Reducing Readmissions Rates through Coordination and Communication

San Francisco General Hospital

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San Francisco General Hospital (SFGH) is the only public safety net hospital in San Francisco. Its patient population is diverse and particularly at risk for readmission. On average, 8-10 percent of admitted patients are marginally housed or homeless. According to the SFGH Annual Report (Fiscal Year 2012-2013), approximately 30 percent of patients are uninsured, 40 percent are Medicaid and 20 percent are Medicare. Nine percent of patients are over the age of 65.

SFGH leadership recognized an opportunity to lead the way in developing a comprehensive, systems-based care transitions program that would provide patients with the proper care and the tools they need to stay out of the hospital. The SFGH Care Transitions Taskforce was chartered for this purpose in October of 2012. The Taskforce grew through grassroots relationship-building into an organized, multidisciplinary working group comprised of inpatient and outpatient providers. Their collective goal is to reduce readmissions by 15 percent and standardize processes of care. The Taskforce serves as a central organizing platform which supports pilots of new formal care transitions initiatives, helps to disseminate projects throughout the network of providers in the continuum, and partners with initiatives that include but are not limited to the San Francisco Health Network.

One such initiative is the CMS-funded San Francisco Community Care Transitions Project (SFCCTP). The SFCCTP is a coalition of eight hospitals, nine community-based organizations and the San Francisco Department of Aging & Adult Services that works to bridge the gap between hospital discharge and strong recovery. For up to six weeks post-discharge, social workers provide coaching, care coordination and services previously unavailable to elderly and disabled patients.

The Care Transitions Taskforce has successfully minimized duplication of services and allowed for more effective communication between providers in order to optimize efficiency and improve patient outcomes. The Taskforce has also invested in streamlining access to medical information by creating a robust data dashboard which allows inpatient and outpatient care teams to receive timely and meaningful feedback about readmissions and process measures of care transitions. The taskforce is currently working on improving identification of patients who will most benefit from transitions interventions.

In the Fall of 2012, the SFGH Transitional Care Nursing Program was implemented to foster safer transitions from the hospital to the community and to prevent readmissions among high-risk patients (≥55 years old with core measure diagnoses). This nursing-based intervention incorporates motivational interviewing, bedside teaching and coaching, expanded medication reconciliation, a personalized discharge plan, and post discharge phone calls for 30 days. The program now averages a 30-day, all-cause readmission rate of 10 percent (Figure 1).

Critical Components

Leadership involvement is critical to facilitating culture change and sustaining successful programs. Despite limited resources, the Taskforce has increased its membership (30+ active contributors), gained executive sponsorship, and enhanced health information technology.

Relationship building within the community is essential for the sustainability of the program. The partnerships between SFGH and key community stakeholders have promoted improvements in coordinated care delivery, increased access to medical information, and enhanced care transitions from hospital to home.