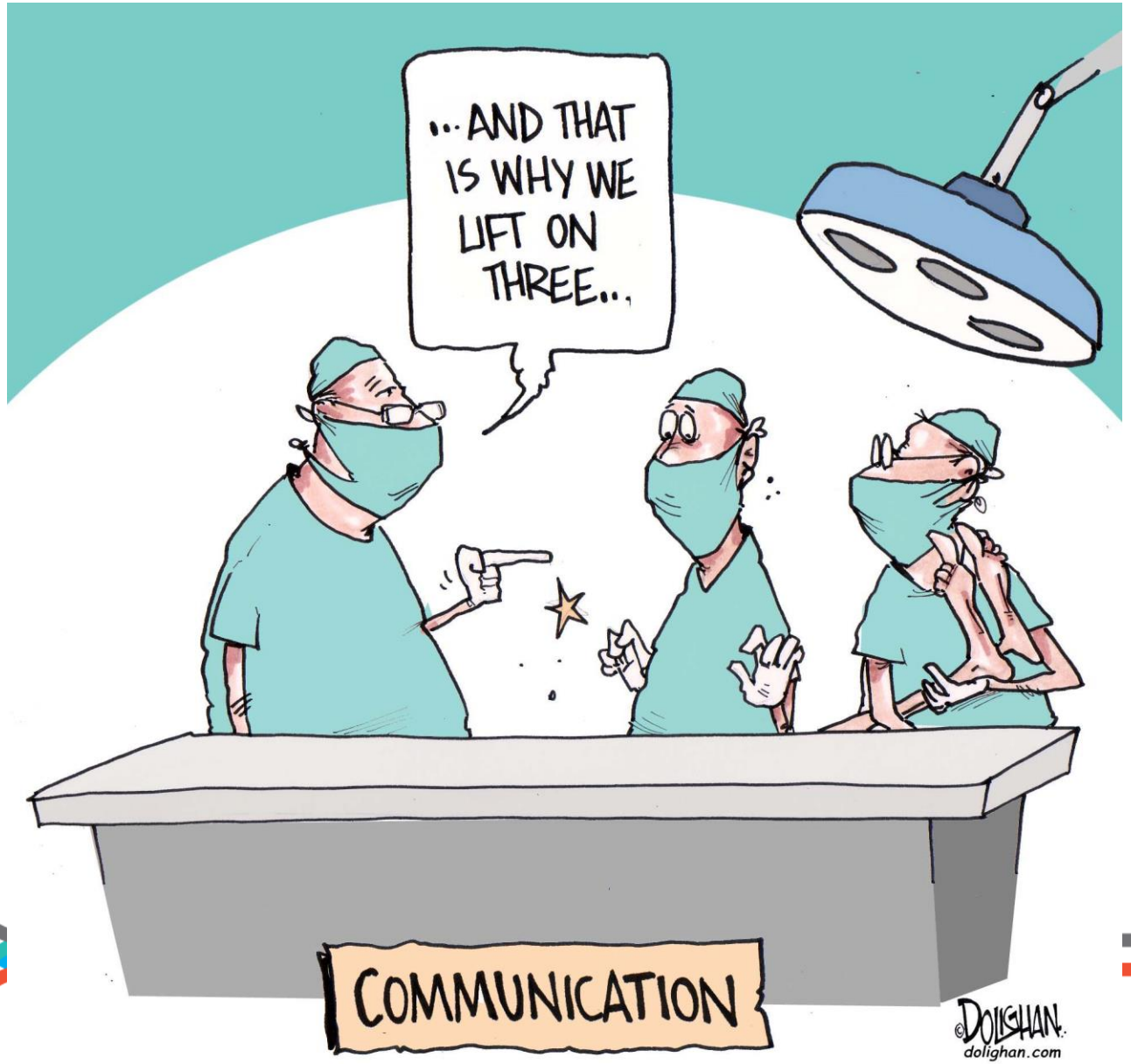
SNF & Rehab Care

CARE TRANSITIONS TASKFORCE: FIRST STEPS

SFGH Care Transitions Taskforce

- Initial goals:
  - » Conduct inventory transitions initiatives across SFHN
  - » Do gap analysis/needs assessment
  - » Gather data
  - » Strategize around initiating improvement work

GAP ANALYSIS: COMMUNICATION



GAP ANALYSIS: COORDINATION & TARGETED INTERVENTION

- Lack of timely follow-up post-discharge
- No definition of/approach to high-risk patients
- No process for deploying right intervention to right patient
- No data to support the work

CARE TRANSITIONS TASKFORCE: FIRST STEPS

SFGH Care Transitions Taskforce

- Initial goals:
  - » Conduct inventory of transitions initiatives across SFHN
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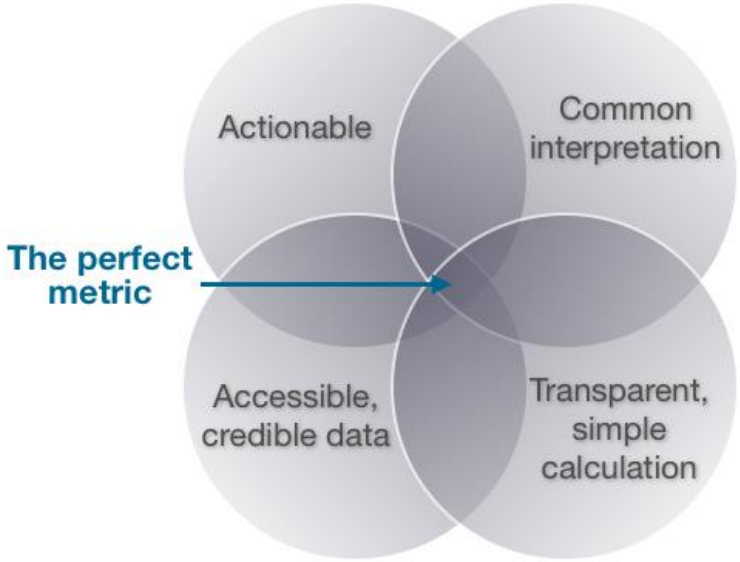
DATA & DASHBOARDS

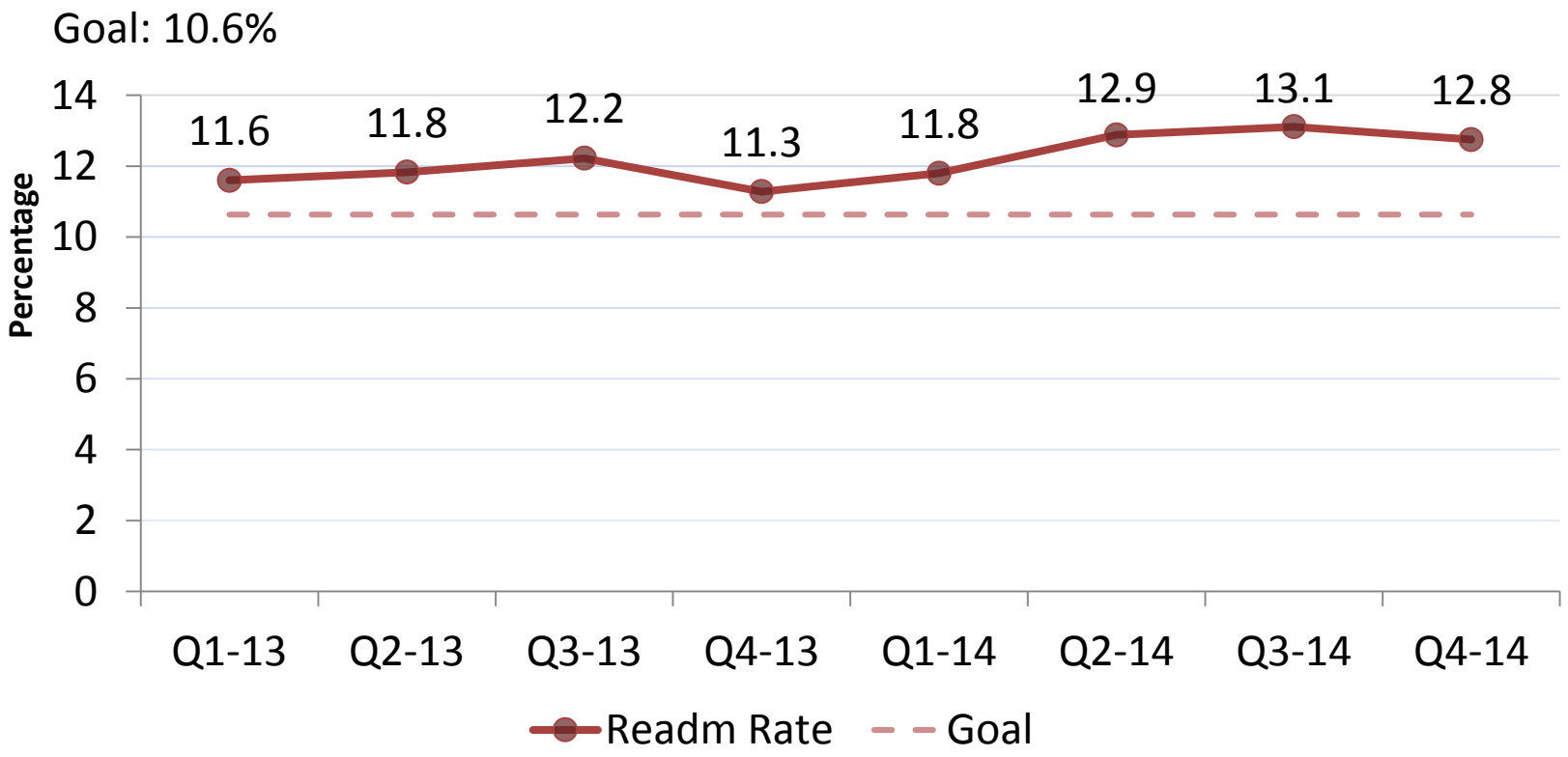
- >60 siloed databases
- Iterative process to find relevant process and outcome measures



"Data isn't like your kids, you don't have to pretend to love them equally."

Amanda Cox, NY Times

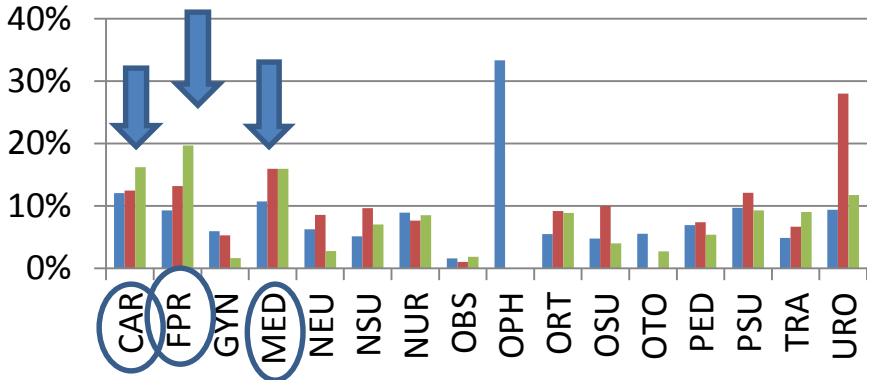
SFGH 30-DAY ALL-CAUSE READMISSION RATE

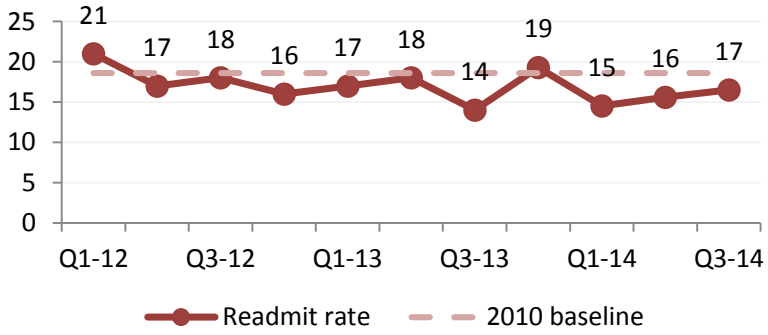


Source: UHC

DASHBOARD: READMISSION VARIABLES

- Service and unit
- DRG
- Homeless
- Mental health/ substance use dx
- Zip code
- Patients who leave AMA





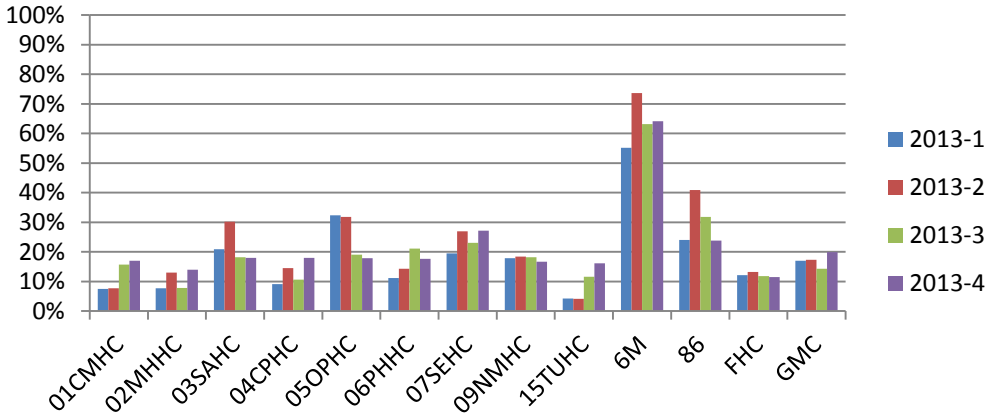
Location*	Zip Code	Count
1. Bayview	94124	223
2. Mission	94110	211
3. SOMA	94103	196
4. Civic Center/Hayes Valley	94102	171
5. Balboa Park/Excelsior	94112	166
6. Visitacion Valley	94134	119
7. Tenderloin/Nob Hill/ Russian Hill	94109	79
8. Potrero Hill/ Dogpatch/ Mission Bay	94107	51
9. Sunset District	94116	47
10. Pac Heights/Lower Pac Heights/Western Addition	94115	45

*Determined using Google Maps

Index DRG	2013-1	2013-2	2013-3	Avg
CHF NOS	22%	20%	39%	27%
PNEUMONIA ORGANISM NOS	15%	14%	17%	15%
ABDOMINAL PAIN-SITE NOS	11%	24%	20%	18%
ALCOHOL WITHDRAWAL	15%	21%	20%	19%
SHORTNESS OF BREATH	17%	13%	21%	17%

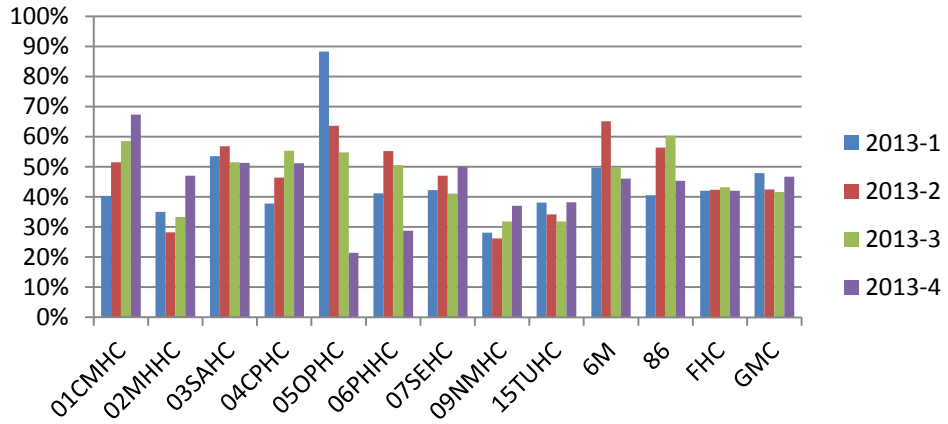
DASHBOARD: PRIMARY CARE PROCESS MEASURES

Proportion of Patients Attending PCP F/U Appt Within 7 Days



Definition: # patients discharged from SFGH who attend any PCP, RN, or pharmacy appointment at PCH within 7 days/# patients discharged from SFGH who have CHN/COPC providers; excludes patients with providers outside of CHN/COPC and patients unassigned to PCP. Stratified by clinic.

Proportion of Patients Attending Any F/U Appt Within 7 Days



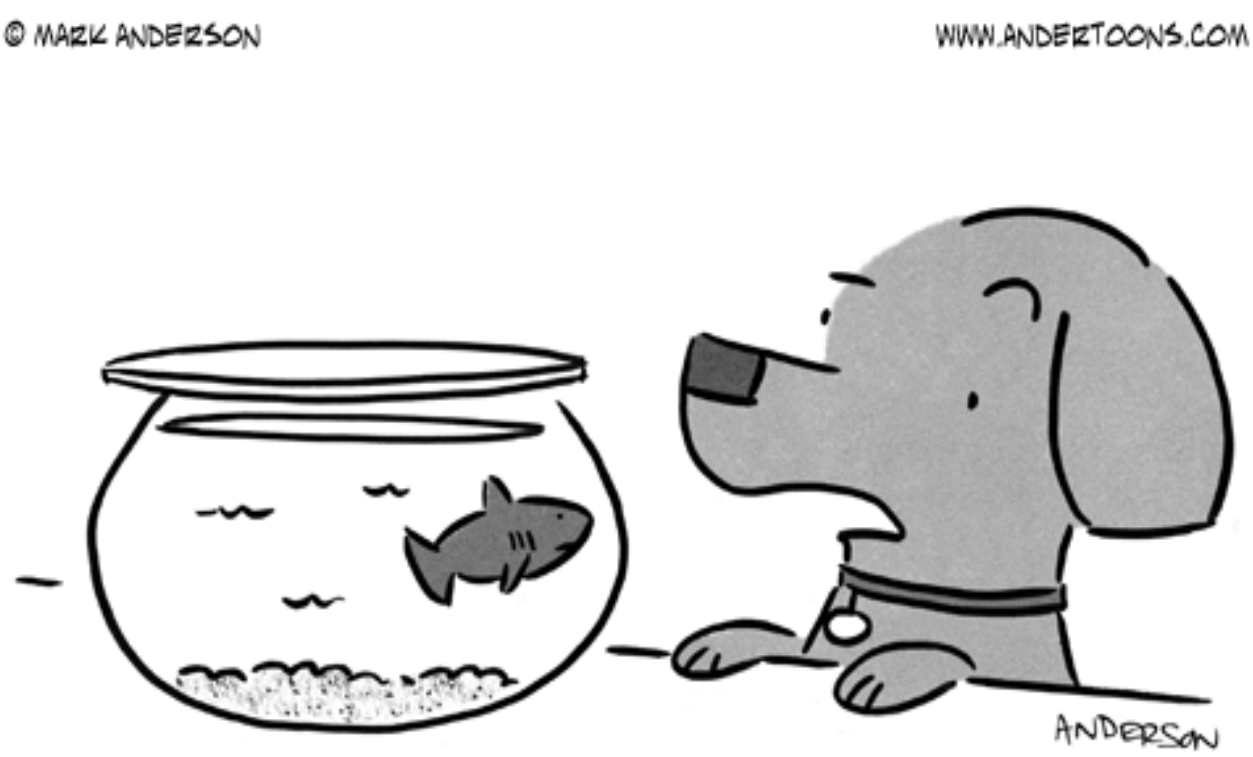
Definition: # patients discharged from SFGH who attend any appointment (primary care or specialty) within 7 days/# patients discharged from SFGH; excludes patients with providers outside of CHN/COPC and W82 Urgent Care. Includes patients without PCP. Stratified by clinic.

DASHBOARD: PROMPTING IMPROVEMENT WORK

- Our data showed us:
  - » Timely outpatient follow-up inadequate
  - » Few patients going to SNFs, SNF readmissions low
  - » CHF readmissions = pain point

- Our data prompted action plan:
  - » Partnering with primary care leadership
  - » Disseminating data to outpatient stakeholders
  - » Pilots of new care transitions initiatives
  - » Scaling up successful pilots

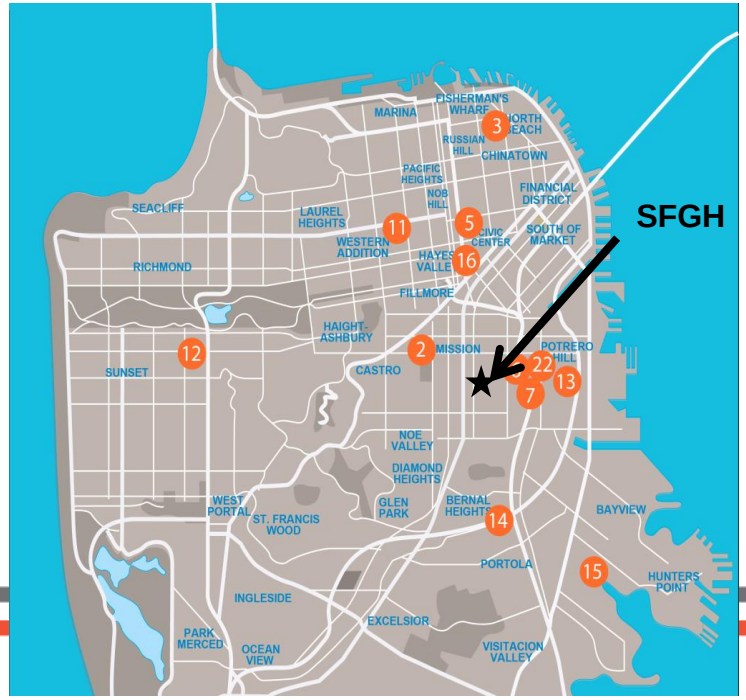
PARTNERSHIP



"You make a good point; we both hate the cat.
I'm just not sure what it is you'd bring to a partnership."

PARTNERING WITH PRIMARY CARE: KEY CONCEPTS

- Essential to have primary care representatives as part of the core group of a hospital-based care transitions taskforce.
- Hospital-based care transitions efforts must have buy-in of primary care leadership.



There are 12 SF Health Network primary care clinics for adults.

PARTNERING WITH PRIMARY CARE: EXAMPLE OF EARLY PILOT

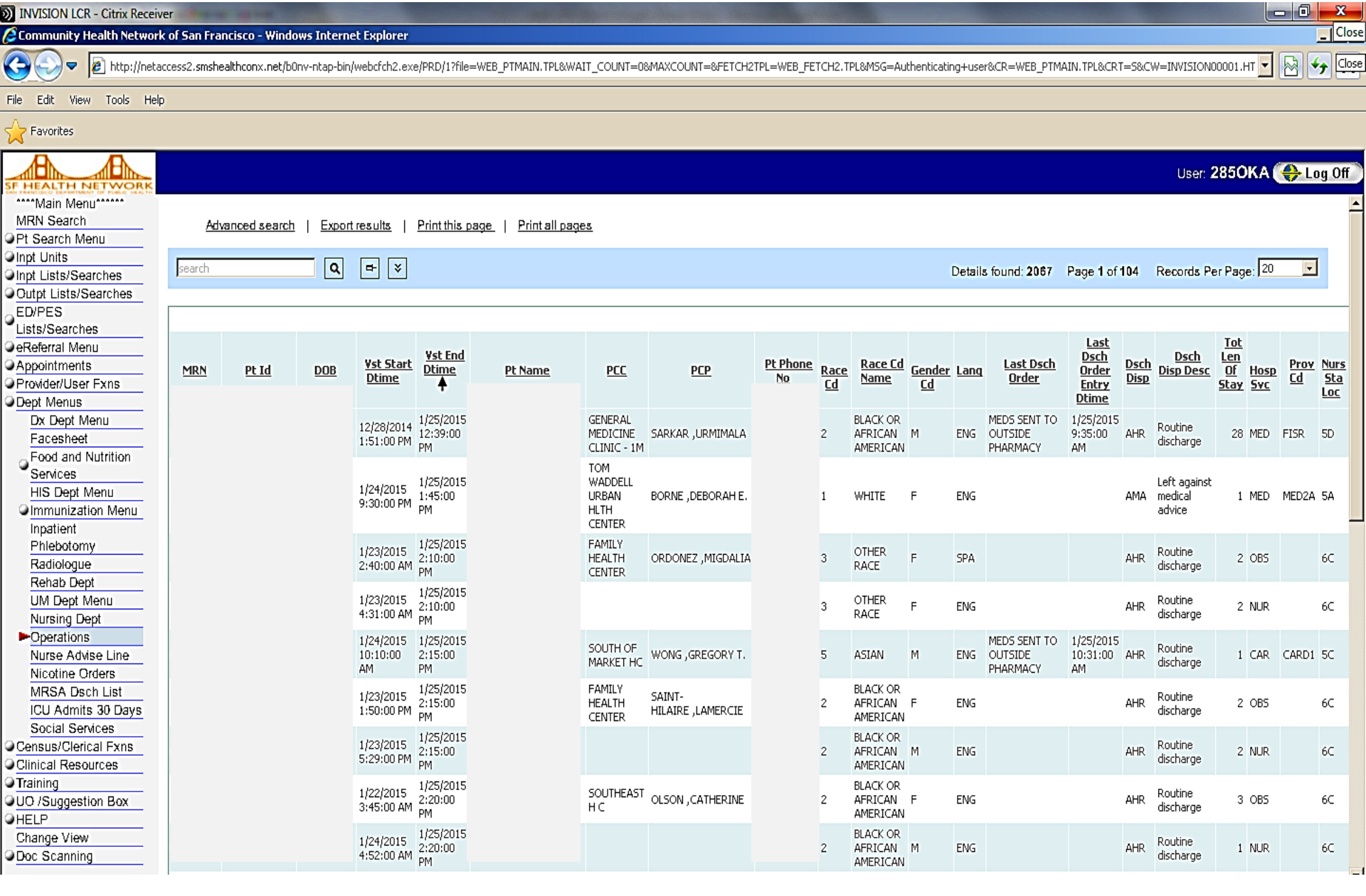
- California Quality Collaborative Pilot:
  - » Three primary care sites
  - » Two different approaches
    1. Resource intensive, team-based approach, high touch, limited target population
    2. Resource limited, lower touch, broader reach
- Both pilots increased scheduled and attended follow-up
- 2nd pilot expanded to other clinics

TAACT
TAKE ACCOUNTABILITY FOR AMBULATORY CARE TRANSITIONS

LEARNINGS FROM PRIMARY CARE PILOTS: DISCHARGE DATABASE

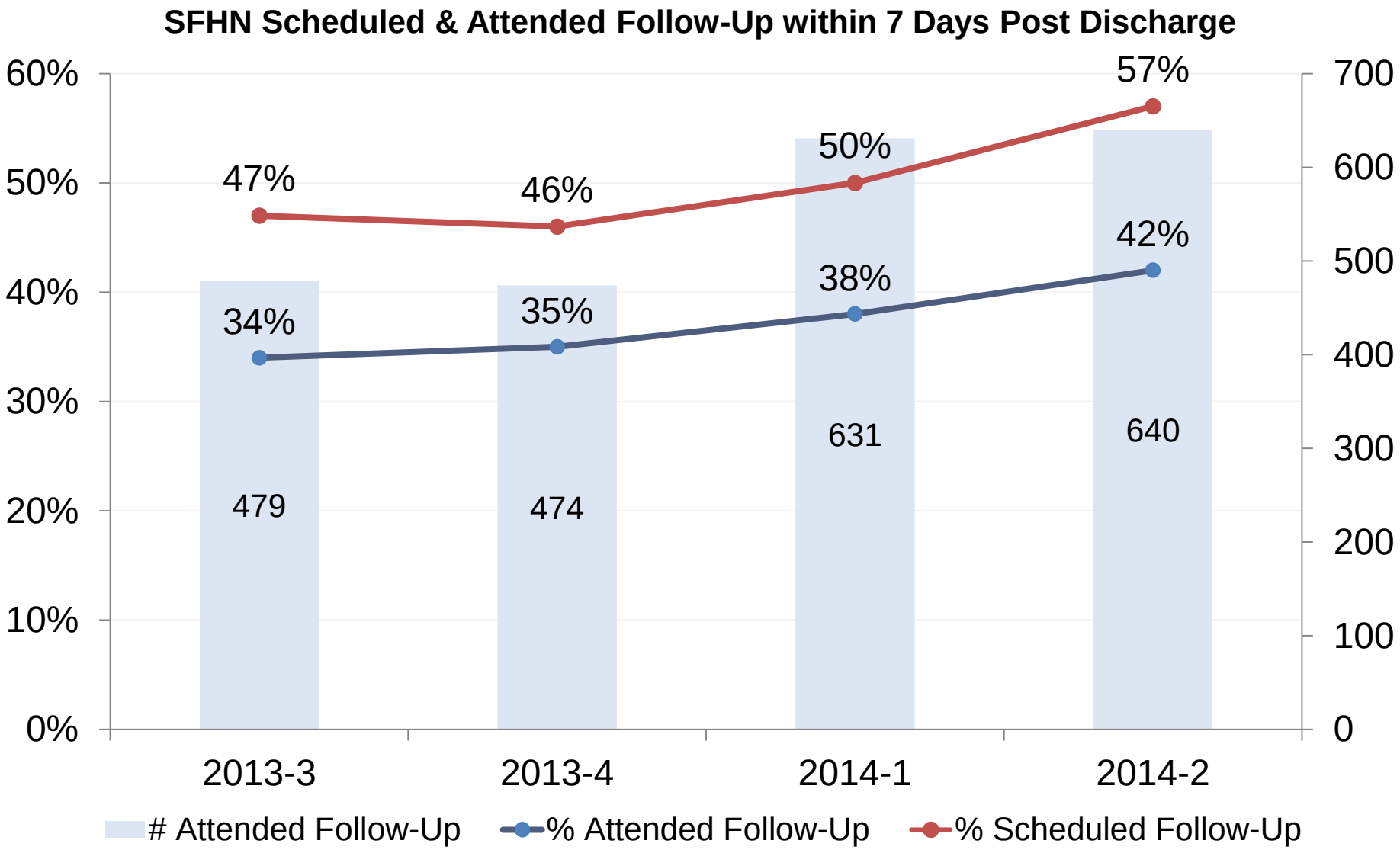
- Clinics needed timely information about discharged patients.
- SFGH Discharge Database:
  - » Integrated into EHR, updated daily
  - » Accessible to inpatient and outpatient staff & providers
  - » Sortable & customizable
  - » Integrated into work flow -> ideally reduces work
- Initially piloted at two SFHN clinics – now implemented across network.

DISCHARGE DATABASE

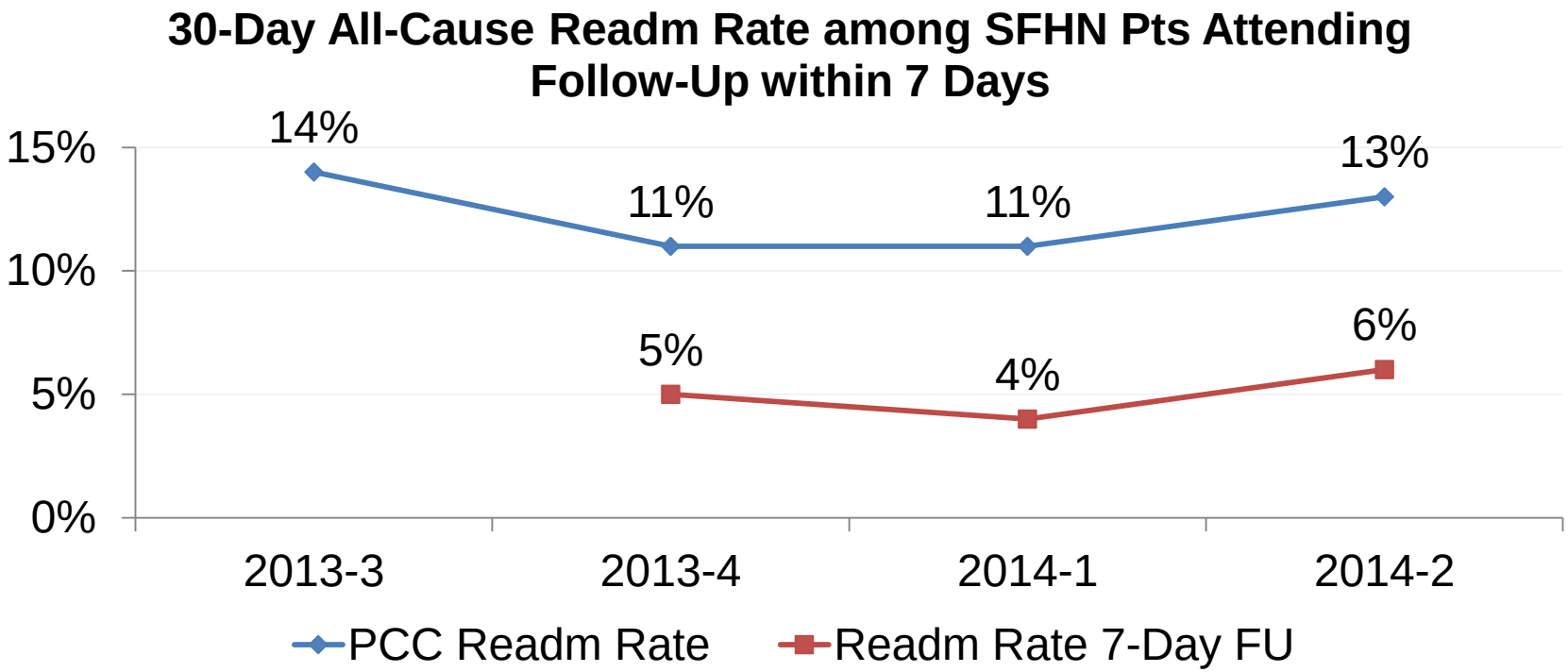


MRN	Pt Id	DOB	Vst Start Dtime	Vst End Dtime	Pt Name	PCC	PCP	Pt Phone No	Race Cd	Race Cd Name	Gender Cd	Lang	Last Dsch Order	Last Dsch Order Entry Dtime	Dsch Disp	Dsch Disp Desc	Tot Len Of Stay	Hosp Svc	Prov Cd	Nurs Sta Loc
			12/28/2014 1:51:00 PM	1/25/2015 12:39:00 PM		GENERAL MEDICINE CLINIC - 1M	SARKAR ,URMIMALA		2	BLACK OR AFRICAN AMERICAN	M	ENG	MEDS SENT TO OUTSIDE PHARMACY	1/25/2015 9:35:00 AM	AHR	Routine discharge	28	MED	FISR	5D
			1/24/2015 9:30:00 PM	1/25/2015 1:45:00 PM		TOM WADDELL URBAN HLTH CENTER	BORNE ,DEBORAH E.		1	WHITE	F	ENG			AMA	Left against medical advice	1	MED	MED2A	5A
			1/23/2015 2:40:00 AM	1/25/2015 2:10:00 PM		FAMILY HEALTH CENTER	ORDONEZ ,MIGDALIA		3	OTHER RACE	F	SPA			AHR	Routine discharge	2	OBS		6C
			1/23/2015 4:31:00 AM	1/25/2015 2:10:00 PM					3	OTHER RACE	F	ENG			AHR	Routine discharge	2	NUR		6C
			1/24/2015 10:10:00 AM	1/25/2015 2:15:00 PM		SOUTH OF MARKET HC	WONG ,GREGORY T.		5	ASIAN	M	ENG	MEDS SENT TO OUTSIDE PHARMACY	1/25/2015 10:31:00 AM	AHR	Routine discharge	1	CAR	CARD1	5C
			1/23/2015 1:50:00 PM	1/25/2015 2:15:00 PM		FAMILY HEALTH CENTER	SAINT-HILAIRE ,LAMERCIE		2	BLACK OR AFRICAN AMERICAN	F	ENG			AHR	Routine discharge	2	OBS		6C
			1/23/2015 5:29:00 PM	1/25/2015 2:15:00 PM					2	BLACK OR AFRICAN AMERICAN	M	ENG			AHR	Routine discharge	2	NUR		6C
			1/22/2015 3:45:00 AM	1/25/2015 2:20:00 PM		SOUTHEAST H C	OLSON ,CATHERINE		2	BLACK OR AFRICAN AMERICAN	F	ENG			AHR	Routine discharge	3	OBS		6C
			1/24/2015 4:52:00 AM	1/25/2015 2:20:00 PM					2	BLACK OR AFRICAN AMERICAN	M	ENG			AHR	Routine discharge	1	NUR		6C

PARTNERING WITH PRIMARY CARE: POST-DISCHARGE ACCESS



PARTNERING WITH PRIMARY CARE
POST-DISCHARGE ACCESS



	Median	Range
2013-4	5%	0-8%
2014-1	4%	0-8%
2014-2	6%	0-11%

INPATIENT WORK

- Communication & Coordination:
  - » Email prompt built into EHR
  - » Discharge summary and patient discharge plan built-in to EHR
  - » Post-discharge follow-up scheduled prior to discharge
  - » Warm line established

- Agreed-upon definition of high risk patients

Care Transitions Taskforce members brainstorm barriers to successful transitions within the SF Health Network.

INTERVENTIONS FOR HIGH RISK PATIENTS

- Standardized approach to deployment of interventions for high risk patients
  - » SFGH Transitional Care Nursing Program
  - » CHF Transitions Pharmacist
  - » SF Community Care Transitions Program

Richard Santana RN & bedside nurse check on a patient enrolled in the SFGH Transitional Care Nursing program.

TRANSITIONAL CARE NURSING: MEDICATION INSTRUCTIONS

Polyglot's Meducation™

SF HEALTH NETWORK

San Francisco General Hospital and Trauma Center
1001 Potrero Ave, San Francisco, CA 94110
415-206-4901

ID: HKLN525E
Created: 2/18/2015

EVERY DAY: Medicine you need to use every day.

	Morning	Noon	Evening	Bedtime	
Amlodipine 10 MG Oral Tablet	1				Take by MOUTH. For high blood pressure. You should keep taking this medicine until you are told to stop.
Benazepril HCl Tablet 10 mg	1				Take by MOUTH. For high blood pressure. You should keep taking this medicine until you are told to stop.
doxycycline 100mg	1		1		Take by MOUTH. For pneumonia. Use for 7 days.
Qvar Inhaler 80 mcg/inh	2 puffs		2 puffs		BREATHING medicine. For asthma. You should keep taking this medicine until you are told to stop.
atorvastatin 40 MG Oral Tablet				1	Take by MOUTH. For high cholesterol. You should keep taking this medicine until you are told to stop.

- 5th to 8th grade reading level
- Uses Universal Medication Scheduling language & pictograms

Can be translated into 18 different languages

n Francisco General Hospital and Trauma Center
1001 Potrero Ave, San Francisco, CA 94110
415-206-4901

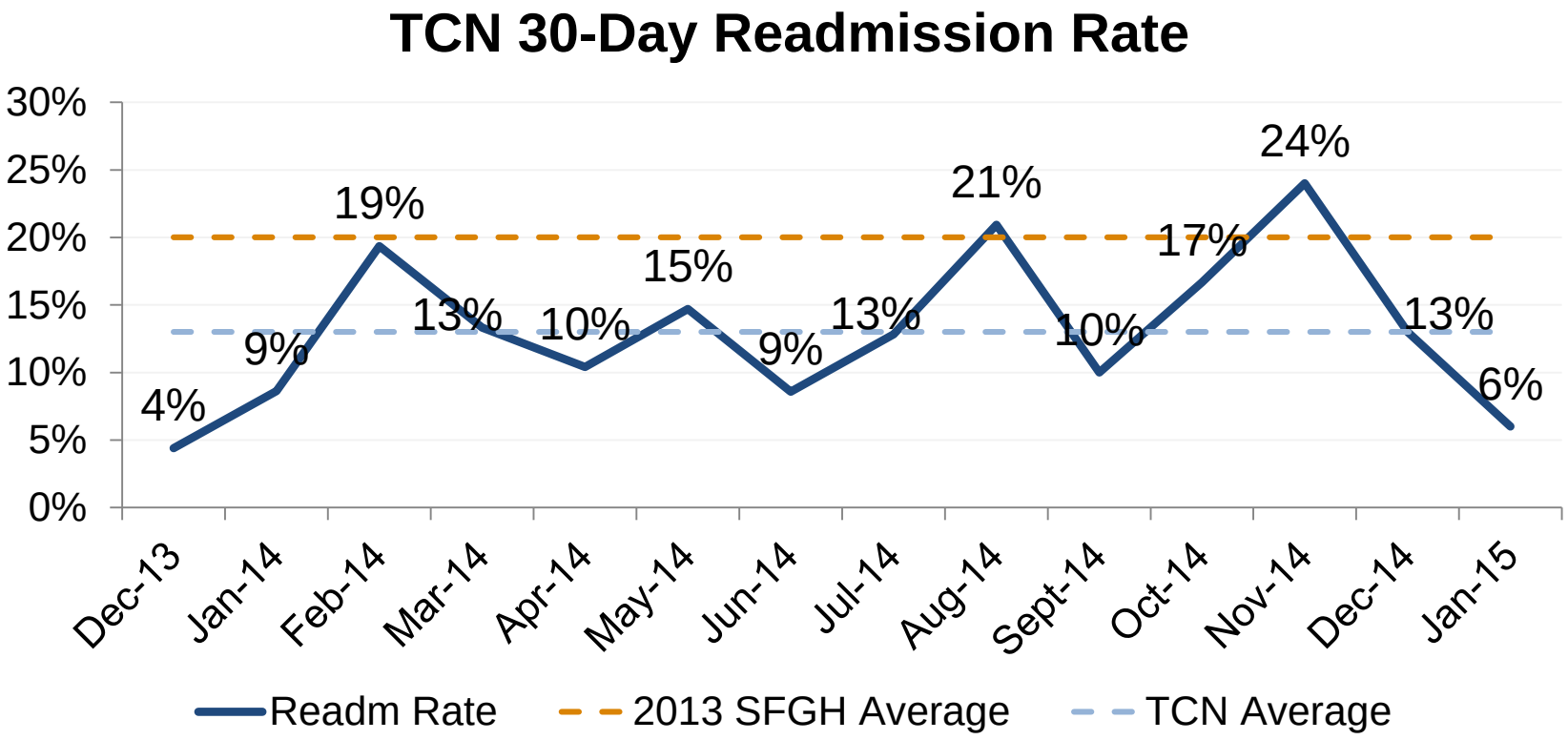
SF HEALTH NETWORK

ID: HKLN525E
Created: 2/18/2015

每天：需要每天使用的藥物。

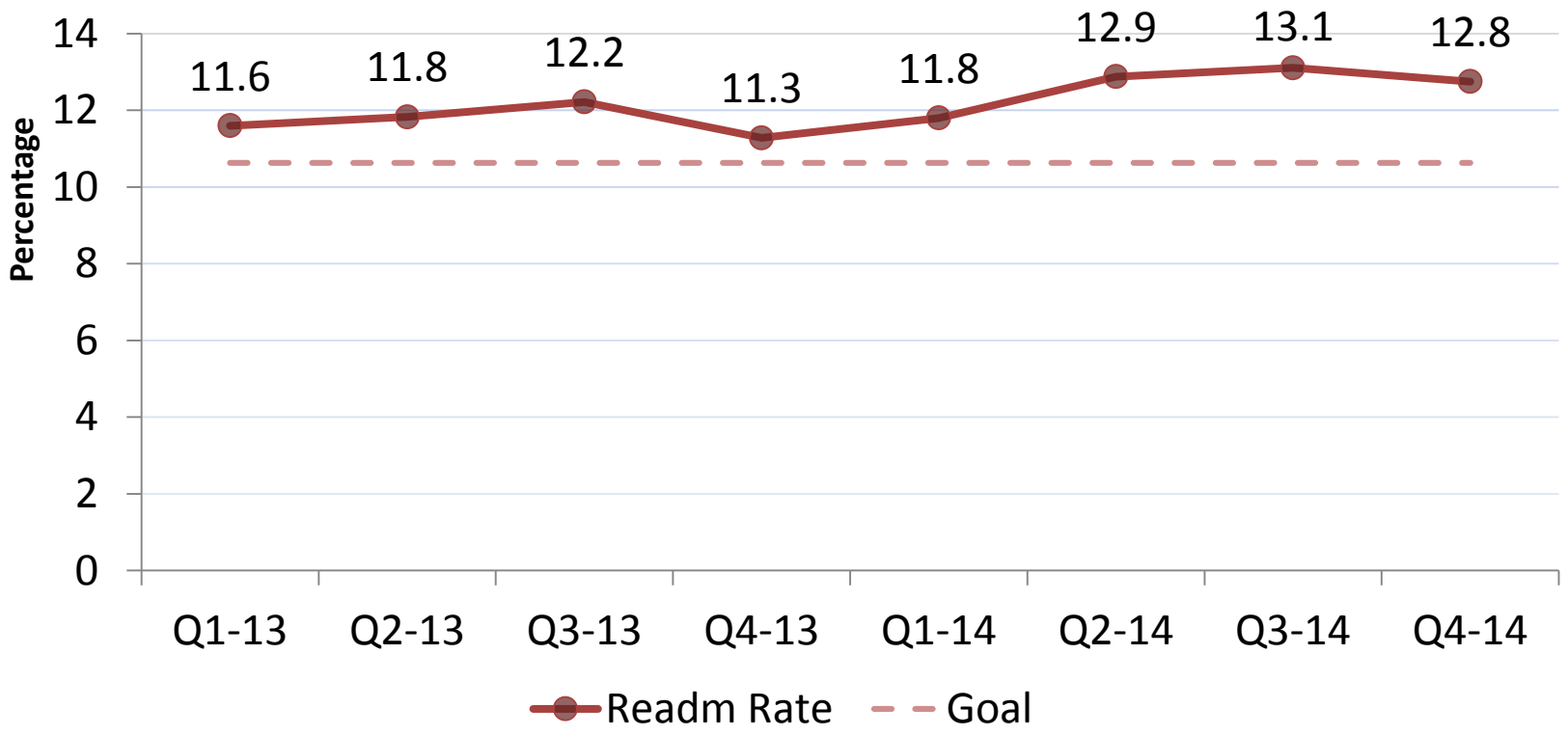
	早上	中午	傍晚	就寢時	
Amlodipine 10 MG Oral Tablet	1				口服。 用來治療高血壓。 您應持續服用本藥物，直到醫師指示停止服用為止。
Benazepril HCl Tablet 10 mg	1				口服。 用來治療高血壓。 您應持續服用本藥物，直到醫師指示停止服用為止。
doxycycline 100mg	1		1		口服。 用來治療肺炎。 使用 7 天。
Qvar Inhaler 80 mcg/inh	2 口		2 口		呼吸用藥。 用來治療氣喘。 您應持續服用本藥物，直到醫師指示停止服用為止。
atorvastatin 40 MG Oral Tablet				1	口服。 用來控制高膽固醇。 您應持續服用本藥物，直到醫師指示停止服用為止。

TRANSITIONAL CARE NURSING: READMISSION RATES



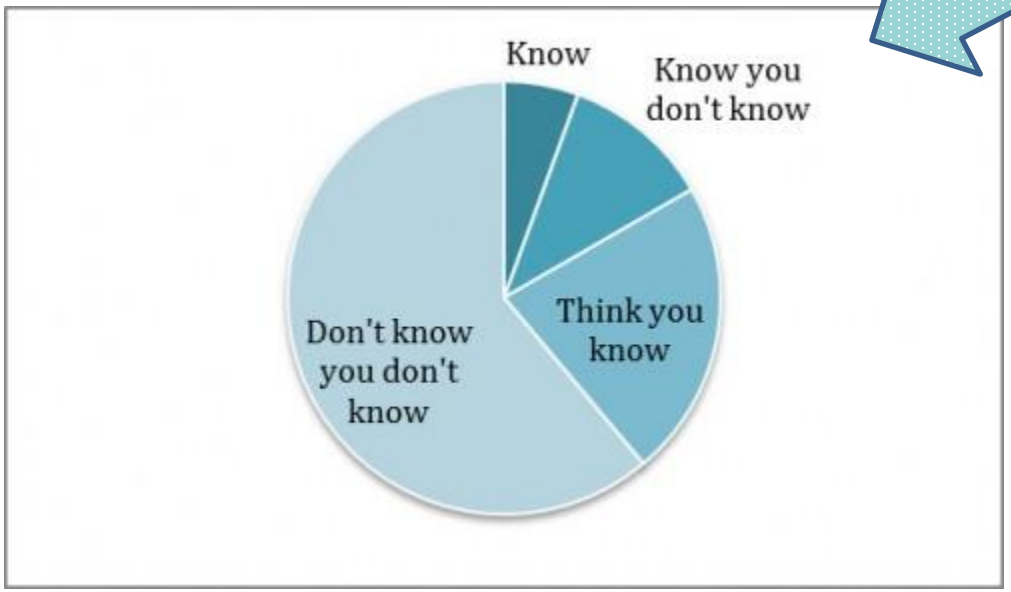
SFGH 30-DAY ALL-CAUSE READMISSION RATE

Goal: 10.6%



Source: UHC

NEW DIRECTIONS



READMISSION ANALYSIS: NEW LEARNINGS

Analysis of Readmissions	
Payer source	Medi-Cal readmissions > Medicare & uninsured
Behavioral health burden	22% of Medi-Cal readmissions with behavioral health diagnosis (vs. 11% total readmissions)
High users	20% of the Medi-Cal readmissions driven by 220 people
Timing of readmission	36% w/in 7 days of discharge
Diagnoses	Top 10 discharge diagnoses→only 26% of all readmissions

PATIENT & PROVIDER INTERVIEWS

Patient Interview Findings
1. **Housing, transportation, money**: “I have trouble with transportation and money. I don't want to use money to take public transportation to go to see doctors often."
2. **Medication-related issues**: "If I had enough medication, I wouldn’t be here.“
3. **Better access to intensive services**: “Respite is good…but I probably need more.”
4. **Discharged too early**: "Maybe if the hospital could keep me a little longer for observation."
5. **Substance use & environmental factors**: “[My] lifestyle is the same once I leave the hospital…the habit grabs me back…smoking and drinking."
6. **Nutrition**: “I have diabetes and high blood pressure…I try to follow my diets but it still didn't help me stay out of the hospital.”

Provider Quotes
1. “The pt has an IHSS worker for 4 hours/day who does an excellent job of overseeing her medications and care…when the IHSS worker is not there, the pt does not use her COPD medications or ambulate as we have recommended…could be helpful to increase the daily hours for the IHSS worker.”
2. “This patient needs long term housing of a kind that's minimally available in SF. She would be a good candidate for intensive case management or for HUH housing.”
3. “The patient wasn't ready to be discharged…the patient was organized and literate…but wasn't back to baseline when she was sent home, so at her timely follow-up appointment, we sent her to the ED and she was readmitted.”

Source: HOMERUN

NEXT STEPS

- Deeper dive into Medi-Cal population
- Partnering with managed Medi-Cal programs
- Examining frequent users and their impact
- Partnering with behavioral health and case management
- Ongoing innovations and improvements
  - » Creating robust outpatient CHF program
  - » Expanding role of pharmacists across the Network
  - » Improving tools for LEP and LHL patients
  - » Bringing the patients' voice to the taskforce

KEY LESSONS

- A cross-continuum, multidisciplinary team is an important part of care transitions improvement work - it takes a village!
- Hospitals benefit from partnering with primary care; engaging primary care leadership should be a key strategy in care transitions improvement work.
- Other key strategies include identifying high risk patients & deploying right intervention to right patient at right time