Improving Care Transitions: Creating Your Evidence-Based Approach

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San Francisco Health Network Primary Care
San Francisco General Hospital
Assistant Clinical Professor
UCSF Dept. of General Internal Medicine
Outline

• Readmissions vs Care Transitions
• Quality Improvement Drivers
• Connecting the Best Case Models
• Our Work in Progress
• Current Understanding and Vision
Readmission Basics

• In 2011: **3.3 million** 30 day readmissions among adults in US

<table>
<thead>
<tr>
<th>Condition</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare national average</td>
<td>18%</td>
</tr>
<tr>
<td>COPD</td>
<td>17-25%</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>20%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>25%</td>
</tr>
</tbody>
</table>

• Medicare cost: **$15 to $17 billion per year**

• **SFGH all cause readmission rate 2013-2014**: **12.6%**
Readmissions: A Complicated Metric

- **Definition**: is 30 days an appropriate timeframe?

- **Data**: no comprehensive source, easier to get subgroup data

- **Universal access** leads to increased utilization (esp. among lower SES)

- **Risk adjustment**: similar %’s between systems if control for patient characteristics

- **Preventable?** 23-30% readmissions appear to be avoidable

- **No national consensus** on preventability or approach
Can readmissions be prevented?

Goals:
- Identify patients at high risk of re-hospitalization and target specific interventions to mitigate potential adverse events
- Reduce 30 day readmission rates
- Improve patient satisfaction scores and H-CAHPS scores related to discharge
- Improve flow of information between hospital and outpatient physicians and providers
- Improve communication between providers and patients
- Optimize discharge processes

Funding: >$2 million, via institutional, grant, federal and insurance-based funding

Results to date: Decreased readmissions by 13% (Absolute reduction = 2%: 14.7% to 12.7%)
Should readmissions be a focus?

- ? Effect on morbidity & mortality
  - Eg. COPD readmission = independent mortality predictor (OR 1.85)
  - Other studies (eg. Krumholz, JAMA 2013) have found little to no correlation

- Lost income & time in community
  - Likely a negative psychosocial impact

- Hospital acquired risk
  - ~10% risk of HAC/unnecessary inpatient day

Krumholz JAMA 2013
**But wait...Hot off the presses!!!**


**A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial.**

**CONCLUSIONS:** A patient navigator intervention among high risk, safety-net patients decreased readmission among older patients while increasing readmissions among younger patients. Care transition strategies should be evaluated among diverse populations, and younger high risk patients may require novel strategies.

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**Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge.**

Jackson C¹, Shahsahebi M², Wedlake T¹, DuBard CA³.

**RESULTS:** The final study sample included 44,473 Medicaid recipients with 65,085 qualifying discharges. The benefit of early follow-up varied according to baseline readmission risk. For example, follow-up within 14 days after discharge was associated with 1.5%-point reduction in readmissions in the lowest risk strata (P < .001) and a 19.1%-point reduction in the highest risk strata (P < .001). Follow-up within 7 days was associated with meaningful reductions in readmission risk for patients with multiple chronic conditions and a greater than 20% baseline risk of readmission, a group that represented 24% of discharged patients.
Readmissions as an *accountability measure*: Patient and health system-centered benefit can be achieved through improved transitions of care.

*Adapted from Health Policy blog of Ashish Jha MD, Harvard School of Public Health*
Drivers of Care Transitions QI

• National
  – CMS penalty up to 3% of yearly hospital reimbursement
  – HCAHPS Patient Satisfaction

• Community
  – SFHP P4P bonus to PCMH’s

• Hospital/Individual
  – Optimal, patient-centered care
Models for Improving Care Transitions

- Care Transitions Intervention
- Transitional Care Model
- Project RED (Re-Engineered Discharge)
- Project BOOST (Better Outcomes for Older Adults through Safe Transitions)
- Transforming Care at the Bedside (TCAB)
- STAAR (State-Action on Avoidable Rehospitalizations)
- INTERACT II (Interventions to Reduce Acute Care Transfers) – SNF based
Comprehensive Patient Care

- Biomedical
- Mental Health
- Health-Related Behaviors
- Family Systems
- Issues of Cognition & Capacity
- Food Security/Nutrition
- Housing and Domestic Safety
- External Guidelines & Regulatory Requirement
Key Components of Ideal Transitions of Care

- Discharge Planning
- Complete & timely communication of information
- Medication safety
- Social & community support
- Promotion of self-management
- Advance care planning
- Care coordination
- Symptom monitoring & management
- Outpatient follow-up

K. Oza MPH, adapted from Burke et al JHM 2013
10 Building Blocks of High Performing Primary Care

Bodenheimer et al (2014)

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future

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- Template of the future
- Discharge Planning
- Complete & timely communication of information

K. Oza MPH, adapted from Burke et al JHM 2013
San Francisco Health Network

• San Francisco’s only complete care system
  – Primary care for all ages
  – Dentistry
  – Emergency & trauma treatment
  – Medical & surgical specialties
  – Diagnostic testing
  – Skilled nursing & rehabilitation
  – Behavioral health
San Francisco General Hospital and Trauma Center

• San Francisco’s public hospital
  – Devoted to care of the city’s most vulnerable residents
  – Sole provider of trauma and psychiatric emergency services in SF
• Serves over 100,000 patients per year
• 16,000+ admissions/year
  – 20% of the city’s inpatient care
• Average LOS adult inpatients is 5 days
Readmissions at SFGH

- 64% of readmitted patients have Medi-Cal coverage.
- 60% of readmitted patients have mental illness.
- 28% of readmitted patients have a substance use diagnosis.
- 16% of readmitted patients are homeless.
- 28% of readmitted patients are not empaneled with a PCP.
- 33% of readmissions occur within 7 days of discharge.
- 326 individuals accounted for 1734 hospitalizations & 764 readmissions (47% of all readmits).

Data analysis by K. Oza MPH (SFGH Care Transitions Taskforce)

Top 5 Discharge APR-DRG | SFGH 30-Day Readmit Rate (%) | AEH Public Hospitals 30-Day Readmit Rate
--- | --- | ---
COPD* | 25.8% (78) | 20.8%
Heart Failure* | 24.8% (103) | 20.0%
Renal Failure | 24.7% (44) | 19.1%
Sepsis | 13.6% (67) | 16.6%
Cellulitis | 11.3% (55) | 10.2%
Team-Based Complex Care Planning
FMIS MULTIDISCIPLINARY ROUNDS FORMAT
Monday – Friday 8:30AM – 3B Conference Room

Goal 1-2 minutes/patient

Begin with:
- Name, age & hospital unit
- Primary diagnosis & inpatient treatment needs
- Expected d/c date and location – try to anticipate DC 1-2 days in advance

eg. “Mr. John Jones is a 65 year old man on 5C with community acquired pneumonia. He is receiving IV antibiotics and we expect d/c home in 3 days.”

Then note the following as needed:
For SW
1) Housing instability?
2) Non-home discharge location? (SNF, respite, board & care)
3) Home care needs? (RN, skilled therapy – PT/OT, social work)
4) Substance use disorder?
5) Family systems issues? (neglect, abandonment, violence)
6) Other general social concerns?

For UM
1) Need for placement?
2) Referral to Care Transitions Nursing?
   - Admit for HF, COPD, DM w complications, PNA, or ACS/MI
   AND >55yo or readmit in past 30 days

For skilled therapists (PT/OT/ST)
1) Current mobility? (eg. bedrest, NWB, assistive devices)
2) Baseline mobility? (eg. fully independent, ADL dependent in community, long term SNF due to mobility impairment)
3) Cognitive deficit from baseline?
4) ADL deficit from baseline?
5) Speech and/or swallowing deficits from baseline?
<table>
<thead>
<tr>
<th>Resource</th>
<th>Who qualifies</th>
<th>What it is</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Respite</td>
<td>Homeless with time-limited active medical problem or chronic problem needing stabilization.</td>
<td>“Home health for people who don’t have a home”-shared room for women, dorm for men, RNs, NPs and SW’s on site, meals, transportation Can come and go, can stay during the day.</td>
<td>Similar in feel to shelter. No place to store belongings. Patients free to come and go. Patients must be independent in ADL’s &amp; continent. Not appropriate for patients whose primary problem is substance use.</td>
</tr>
<tr>
<td>Shelter</td>
<td>Anyone</td>
<td>Shared room with cots and/or bunk beds, some meals.</td>
<td>Must wait for bed, must leave during the day unless letter given, no medical services.</td>
</tr>
<tr>
<td>Residential Substance rehab</td>
<td>Active substance addiction.</td>
<td>Shared room, meals, medication supervision, substance treatment.</td>
<td>SW must call on day of discharge to assess bed availability. Usually must be willing to participate in chores.</td>
</tr>
<tr>
<td>Medical detox (eg. Joe Healy)</td>
<td>Actively receiving medication for alcohol withdrawal, stable enough to be outpatient.</td>
<td>Medically supervised detoxification program (with substance treatment services.)</td>
<td>Usually outside of eligibility window by the time patient is stable.</td>
</tr>
<tr>
<td>Acute Diversion Unit</td>
<td>Patients with active psychiatric disorder-referred by psych consult.</td>
<td>Short term intensive psych treatment program in supervised environment.</td>
<td>Usually limited to subset of high-risk psychiatric patients. Typically not staffed for medical complexity.</td>
</tr>
<tr>
<td>SRO (Single-Room Occupancy)</td>
<td>Anyone who can pay $500-800/month</td>
<td>One room efficiency, +/- bathroom, may be temporary or permanent, often 28 day limit</td>
<td>No on-site services, may lack easy bathroom access, usually cannot arrange on hospital discharge unless self-pay.</td>
</tr>
<tr>
<td>DAH (Direct Access to Housing)</td>
<td>Homeless, those with active mental health or substance use, medical problems prioritized.</td>
<td>DPH-run SROs that have wraparound services on site, may include nursing, SW, CM. Permanent housing.</td>
<td>Long wait list (currently closed), usually not available on d/c from hospital. No 24 hour support. Uses 30% of income.</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>Homebound or limited mobility patients (exact criteria vary by insurance and company).</td>
<td>Home nursing (labs, med rec, wound care, BP checks), PT, OT, or social work.</td>
<td>Must have responsible provider (usually PCP), very functional patients may not qualify, need stable housing.</td>
</tr>
<tr>
<td>Home Health</td>
<td>&gt;65, disabled, or blind and must have Medi-Cal. Many patients with mental health/substance dx qualify (hours vary).</td>
<td>Lay person (selected by patient or by agency) who provides assistance with ADLs &amp; IADL’s (cooking, cleaning, shopping, laundry, etc.) or “protective supervision.”</td>
<td>No skilled medical care, usually maxes out at 7 h/day, may have share of cost.</td>
</tr>
<tr>
<td>In-home Support Services (IHSS)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Brief, structured format for MD:nursing huddle and provider:patient discussion.

Core (Provider/RN) Interdisciplinary Round Questions
1) Plan for the day.
2) Estimated Discharge Date
3) Anticipated Disposition.
4) Needs for Discharge

Core (Provider/Patient) Interdisciplinary Round Questions
1) You are here for ____.
2) We are doing ____ to treat your diagnosis.
3) We expect that you will be able to get out of the hospital ____.
4) What can we do for you today?
Cross-System Communication and Care Coordination
Pharmacy Interventions and Medication Reconciliation
Vision for SFHN Primary Care

- Improve the health of the patients we serve
- Ensure excellent patient experience
- Sustainable Patient- and Family-Centered Care
- Optimize access, operations, and cost-effectiveness
- Build a foundation of a healthy, engaged, and sustained primary care workforce
Improving Post-discharge care

• Standardization of post-discharge visits
  – Timing
  – Team based care

• Metrics for each health center
  – Monthly rates of follow up within 7 days of d/c
  – Readmission rates

• Services for high risk patients, such as case management, home health services, supportive housing, Bridge clinic, Respite, caregiver support
Dear Dr. Chase,

Your patient Jane Smith MRN 01234567 was admitted for COPD exacerbation.

At admission, we found that she had run out of her inhalers and did not have any refills. She has been smoking cocaine every 2-3 days. She had hypercapnic respiratory failure in the SFGH ED and required urgent BiPAP. We plan to treat with steroids, bronchodilators, evaluate for pneumonia and provide cocaine cessation resources.

We estimate that the patient will be discharged on: 5/1/2015

**Primary care follow-up** – please reply with date and time for a visit within 7 days after the expected discharge date. Primary care clinic pharmacist/medication reconciliation visit should be scheduled for medication literacy teaching.

**Specialty clinic follow-up** – please schedule appointment after the expected discharge date and reply with date and time:

1. **Better breathing class** Indication for referral: COPD
2. **COPD NP Clinic** Indication for referral: COPD

To communicate with us, please (1) reply to this email *and/or* (2) page (before 7:30AM or after noon) using the table below.

Sincerely,
The FMIS team
Post-discharge phone calls

- Call within 72 hrs of discharge
- HW, MA, or RN
- Scripted
  - Appts
  - Meds
  - Red flags
  - Primary care access
Complex Care Management
Patient Education and Supported Self-Management
Spanish language self-management guide produced by the UCSF Center for Vulnerable Populations, 2007
Medication Instructions with *Polyglot’s Meducation™*

### 5th to 8th grade reading level

- Uses universal medication scheduling language & pictograms

### Can be translated into 18 different languages

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Morning</th>
<th>Noon</th>
<th>Evening</th>
<th>Bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amiodipine 10 MG Oral Tablet</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benazepril HCl Tablet 10 mg</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline 100mg</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qvar Inhaler 80 mcg/inh</td>
<td>2 puffs</td>
<td>2 puffs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atorvastatin 40 MG Oral Tablet</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Chinese Translation

<table>
<thead>
<tr>
<th>Medicine</th>
<th>早上</th>
<th>中午</th>
<th>晚上</th>
<th>夜里</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amiodipine 10 MG Oral Tablet</td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Doxycycline 100mg</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qvar Inhaler 80 mcg/inh</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atorvastatin 40 MG Oral Tablet</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Multilingual Heart Failure Education

Monitor My Heart Failure Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>Record Weight</td>
</tr>
<tr>
<td>Swelling</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
</tr>
</tbody>
</table>

- **Good** (呼吸, 好)
- **Caution** (水腫, 注意)
- **Danger** (體重, 危險)

*Developed by: Chinese Hospital 848 Jackson Street, San Francisco, CA 94133 www.chinesehospital-sf.org 03-25-2010*
Business Cards and Warmline

**Family Medicine Inpatient Service**
at San Francisco General Hospital

For questions after you go home, call your primary care clinic or call 415-206-8651 (M-F, 8AM-4PM).

**APPOINTMENT INFO:**

- Nurse Advice Line 415-206-8609
- Family Health Center 415-206-5252
- Maxine Hall Health Center 415-292-1300
- Ocean Park Health Center 415-682-1900
- Potrero Hill Health Center 415-648-3022
- Silver Avenue Health Center 415-657-1700
- Southeast Health Center 415-671-7000

**三浦市總醫院家庭醫學住院服務**

出院后，如果您有任何问题，请致电您的主要医疗诊所或致电 415-206-8000，询问并翻译，然后转分机 6-8651 (周一至周五上午8点至下午4点)。

**約診資訊:**

- 護士諮詢專線: 415-206-8609
- 家庭健康中心: 415-206-5252
- Maxine Hall健康中心: 415-292-1300
- Ocean Park健康中心: 415-682-1900
- Potrero Hill健康中心: 415-648-3022
- Silver Avenue健康中心: 415-657-1700
- Southeast健康中心: 415-671-7000

**El Servicio de Medicina Familiar**
en el Hospital General de San Francisco

Si tiene alguna pregunta después de que lo den de alta, llame a su clínica de atención primaria o llame al 415-206-8800 y pida un intérprete; luego pida que lo transfieran a la extensión 6-8651 (de lunes a viernes, de 8 a.m. a 4 p.m.)

**INFORMACIÓN SOBRE LAS CITAS:**

- Línea de asesoría de enfermeras 415-206-8609
- Centro de Salud Familiar 415-206-5252
- Centro de Salud Maxine Hall 415-292-1300
- Centro de Salud Ocean Park 415-682-1900
- Centro de Salud Potrero Hill 415-648-3022
- Centro de Salud Silver Avenue 415-657-1700
- Centro de Salud Southeast 415-671-7000
Building a Community of Support
Data Capture, Analysis and Metrics
SFGH Care Transitions Taskforce: a multidisciplinary QI workgroup aligning initiatives across continuum of care within and outside of SFGH and SFHN.
<table>
<thead>
<tr>
<th>MRN</th>
<th>Pt Id</th>
<th>DOB</th>
<th>Vst Start Time</th>
<th>Vst End Time</th>
<th>Pt Name</th>
<th>PCC</th>
<th>PCP</th>
<th>Pt Phone No</th>
<th>Race</th>
<th>Race Cd Name</th>
<th>Gender</th>
<th>Lang</th>
<th>Last Disc Order</th>
<th>Last Disc Order Time</th>
<th>Disc Dirn</th>
<th>Disc Disp Desc</th>
<th>Tot Len Of Stay</th>
<th>Home Src</th>
<th>Prov Cd</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
<td></td>
<td>4/13/2015 5:05 PM</td>
<td>6/5/2015 12:25 PM</td>
<td>WHITE</td>
<td>M</td>
<td>ENG</td>
<td>6 AMERICAN INDIAN/ALASKA NATIVE</td>
<td>M</td>
<td>KHAYAMBASHI, SHIYEA C.</td>
<td>6/5/2015 0:15 AM</td>
<td>ATC</td>
<td>Transferred to a critical access hospital (CAH)</td>
<td>63 SNF</td>
<td>FMBE</td>
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<td></td>
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<td></td>
<td>6/26/2015 5:10 PM</td>
<td>6/5/2015 12:20 PM</td>
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<td>M</td>
<td>ENG</td>
<td>6 AMERICAN INDIAN/ALASKA NATIVE</td>
<td>M</td>
<td>GRENIER, ELISE</td>
<td>6/5/2015 0:15 AM</td>
<td>ATC</td>
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<td>63 SNF</td>
<td>FMBE</td>
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<td></td>
<td>1</td>
<td></td>
<td>5/10/2015 9:24 AM</td>
<td>6/5/2015 12:50 PM</td>
<td>WHITE</td>
<td>M</td>
<td>ENG</td>
<td>6 AMERICAN INDIAN/ALASKA NATIVE</td>
<td>M</td>
<td>TANG, CHINTAN</td>
<td>6/5/2015 0:15 AM</td>
<td>ATC</td>
<td>Transferred to a critical access hospital (CAH)</td>
<td>63 SNF</td>
<td>FMBE</td>
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<tr>
<td></td>
<td>1</td>
<td></td>
<td>6/1/2015 1:55 PM</td>
<td>6/5/2015 1:00 PM</td>
<td>WHITE</td>
<td>M</td>
<td>ENG</td>
<td>6 AMERICAN INDIAN/ALASKA NATIVE</td>
<td>M</td>
<td>TANG, CHINTAN</td>
<td>6/5/2015 0:15 AM</td>
<td>ATC</td>
<td>Transferred to a critical access hospital (CAH)</td>
<td>63 SNF</td>
<td>FMBE</td>
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**UCSF**

**SF HEALTH NETWORK**
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
**Challenge #1: Improve Care Transitions & Reduce Readmissions**

<table>
<thead>
<tr>
<th>What we are doing well:</th>
<th>What we are working on:</th>
<th>Plans in development:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Multidisciplinary Rounds (MD, Pharmacy, SW, UM, PT) focusing on successful transition to community</td>
<td>FMIS Patient Navigator -- hire <em>new position</em> for discharge planning and phone follow-up</td>
<td>Identify highest needs patients and collaborate with PCPs and ambulatory care for complex care planning across SFHN</td>
</tr>
<tr>
<td>Email-based Care Transition Communication on Admission &amp; Discharge</td>
<td>Call community pharmacies to give pager number for discharge prescription questions</td>
<td>Create SFGH discharge prescription warmline for community pharmacies</td>
</tr>
<tr>
<td>Work with patient &amp; PCP during admission on goals of care and long term planning</td>
<td>Consistent distribution of FMIS Business Card with Warmline Instructions</td>
<td>FMIS pharmacist-Primary care pharmacist collaboration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Patients with Scheduled Follow-Up at Discharge <em>(Nov 2014-Jun 2015)</em></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appt in &lt; 7 days</td>
<td></td>
<td><strong>Goal outcome measure:</strong></td>
</tr>
<tr>
<td>82%</td>
<td></td>
<td>reduce readmission rate</td>
</tr>
<tr>
<td>Appt in &lt; 14 days</td>
<td></td>
<td><strong>FMIS 30 day Readmission Rate</strong> (3 month average)</td>
</tr>
<tr>
<td>96%</td>
<td></td>
<td>16.4%</td>
</tr>
<tr>
<td>Any follow-up appt</td>
<td></td>
<td><strong>Our Goal:</strong> Medicare Readmission Rate</td>
</tr>
<tr>
<td>97%</td>
<td></td>
<td>15.6%</td>
</tr>
<tr>
<td>Universal EHR access to all documentation on date of service</td>
<td></td>
<td><strong>To reach our goal, we need 5 fewer readmissions/month</strong></td>
</tr>
</tbody>
</table>
% SFHN Primary Care patients who attended an appointment within 7 Days of discharge

- Pilots begin in 4 clinics
- Script revised
- Spread to 8 additional clinics
- Script revised
- Reduced access during holidays

Median (SFHN PCCs)  Goal (50%)
Current Understanding

- **Readmissions are complex & costly** for patients and health systems

- **Outcomes involve a diverse set of contributing factors**, variable by patient, health system and community

- **No consensus** on exact definition of *readmission* or prevention
  - Bigger win is to **improve transitions of care**

- Engage **stakeholders**, create high functioning **teams**, connect through **efficient EBM processes**, track & distribute **data**
Big Picture Goals

1. Team-oriented, standard-work approach for care transitions from hospital to community – *critical to align hospital and primary care.*

2. Reduce total readmissions by 15-20% (the preventable component)
With thanks to the Moore Foundation, the SF General Hospital Foundation, the SFGH Care Transitions Taskforce, & our partners from SFGH and SFHN.
References


• Hansen LO et al. Project BOOST: Effectiveness of a multihospital effort to reduce rehospitalization J Hosp Med: 2013 Aug 8 (8).


Even More References

• Krumholz HM et al. Relationship Between Hospital Readmission and Mortality Rates for Patients Hospitalized With Acute Myocardial Infarction, Heart Failure, or Pneumonia. JAMA. 2013;309(6):587-593.


• 364 Hospitals Have High Rates Of Overall Readmissions, New Medicare Data Show: www.kaiserhealthnews.org
Web Resources

Institute for Healthcare Improvement
www.ihi.org

America’s Essential Hospitals
www.essentialhospitals.org

Society for Hospital Medicine BOOST
www.hospitalmedicine.org/boost

ProjectRED (Re-Engineered Discharge)
www.bu.edu/fammed/projectred
More Web Resources

US Dept of Health and Human Services Partnership for Patients
www.healthcare.gov

Hospital Consumer Assessment of Healthcare Providers and Systems
www.hcahpsonline.org

Agency for Healthcare Research and Quality www.ahrq.gov

San Francisco Health Network http://www.sfhealthnetwork.org/