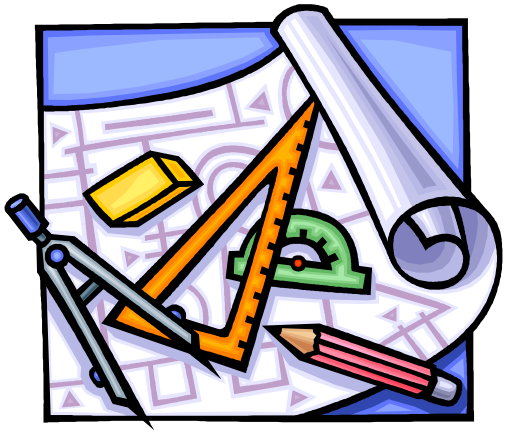
A BLUEPRINT FOR CHANGE



Recommendations To Improve Transitional Care Services from Hospitals in San Francisco©

March 24, 2008

Prepared for San Francisco Senior Centers

With support from the Department of Aging and Adult Services (DAAS) and Planning for Elders in the Central City (PECC)

THANKS!

This report would not have been possible within the time and resources available without significant support from the following individuals and organizations:

Anne Hinton and the Department of Aging and Adult Services for their financial and programmatic support of the Transitional Care Planning Project and the Homecoming Services Network.

Holly Brown-Williams and her colleagues at Health Research for Action, UC Berkeley whose comprehensive assessment *From Hospital To Home: Improving Transitional Care for Older Adults* became the lens through which we looked at issues and opportunities in San Francisco.

Bob Trevorrow, Kathleen Mayeda, and Sandy Thongkhamsouk at the San Francisco Senior Center and the Homecoming Services Program, who have worked extra hard over the past year to develop training, to reach out to other case management and services agencies, to increase the number of seniors and adults with disabilities served, to engage hospital staff and to share lessons learned with others while creating the Homecoming Services Network.

Meg Cooch, James Chiosini, and Alice Dueker of Planning for Elders in the Central City, and members of the Health Care Action Team (HAT), whose commitment to improving discharge planning and transitional care has spanned nearly a decade.

The new Homecoming Services Network, comprised of staff and leaders in the community-based agencies who participated in this project and remain committed to working together:

- Patty Clement, Christian Irizarry and Logan Fredrick, Catholic Charities CYO
- Steve Nakajo and Anna Sawamura, Kimochi, Inc.
- Traci Dobronravova, Angel Yuen and Christabel Cheung, Self-Help for the Elderly
- David Knego and Michael McGinley, Curry Senior Center
- Karen Garrison, Bernal Heights Neighborhood Center
- Michael Blecker and Johnny Baskerville, Swords to Plowshares
- Lolita Kintanar and Estelita Catalig, Episcopal Community Services

Others who shared their expertise and advice at the Case Management and Peer Support Training

- Anne Hinton, Jason Adamek and Linda Edelstein, Dept. of Aging and Adult Services
- Anthony Nicco and Hugh Wang, DAAS IHSS Program
- Margaret Baran, IHSS Consortium
- Donna Calame and Luis Calderon, IHSS Public Authority
- Robin Meese-Cruz, Meals on Wheels
- Erica Hamilton, San Francisco Adult Day Health Network
- Benson Nadell, Long Term Care Ombudsman
- Abbie Yant and Sarah Lee, St. Francis Memorial Hospital
- Judy Shaver, Mishell Nicholas, and Uma Sharma, San Francisco Veterans Medical Center
- Eva Woodward, St. Luke's Hospital

Discharge planning staff and supervisors who responded to questions and offered ideas from the city's hospitals:

- Chinese Hospital
- California Pacific Medical Center
- St. Francis Memorial Hospital
- St. Luke's Hospital - CPMC
- St. Mary's Medical Center
- San Francisco General Hospital Medical Center
- San Francisco Kaiser Foundation Hospital
- San Francisco Veteran's Medical Center
- University of California - San Francisco Medical Center

A host of other individuals and organizations who graciously shared information and insights, especially:

- Donna Schempp and Kathleen Kelly, Family Caregiver Alliance
- Ed Kinchley and worker leaders from SEIU Local 1021
- Cynthia Davis, North and South of Market Adult Day Health
- Center Directors, San Francisco Adult Day Health Network
- Directors of the Neighborhood Resource Centers and Marc Solomon
- Nancy Brundy and Kelly Hiramoto, San Francisco Institute on Aging
- Rita Ryakubik, San Francisco Bay Area Network for End-of-Life Care
- Jean Tokarek, Sutter Visiting Nurses and Hospice
- John Hinton, formerly of the State Department of Health Services
- Susan Poor, Healthcare Planning and Policy Consultant
- Ron Smith, San Francisco Hospital Council
- Elizabeth Zirker, Protection and Advocacy, Inc.
- Mary Counihan and staff, Dept. of Aging and Adult Services, Adult Protective Services
- David Schneider and Donna McGiver, Lumetra
- Ann Marie Marciarille, University of the Pacific and AARP
- Judy Auda, Community Living Campaign
- Diana Jensen, Human Services Agency

We worked hard to include as many of your insights and ideas for improving discharge planning and transitional care as possible in this report.

A special thanks to Matthew Auda-Capel for his skillful job in the initial review and edit of this report.

Growth
Leadership
Unity
Empowerment

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"To build a bridge, whether physical or programmatic, requires a team with specialized skills who share a common goal and follow a layered blueprint that details how their work must fit together for the project to be a success."

Report Overview and Table of Contents

Overview

This Report seeks to provide both a "big picture" view of what is needed, as well as to give each stakeholder or team in the process some specific recommendations.

- Overview and Methodology – Building on a Solid Foundation
- Ten Things We Can Do Right Now - Punch List of Priority Tasks
- Recommendations for Key Stakeholders – Orienting Team Members to the Task Ahead
- A Case Study and specific other highlight to help illustrate the issues
- References and Resources – Where to go for more information

Table of Contents

Transitional Care is defined as services and supports that are provided to an individual across care sites. For this study, the focus is primarily those being discharged from the City's acute care hospitals.

Ten Things We Can Do Right Now

As a compassionate and caring community, San Francisco must establish a standard for quality discharge planning and transitional care, sharing the responsibility of making it happen and sharing the risk if it does not. In doing so, we must plan recognizing the significant diversity of the population, the high percentage of individuals who are older and live alone, and the lack of accessible, affordable housing. Action is needed at all levels, targeted to seniors, adults with disabilities, caregivers, providers, and key stakeholders in our health and long term care systems.

This report outlines things that each and everyone one of us can do - hospital administrators, homecare providers, family members, case managers, friends, discharge planners and future patients - to raise the standard and improve the quality and availability of services and support at this often critical time in a person's life. Remember, the journey of a thousand miles begins with the first step…

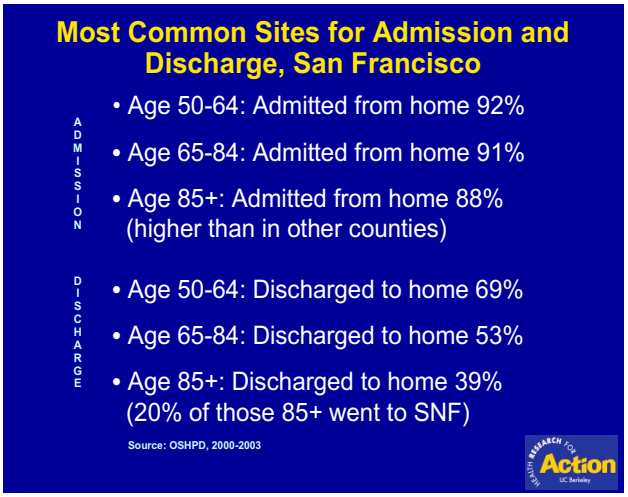
Ten Things We Can Do Now to Improve Transitional Care	
Issue	**Description**
# 1 Discharge Planning	➢ Assure adequate hospital staffing levels to allow good discharge planning ➢ Establish clearer, more uniform standards for identifying high risk clients and delaying discharge until appropriate supports are in place to avoid unnecessary stress and re-hospitalization ➢ Establish standard discharge instructions and checklists to facilitate sharing information and to clarify responsibility across care settings ➢ Provide more immediate access to information, community-based case management and other resources with centralized phone/website access
# 2 Resource Information	➢ Create a simple website to facilitate sharing resource information, download information for patients and caregivers, and facilitate on-line referrals to other providers ➢ Assure that the simple information sheet in multiple languages developed by Planning for Elders and approved through the Hospital Council is distributed along with required Medicare information to all seniors and persons with disabilities at admission and prior to discharge
#3 Consumer/Patient Empowerment	➢ Work with consumer and patient groups to provide training to individuals to empower them in their healthcare matters, including discharge from hospitals and nursing facilities ➢ Expand existing volunteer programs to provide peer and practical support ➢ Expand development of social support networks for high risk, isolated individuals

#4 Community-based Transitional Care	➢ Increase funding for community-based case management and support ➢ Assure quality services through training in transitional care models for community-based case management organizations ➢ Assure that every patient receives a follow-up visit or phone call
#5 Strategic Planning and Problem-solving	➢ Create a workgroup, with neutral staffing and a commitment to sharing information, to help facilitate implementation of these recommendations ➢ Plan an action-oriented Transitional Care Summit to bring together existing resources to bear on the issues discussed in this report ➢ Seek new government and foundation resources dedicated to helping improve San Francisco's transitional care services ➢ Share information and "best practices" with other communities
#6 Patient Information	➢ Support a Continuity of Care Record ➢ Encourage patients and caregivers to develop and carry key patient information and share it with all members of their care team ➢ Continue development of the Case Management Connect project as a vehicle to improve information sharing across settings
#7 Policy and Funding Priorities	➢ Increase DAAS funding for transitional care through the Homecoming Services Network of community-based agencies ➢ Make effective care coordination across sites a policy and funding priority ➢ Prioritize in-home care over institutional care ➢ Increase public awareness of transitional care issues ➢ Continue to streamline eligibility for Medi-Cal funded services and coordinate with Medicare and other benefits ➢ Support legislation at the local, state and federal level that seeks to address the issues raised in this report
#8 Caregivers	➢ Involve caregivers in discharge planning and transitional care issues ➢ Train caregivers on warning symptoms and adverse effects of prescription drugs ➢ Develop social support networks and other informal supports to assist those without available caregivers
#9 Provider Training	➢ Incorporate a component about transitional care issues in current training programs for medical professionals, home care providers, case managers, caregivers, consumers and community volunteers
#10 Commitment to Quality Improvement	➢ Identify and include measures relevant to monitoring quality improvement (QI) in care transitions efforts in local health and long term care planning and evaluation efforts ➢ Decide today that you will take action to make even one of the recommendations in this report a reality

Too often the risk from a poor discharge rests primarily with the patient, not on the insurance company, the hospital or other care providers. The goal of this report is to begin a dialogue on how to more appropriately share the risks and responsibility for a good transition from hospital to home.

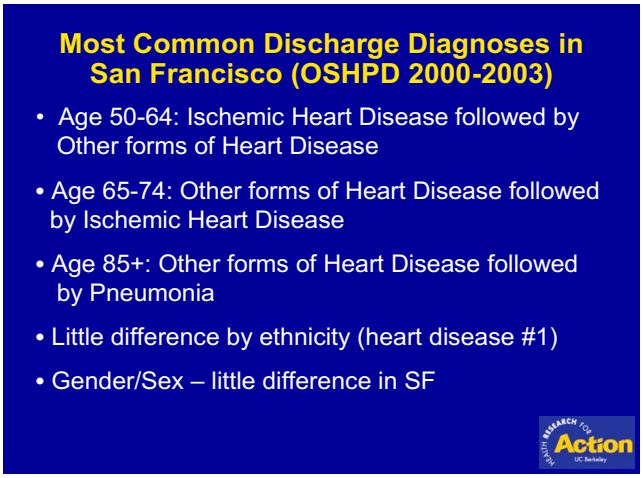
Overview

In the spring of 2007, the Department of Aging and Adult Services initiated funding for the **Transitional Care Management and Support Planning Project.** The scope of the project included funding for training, case management, outreach to hospitals and the development of a "blueprint" to improve transitional care services in San Francisco. At the heart of the process was a commitment to train community-based case managers on the goals and objectives of the Homecoming Services Program model (described below) and improve the communication and referral process from participating hospitals. The target group for the project was seniors and people with disabilities who are being discharged from acute care hospitals and who could benefit from more community-based care and support as they transitioned home. The significant positive outcomes of this short term planning process are also detailed below.



Source: Health Research for Action, U.C. Berkeley

This planning project focused primarily on acute care hospitals. Future planning process should tackle challenges faced in those rehabilitation or nursing facility settings as these facilities are governed by different rules, often have fewer resources and less experienced discharge staff, and fewer options for funding services post-discharge.



Source: Health Research for Action, U.C. Berkeley

Methodology

The timeframe for this planning project was very short, so this report builds significantly on previous research, augmented with more recent experiences of the Transitional Care Planning Project and interviews with key informants.

We hope that you find the discussion and identification of some next steps in a journey to improve transitional care services in San Francisco informative. Please note that while the focus is

primarily on acute care hospitals, there is some brief discussion on discharge from nursing facilities and hospital sub-acute facilities as well as the particular challenges faced with discharging individuals who are homeless or marginally housed.

San Francisco Hospital and Nursing Home Discharge Planning Task Force

San Francisco was ahead of many communities in seeking to address this issue, due to the early outreach and organizing by Planning for Elders and the Healthcare Action Team (HAT). The San Francisco Board of Supervisors responded to the organizing HAT members and their allies who advocated improved planning and accountability when patients are discharged from hospitals and nursing homes.

Through their efforts, the San Francisco Hospital and Nursing Home Discharge Planning Task Force was created by the San Francisco Board of Supervisors in May 2001 (Resolution 10-01). The Task Force was comprised of 18 members from various city departments, hospitals, nursing homes, home care providers, labor unions and community agencies, persons with disabilities and seniors. They found that a lack of sufficient community health and social supports is a main contributor to re-hospitalization, functional decline, dependence and institutionalization. Despite the efforts of hospitals, nursing homes, City and County departments, social service agencies, community groups and consumers themselves. All too often needed support and services were not in place when seniors and people with disabilities were discharged from hospitals.

The Task Force sought input, held hearings, and developed a series of recommendations presented to the Board of Supervisor and adopted in February, 2004 as the **Hospital and Nursing Home Discharge Planning Task Force's Final Report.** It included recommendations that identified concrete ways in which to improve discharge planning and assure that all people get the care and services they need when they leave the hospital. The report was adopted through Resolution 88-04 by the Board of Supervisors in early 2004. Resolution 88-04 urged city departments to develop a plan of implementation based upon these task force recommendations, and the Northern California Hospital Council offered to staff the implementation process. While some of the recommendations have been implemented, most have not. Hopefully, this report will once again remind us of the important issues to be addressed.

Health Research for Action Comprehensive Study of Transitional Care

In April 2006, Health Research for Action at U.C. Berkeley published a comprehensive study of the issue throughout the Bay Area, entitled From Hospital to Home: Improving Transitional Care for Older Adults. This work included a detailed Literature Review, multi-faceted information gathering, input from a broad cross-section of stakeholders, and follow-up discussions with policymakers and funders at a June 2006 Transitional Care Summit. The literature review, research findings, and results of their work are available on their website: http\healthresearchforaction.org/research-evaluation/h2h.html. Researchers then presented highlights of its findings including specific data about San Francisco at a community forum on July 25, 2006. They have increasingly been recognized as a source of solid recommendations for how to improve transitional care for seniors and are regular presenters at State and National trainings and conferences. Their study focused on seniors, but experience has shown that people with disabilities who are not seniors have similar

and often more significant issues when seeking to transition back home with appropriate levels of care and support.

The main findings of the Health Research for Action Report included:

- Care transitions are an increasingly critical health and social problem for seniors and their caregivers
- Some seniors are at very high risk for re-hospitalization and increased morbidity and mortality after discharge
- Transitions can be dangerous for seniors and their care is seldom coordinated
- Hospitals do not prepare patients and caregivers adequately for discharge
- Seniors and caregivers are not informed or trained in critical home-care needs after a hospitalization
- Professionals serving seniors are not adequately trained in effective discharge planning, post-discharge homecare and transitions across care sites
- The medical system does not consider or support the critical role of informal caregivers
- The system of care is badly fragmented and outdated

The findings in From Hospital to Home: Improving Transitional Care for Older Adults provided a framework for highlighting major issues and suggesting possible solutions. To the extent possible, this Blueprint also seeks to recognize areas where hospitals, community-based service providers, consumer or caregiver groups have taken initiative and begun to develop local solutions. This Blueprint also includes a closer look at how issues of diversity, homelessness, and high rates of disability provide additional challenges for San Francisco when compared to its Bay Area neighbors.

Homecoming Services Program Expansion Pilot

From March through July 2007, San Francisco Senior Centers (SFSC) received funding from the Department of Aging and Adult Services to develop case management training, volunteer training (in partnership with Planning for Elders in the Central City), and an initial MOU with interested case management agencies to participate in the training and to provide short term, transitional case management services.

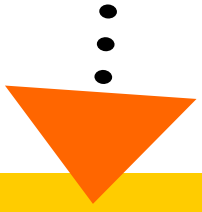
SFSC first established the Homecoming Services Program in 2002 to respond to the critical hospital-to-home needs of isolated seniors who lacked transitional support. In partnership with other community based agencies, Homecoming Services Program provides immediate comprehensive services for medically at-risk low-income seniors after hospital, rehabilitation or convalescent facilities.

Homecoming Services Program is an intensive service provided on a short-term basis until permanent at-home services are arranged or no longer needed. Each client receives an average of 4-6 weeks using a full intensive case management model in coordination with discharge planners through established relationships at designated hospitals. Medical escorts are provided, dwelling preparation is put in place including fresh food stuffs, and light housekeeping. Homecare assistance is arranged and hot meals are delivered if necessary. A care plan is established and implemented and daily contact is offered until the patient is stabilized at home.

This planning process sought to expand this model of transitional care to other agencies on a short-term basis. In the end, twenty different organizations participated in the training and seven case management agencies agreed to participate in the pilot. During the pilot, 30 individuals received intensive case management services. In addition, 35 potential peer volunteers received training in two 3-hour session from Planning for Elders in the Central City. This planning process led to the creation of the Homecoming Services Network (see appendix for more information). It provided valuable feedback on the current state of discharge planning and transitional care in the City and it improved protocols for establishing homecare services, expedited meals and other services needed on an immediate basis in partnership with the DAAS and the Community Living Fund.

Outreach to Other Stakeholders: This brief planning process also included a series of interviews with other stakeholders from the hospital discharge units, community-based agencies and organizations, consumer and caregiver groups, and quality assurance bodies. A list of those interviewed in the process of completing this report and its recommendations are listed at the beginning of this report.

Case Studies and Examples: This Blueprint also uses case studies and examples to illustrate policies and procedures that can enhance or hinder a smooth transition from hospital to home.



Telling Florence's Story

Often efforts to change complex service systems are informed and inspired by the stories of those who lives are shaped by their policies and practices. So we want to tell you the story of Florence. The name is not real, but the experiences are. We hope elements of her story help bring these recommendations to life. For those who have worked on improving discharge planning and transitional care in San Francisco, you know who Florence really is. Florence is no longer with us, but we think she would be pleased to know that her story is still being told to help make life better for other seniors and persons with disabilities.

This Report Was Designed To Be Used

Whether

- **You just read the case study and it encourages you to tell your story, or**
- **You have a specialized role to play related to information systems or case management or discharge planning, or**
- **You appreciate the fact that you or someone you care about will be hospitalized and will have to face some of these issues**

Jump in wherever you like!

ATTENTION ALL SAN FRANCISCANS

Care Transitions are an increasingly critical health and social problem for seniors, adults with disabilities and their care providers in our community

A Community Needs Assessment conducted by the San Francisco Human Services Agency in late 2006 highlights why improving Transitional Care is so important:

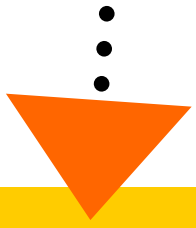
- Seniors and adults with disabilities comprise nearly one-fourth of the city's residents, and the number of those over 85 who are most likely to be at risk of hospitalization is expected to increase at a rate of 5% per year over the coming years.
- A high percentage of seniors and adults with disabilities live alone, as 40 percent of all households with a resident over 60 are single person households (over 40,000 individuals). The percentage living alone is even higher for those 75 and older, where over 19,700 live alone.
- As seniors and adults with disabilities age, the number and complexity of conditions grow making transitions more challenging for the patient and the providers involved. Approximately 45,000 seniors are discharged from San Francisco hospitals each year.
- Care transitions are more likely now to involve multiple sites (acute care unit, sub-acute unit, rehab facility, home) and providers (primary care physician, hospital physician, specialists, hospital nurse, home health nursing, homecare provider, unpaid caregivers) where there is little independent oversight and accountability across sites.
- Individuals needing discharge who have no housing, or have physically inaccessible or inadequate housing, face especially challenging care transitions.
- Lack of comprehensive, funded coverage for transitional care as well as long term care also makes smooth transitions more difficult.
- The isolation and lack of support networks for so many seniors and adults with disabilities compound the problems faced by the service system in helping individuals return home safely and with dignity.

Recommendations

- **Increase public awareness** of the issue and existing resources by launching a public education campaign, coordinated by the Department of Aging and Adult Services, taking advantage of public service announcements, paid and earned media to promote greater awareness of existing resources.
- **Publicly recognize** hospitals, home health agencies, community providers and volunteers who make substantive efforts to improve transitional care.
- **Provide outreach and training to professionals, consumers and caregivers** about how they can improve their chances of a smoother transition from hospital to home.
- **Work in partnership with Lumetra**, the quality assurance arm of Medicare housed in San Francisco that is responsible for implementing new requirements regarding informing consumers about discharge planning rights. Lumetra is the entity responsible for fielding

appeals for those being discharged prematurely. For more information, go to http://www.lumetra.com/ .

- **Develop and track appropriate risk indicators and health outcome measures** related to hospital transitions as part of the health and long term planning efforts of the S.F. Department of Public Health, the S.F. Clinic Consortium, The United Way, the Hospital Council and others.
- **Move toward local policies that assure more universal and equitable access to transitional care and long term care services**, regardless of source of insurance, hospital of discharge, or neighborhood of residence. Expanding funding for the Homecoming Services Network is an important step toward assuring this equitable access and should continue to build a financial partnership with hospitals served as well government.
- **Promote advanced planning, including financial planning,** with individuals to address issues related to assets, long term care insurance and other means to afford both transitional care and long term care.



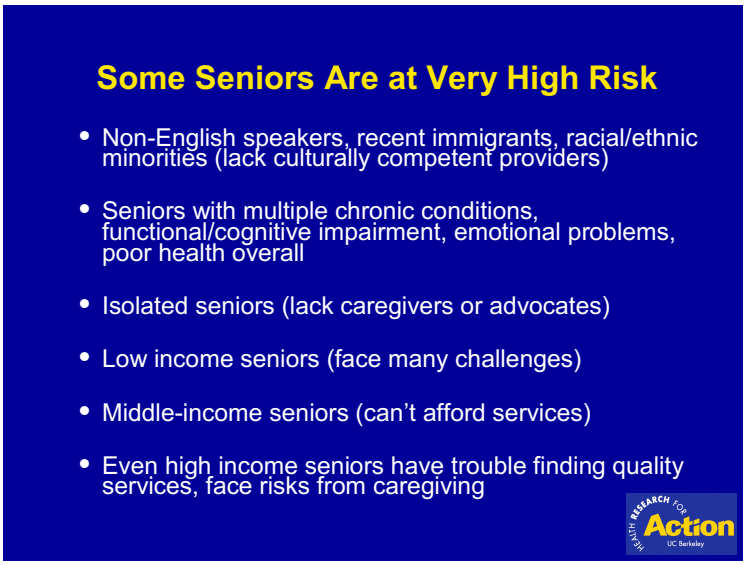
San Francisco Was Florence's Adopted Home.

Like many in San Francisco, Florence moved to the City later in life, leaving what little family she had behind to make a new life for herself here. She first learned to stand up for her rights here as a housing rights advocate, and this confidence helped her fight many battles before she died at age 90. She lived alone, but had a network of friends. She wisely put her name on the waiting list for affordable housing and while she wasn't keen on living with just "seniors", she made the move and found a supportive place to grow old with rents that she could afford on a fixed income.

ATTENTION HEALTH CARE PROVIDERS

Some seniors are at very high risk for re-hospitalization and increased morbidity and mortality after discharge

- A high percentage of San Francisco seniors and adults with disabilities of all ages speak a primary language other than English, increasing challenges for arranging and coordinating care post discharge.
- Over 40,000 San Francisco seniors live alone increasing the risk for patients returning home and needing assistance with activities of daily living, medications monitoring, and care in the evening hours when services are not available.
- A disproportional number of San Francisco seniors and persons with disabilities are poor when compared to other counties and often live in housing where lack of physical access can be a major barrier post-discharge; for example, one or more sets of stairs and bathrooms and bedrooms too small to accommodate assistive devices create additional challenges for San Franciscans.



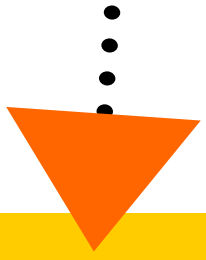
Source: Health Research for Action, U.C. Berkeley

- Some low and most middle-income seniors and adults with disabilities are not eligible for many programs that could provide help with transitional and long term care, yet they do not have the resources to pay for services themselves.
- Even high income seniors and adults with disabilities may have other risk factors that make them vulnerable or unable to find quality services in a timely fashion.
- Hospital discharge units do not uniformly or comprehensively screen for risk factors, nor is the staffing level in hospitals generally sufficient to allow for adequate screening and comprehensive discharge planning.

Recommendations:

- **Expand hospital support for the Homecoming Services Network** and other community based providers that can work in partnership with health care providers to deliver the services and support needed. This program delivers immediate care regardless of income while a more long term plan can be developed. It could include access to homecare and other long term care services on a sliding scale and should be available to those discharged from all SF hospitals.

- **Expand programs that help manage chronic care conditions** – Programs like adult day health, On Lok and PACE, MSSP and Linkages, and a number of programs run by local health providers and community agencies. The Building a Healthier San Francisco December 2004 and the updated information on the Health Matters website (http://www.healthmattersinsf.org/index.php) can provide a way to identify ambulatory sensitive conditions and monitor progress toward preventing unnecessary hospitalizations in the first place.
- **Expand programs that help individuals maintain function during hospitalization**, like the Acute Care for Elders (ACE) Program Unit at SF General. This program, described in more detail on page 21, is a best practice model widely available on the east coast. Currently, it is only available to a limited number of patients at San Francisco General.
- **Expand the resources to help re-build social support networks for seniors and adults with disabilities** identified as being at high risk. Isolation and the lack of practical support for the patient makes it more difficult for hospitals to safely discharge a patient back home.
- **Provide immediate access to needed services and support** by coordinating the use of the Community Living Fund, hospital emergency funds, and other similar resources to provide immediate access to needed services and support (meals, additional homecare, durable medical equipment) to help more seniors and adults with disabilities return back home rather than face a long term placement in a nursing facility
- **Improve cultural, linguistic and literacy competency of providers**
    - Improve cultural and linguistic training for health professionals in hospitals, home and community-based services, with particular emphasis on incorporating formal and informal information that is bi-lingual and bi-cultural in the discharge planning and transitional care process.
    - Increase the degree to which health care professionals interact with and learn about the communities they serve, in partnership with the San Francisco Community Clinic Consortium.
    - Promote adherence to guidelines regarding language access at time of discharge.
    - Expand training to bi-lingual para-professional and informal caregivers around transitional care issues and resources.
    - Assure training include sensitivity to the needs of Lesbian, Gay, Bi-Sexual, Transgender clients.
- **Provide a way for individuals to share information about quality services** related to discharge, like the Home Healthcare Compare website www.homehealthcarecompare.org, or a more informal local blog.
- **Augment hospital-based staff** with a more formalized team of community providers, peers and caregivers who are trained and specialize in transitional care issues, like the Homecoming Services Network and its providers. .
- **Work in partnership with caregiver support organizations** to establish protocols to encourage consumers to designate a lead caregiver/advocate in advance of a hospital stay.
- **Encourage senior, disability and caregiver groups to work in partnership with housing providers to** share information and resources.



Real Choices When It's Time to Leave the Hospital

Florence fell on her way to a party to see friends. She tripped getting out of the cab unaccompanied and fell hard on the sidewalk, suffering a major blow to the head. Because no one knew where she regularly was treated and she had such major trauma, she was whisked off to San Francisco General. When she was medically stable, she was transferred to Laguna Honda Hospital (LHH) for further rehab. If the ambulance had taken her to one of the other major hospitals, LHH would not have been a real option for the discharge planner as other hospitals have very limited ability to refer to LHH. Because LHH is publically funded, access is largely limited to those discharged from SF General or other county programs.

ATTENTION – THOSE CONCERNED WITH ASSURING QUALITY SERVICES THROUGHOUT THE TRANSITION

Transitions can be dangerous for seniors and their care is seldom coordinated

- Legislation defining and mandating discharge planning has been belated and contains few mechanisms to enforce standard levels of care.
- Seniors and caregivers throughout San Francisco still complain of difficulties accessing adequate support post-discharge.
- Seniors and adults with disabilities discharged on Fridays in advance of reduced hospital staff over the weekend find it particularly difficult to arrange transitional care services. Yet more individuals are discharged on Friday than any other day of the week. If a study done by the Ottawa Health Research Institute in Canada is any indication, those patients discharged on Friday had a higher re-admission and mortality rate than those discharged other days of the week.
- Staffing ratios of social workers or discharge planners to patients are often extremely high. Caseloads of 50 or more are not uncommon and this often prevents the discharge planner from doing a thorough job because of time and resource limitations. Furthermore the jobs of social service staff are often not concretely defined and are complex and involve addressing family or patient psychological crises as well as other emergency situations.

The Joint Commission on Accreditation of Healthcare Organizations (JACHO), that promotes measurable quality standards and outcomes, currently has only one measure that addresses this discharge arena, although more are expected in the future. Currently, measurement of this area in San Francisco hospitals shows an extreme range between the best and worst performing hospitals in San Francisco (see page 21).

Recommendations

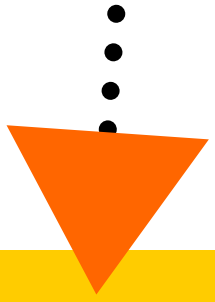
- **Assign responsibility to hospital staff or volunteers to follow-up with patients after discharge**. Studies have shown that even something as simple as a follow-up phone call post-discharge has improved patient satisfaction with the discharge process (See Health Research for Action, Review of Literature 2006).
- **Begin discharge planning at admission,** Programs like the Bridge Program at UCSF and the ACE unit at SF General are examples where extra efforts is made to institute advance planning and establish community linkages early in the process.
- **Increase the use of community-based care coordination positions** to monitor and support patients after discharge. Efforts to establish the Homecoming Services Network is a step in this direction.
- **Expand dedicated funding for transitional care** to agencies trained and supported as a part of the Homecoming Services Network.
- **Create a simple consent mechanism that enables patients to approve sharing information** important for their safe discharge among providers at inpatient, outpatient and post-discharge care sites as well as with their designated advocate.

- **Support development of the Case Management Connect Project**, a partnership between DAAS and DPH to set standards and improve coordination, including development and expansion of shared basic client data with a variety of providers through a secure network with the client's permission.
- **Establish outcome measures** that document the cost-effectiveness of improving discharge planning and expanding transitional care services. While tracking re-admissions is one tool, a more universal measure might be tracking "hospital days saved".
- **Encourage broader adoption of financial incentives** that link cross-institutional performance to provider pay at the state and federal level.
- **Develop a comprehensive framework for risk assessment** in San Francisco hospitals that can be promulgated as a community standard. Communities in Florida, Georgia, and elsewhere are moving towards adhering to a uniform "check-list" of assessed needs and assuring patients are uniformly evaluated for potential post-care needs upon admission to the hospital as well as near the time of discharge.
- **Work with chronic care management programs** of primary care and community health providers to incorporate risk assessment practices into care planning and assure those programs are contacted to help each individual transition home with on-going monitoring and support.
- **Require hospitals to post their discharge policies and procedures**, since these policies provide the basis for evaluating quality of care and conformance with licensing standards.
- **Work to eliminate disparities of access to transitional care and community-based services based on hospital-of-discharge**. Access to Laguna Honda and other long term care facilities are not uniformly available to patients at discharge from individual hospitals.
- **Establish citywide staffing ratios for the discharge planning function,** and create concrete definitions of job responsibilities for social service staff/social workers/discharge planners.
- **Work to eliminate disparities of access to transitional and community-based services based on insurance status**.
- **Reward hospitals that incorporate risk assessments** conducted over time to evaluate changing health status and need.
- **Implement a pilot program that trains seniors as volunteer peer advocates** who assist other seniors and their caregivers during the transition from hospital to home transition.

High Risk Screening Criteria

- Over the age of 70
- Multiple diagnoses and co-morbidities
- Impaired mobility
- Impaired self-care skills
- Poor cognitive status
- Catastrophic injury or illness
- Homelessness
- Poor social supports
- Chronic illness
- Anticipated long term health care needs (e.g., new diabetics)
- Substance abuse
- History of multiple hospital admissions
- History of multiple visits to emergency room

- **Encourage seniors and adults with disabilities to designate a trusted friend and/or advocate** who can work with the hospital and community-based providers to improve communication and assure needed services are in place.



Was Florence Poor Enough to be Eligible for Medi-Cal?

Florence, like so many San Francisco senior and disabled residents, was a member of the group she called the "upper poor": Just a little too much money to clearly qualify for public benefits, but not enough to pay for needed services without significant help. Florence's experience in trying to qualify was a roller-coaster ride with everyone saying something different. The hospital discharge planner told her advocate not to bother, it would take six months or more to become eligible (wrong answer). The Medi-Cal eligibility worker determined she was eligible but would have a very large share of cost (incorrect). The IHSS Eligibility staff determined she was income eligible but her small retirement account of less than $10,000 made her ineligible unless she spent down to $2,000. Her small account represented a lifetime of savings and was a symbol of her ability to remain independent and have a little money to spend however she wished—to go out, to take a trip, to give a gift, to have a life that was not totally dependant.

Lumetra is own of three Medicare Advantage Quality Review organizations in the nation, contracted by the Centers for Medicare and Medicaid Services (CMS) to begun a regular series of quality improvement trainings for providers, which highlight some of the following "best practices".

Care Transitions Best Practices – Lumetra	
Intervention	**Description**
Discharge Planning	➢ Use structured discharge instructions and checklists ➢ Train patients on warning symptoms and adverse events ➢ Increase communications between the sending and the receiving providers
Communication	➢ Collaborate with practitioners across clinical settings to develop and implement a coordinated care plan ➢ Facilitate coordination among providers and settings ➢ Provide discharge instructions in multiple languages and basic reading levels
Transition Coach	➢ Help patients improve healthcare navigation skills ➢ Review medications and warning symptoms ➢ Conduct onsite and telephonic visits ➢ Reinforce to patients the importance of a follow-up visit and schedule before discharge
Follow-up	➢ Assess patient treatment adherence ➢ Follow-up with patient visits or phone calls ➢ Verify and obtain a medication history
Medication Reconciliation	➢ Clarify and ensure that medications and doses are adequate ➢ Reconcile and resolve discrepancies ➢ Use electronic health records systems, telemedicine, e-prescribing and bar coding
Health Information Technology	➢ Support a Continuity of Care Record ➢ Consider using electronic sign-out tools
Personal Health Record	➢ Encourage patients and caregivers to use, carry, and share a PHR with all members of their care team ➢ Create core data elements to facilitate care coordination ➢ Support patient involvement and decision-making
Patient Self-Management	➢ Facilitate assessment, goal, and action plan setting ➢ Facilitate patient education in behavior change ➢ Use patient reminders ➢ Prepare caregivers on what to expect at the next care setting and with appropriate discharge information
Caregivers	➢ Train caregivers on warning symptoms and adverse effects ➢ Develop, implement, and evaluate a continuous care transition process improvement system
Care Transitions Quality Improvement Measures	➢ Use care coordination measure to monitor quality improvement (QI) care transitions efforts

ATTENTION HOSPITALS

Hospitals do not prepare patients and caregivers adequately for discharge

Over the past 10 years San Francisco has seen a simultaneous increase in inpatient hospital usage and home and community based long term care services available to seniors and people with disabilities. The Olmstead decision of the Supreme Court puts additional responsibility on hospitals to assure patients are provided information and reasonable choices about their options for continuing care and the services available to them should they choose to return home.

It is imperative that individuals understand their rights and get appropriate support in the areas of dispute resolution, hearings and other grievances. Similar programs operate in the arena of mental health, housing rights, nursing facilities and homeless shelters that receive public funding. The Board of Supervisors committed funds for this purpose in July 2007, but implementation has been delayed because of budget shortfalls. It is hoped that this project will be funded in the 2008-09 budget year.

Evaluating Hospital Performance

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which evaluates and accredits hospitals, has established a number of measures to assess quality. One measure relates to the number and percentage of recovering cardiac patients who receive discharge instructions. Of the 10 San Francisco hospitals evaluated, the scores ranged from a high of 90% of all patients to a low of 39% of patients receiving discharge instructions. Only one San Francisco hospital scored in the top 10% of the state (above 88%). Clearly, hospitals could do more to share their best practices. More information about hospitals performance is available at www.hospitalcompare.hhs.gov.

Cost can not be the determinant factor under Olmstead for government to deny one mode of care over another post hospital. But lower costs can be an additional outcome. The work done by Eric Coleman at the University of Colorado has demonstrated that his Care Transitions Intervention model reduces medical bills (www.caretransitions.org). Studies by Mary Naylor at the Hartford Center of Geriatric Nursing Excellence have also documented that transitional care can improve outcomes while reducing costs.

Recommendations:

- **Provide training for patients and their family caregivers**
  - Form partnerships with existing caregiver organizations like the Family Caregiver Alliance to develop and distribute specific information for caregivers on post-acute care tasks.
  - Develop hospital and home-based patient and informal caregiver training modules specific to the medical needs and conditions of diverse patients after discharge.
  - Create care support centers in hospitals for education and training.
- **Involve clinicians more fully in the discharge process and training**

    - Develop checklists with specific information by medical conditions and adopt other tools and procedures.
- **Develop protocols that assure medication reconciliation and monitoring is a part of the transitional care process**, with provider responsibility clearly assigned and appropriate caregivers trained.
- **Support and evaluate implementation of new JACHO indicators on hospital discharge planning and transitional care** as a part of the hospital accreditation process.
    - Independently assess compliance with new JCAHO requirements
- **Incorporate transitional care into the program priorities of relevant federal organizations.**
    - Share research findings with relevant government agencies and organizations.
- **Create a patient advocate or ombudsman function for acute care hospitals.**
- **Recognize and promote "best practice" models working in hospitals in San Francisco, including building working relationships with community-based transitional care agencies.** ***Some examples include***:
    - Acute Care for the Elderly (ACE) units work in a comprehensive way to maintain function during hospital stays with prepared environments, patient centered care, early discharge planning, and medical care review.

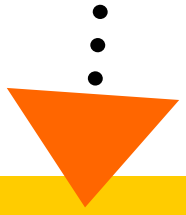
Effects of the ACE Program		
Discharge Outcome	ACE	Usual Care
Excellent/Good Health	51%	36%
Better Able to Walk	19%	14%
# Depressive Symptoms	3.7	4.6
Return Home	86%	78%
New England Journal of Medicine 1995: 332:1338-44		

    - Advice to patients from ACE has universal appeal:
        - Avoid hospitalization through preventive care – hospitalization can lead to significant, if not complete, loss of function
        - If possible, ask to go to an ACE unit
        - Bring someone along and/or designate an advocate
        - Ask questions about diagnosis, procedures, medications
        - Ask for a written summary of what happened, your discharge plan – including medications – and whom you should call if you have questions

Spotlight on Medication Safety – Research compiled by Family Caregiver Alliance highlights the impact of problems associated with medication therapy. Of all age groups, seniors benefit most from taking mediations and risk the most from failing to take them properly. "Medication non-adherence accounts for more than 10% of older adult hospital admissions (Vermiere, 2001), nearly one fourth of nursing home admissions (Strandberg, 1984), and 20% of the preventable adverse drug events among older persons in the community setting (Gurwitz, 2003)." All too often, medication reconciliation does not happen as the patient moves through care settings and medical professionals, leaving the patient wondering which medications to take – those they were taking before, those new drugs they received in the hospital, or drugs recommended by their primary care physician post-hospitalization. A recent article in the Wall Street Journal (12/12/07) highlights the importance of medication management in "Keeping Patients from Landing Back in the Hospital."

- A Robert Wood Johnson Foundation project in Florida, Life: Act II sponsored by the local United Way in partnership with local hospitals, enlisted the hospitals to do their own self-assessment and offered to "embed" staff familiar with community resources on-site at the hospital.
- The work of Dr. Eric Coleman and Mary Naylor provide leadership in the areas of creating and replicating best practices.
- The Homecoming Services Network provides a particularly relevant model when working in diverse communities with low and middle income individuals, including those that have no available caregivers.

- **Hospitals need to increase the discharge and social work staff time available** by establishing and implementing reasonable staffing levels, either voluntarily or through public action.



Maintaining Quality Medical Care
Florence settled in nicely after returning home, but issues of pain persisted and getting out to see her regular doctor became difficult. However, Florence was referred by a friend to the HouseCalls Program of UCSF, which provides a medical team including a trained geriatrician who became her regular physician and was available to come to her and monitor her healthcare needs on an on-going basis. They helped adjust her medications as needed and were able to bring in home health care and eventually hospice care at the end of her life.

ATTENTION - SENIORS AND PERSONS WITH DISABLITIES

Seniors and caregivers are not informed or trained in critical home-care needs after hospitalization

The Health Research for Action Study, the work of the Healthcare Action Team (HAT) and others have well documented that seniors, persons with disabilities and their hands-on care providers all too often feel disempowered and sometimes down right deserted as they transition out of hospitals and nursing homes. Even worse, they cannot find a real way to understand or exercise their right to a good discharge and supportive services. All hospitals have policies that say good discharges should be the norm, and the highest court in the land, the Supreme Court, has spoken to guarantee individuals have the right to choose alternatives to long term hospital or nursing home placement, with an assumption that institutions need to respect and help guarantee that right. But all too often, financial pressures get in the way of these rights and services.

At the same time, health and social service providers recognize that consumers want and need to play a greater role in their own care to improve outcomes and patient satisfaction. Work at the University of Colorado by Dr. Eric Coleman has helped document the issues and helped call for changes that strengthen the patient's role. At the heart of his work is the empowerment of the patient and the use of a Personal Health Record that can inform providers across care settings. His work also effects significant cost reduction to hospitals and insurance companies, making it more than worthwhile for all involved. More information is available at www.caretransitions.org.

Studies have shown that providing good discharge information, making follow-up phone calls, providing access to transitional care coach, peer advocates, and better trained hands-on caregivers can all improve discharge from the consumer point of view. An overwhelming percentage of San Francisco's seniors and adults with disabilities live alone, creating a unique challenge for this city. The Homecoming Services Program provides real hands-on experience for how to develop transitional care programs in communities that are culturally and ethnically diverse and places where many are lacking basic family supports.

Recommendations

- **Require simple, easy to understand information on discharge appeal rights in appropriate languages and formats** for patients being discharged from all San Francisco hospitals (in keeping with the new requirements to inform Medicare patients of their right to appeal their discharge). Make sure that information is in several languages and accessible to people with low literacy.

- **Require that information about community-based services be provided to assist in the transition from the hospital**. San Francisco hospitals and community-based agencies could work together to provide patients and their designees with a simple document containing the same information in several commonly spoken languages. Such a handout, included as an Attachment, was vetted and approved through the Northern California Hospital Council but never implemented. It would be provided at admittance to explain the process and patients' rights to a discharge plan and provided again at least 24 hours before they are to leave to make clear what they should expect and whom to call if they want to appeal their discharge. Each notice should give a phone number to call if they have questions about their rights. Similar tools have been developed by Hospital Foundation in New York.
- **Produce educational materials and related resources to address the pre-and post-discharge needs of seniors and caregivers specific to their health care issues.** The Family Caregiver Alliance has developed such material on it website at www.caregiver.org.
- **Create a simple, consumer friendly website and associated central phone number** that can provide links to formal resources and informal support in the transition process in appropriate languages and formats.
- **Develop informed and empowered consumers and caregivers** as an important component of increasing the likelihood of a good discharge through programs like the Senior Survival School (www.seniorsurvivalschool.org).
- **Fund the Consumer Peer Training Program piloted during the Transitional Care Pilot Project planning process** to make trained peers available to agencies, faith communities, housing providers and others.
- **Encourage consumers to appoint a surrogate decision-maker** who can be their advocate and play a role in assuring providers communicate with one another for the benefit of the patient.
- **Encourage consumers to participate in organizations that keep them from becoming isolated** and that can help rally volunteers for practical support upon discharge (senior centers, faith communities, other social networks).

Transitional Care "Team" Makes for a Smooth Transition Home

The Homecoming Services Program of San Francisco Senior Center helped make Florence return home was as smooth as possible. They made sure her IHSS was approved and a provider sensitive to her needs was available the day she returned. Florence's friends helped clean her apartment and buy food (otherwise Homecoming Services could have arranged that). Homecoming Services staff brought over a few needed items, like a commode chair, and helped arrange for home delivered meals and a med-alert system to help everyone feel more secure at night.

- **Mobilize consumers to tell their story** to policy-makers through groups like Planning for Elders (PECC), Senior Action Network (SAN), the California Alliance for Retired Americans (CARA), AARP and others – to be the "squeaky wheels" that can bring attention to the problems.
- **Learn and use existing complaint and appeal processes**, including those of Lumetra and the California Department of Health Services.
- **Urge consumers to take charge of their health care records**, and assure that care providers have access to information about emergency contacts, medications and chronic health conditions. Dr. Eric Coleman and others have developed and promoted the use of these personal health care records.
- **Assure that the new Long Term Care Consumer Rights Initiative works** with hospital discharge planners so that patients have access to publicly funded home and community based Medi-Cal or other services. This assures a real choice of options in the spirit of the Olmsted decision at the point of discharge.

ATTENTION – NON-HOSPITAL BASED CARE PROFESSIONALS AND PARA-PROFESSIONALS

Many care professionals, both on the hospital side and the community side, know what is needed. But missing pieces in the continuum of care frustrate their attempts to provide quality transitional care services and support. The Homecoming Services Network's initial pilot project highlighted and began to address some of these issues, with an emphasis on addressing "immediate" needs – i.e. the individual is coming home tomorrow and lives alone, has no food in the refrigerator, no access to money to fill prescriptions or even to pay for transportation home. No one is clear if their income and assets make them eligible for Medi-Cal nor whether they can pay for service out of pocket. Below are some specific issues, and recommendations for this sector:

Access to Transitional Care Services

Hospital discharge staff expressed their need to be able to identify a community partner – case manager or other care coordinator – to whom they could hand off care and feel confident that the patient would not fall through the cracks in terms of accessing needed services. S.F. Senior Centers' Homecoming Services Program has provided that support to St. Francis Memorial and St. Mary's Hospitals for several years, and the pilot project has increased outreach and received the same response from many of the other San Francisco Hospitals:

- **Expand the Homecoming Services Network** as a vehicle to provide on-going training, coordinated referrals, and expedited access to resources, mutual assistance and problem-solving.
- **Expand dedicated funding for transitional care**, so that key agencies with appropriate language capacity are adequately prepared and have staff with smaller case loads so they can respond immediately to help assure a smooth landing for patients being discharged from the hospital and nursing facilities.
- **Create a single access point** for discharge planners to access transitional care services through the Homecoming Services Network.

Access to Homecare and IHSS

Help at home once the patient is discharged from the hospital can be the critical factor in whether the patient continues to maintain and regain function or returns more quickly to the hospital. Over the years, the IHSS Program has received significant funding to improve wages and benefits and increase training and support for workers and consumers. It has also established an IHSS Registry to help match the needs of consumers with the skills of workers, and an IHSS Discharge Liaison Program to work more proactively with hospitals and case managers to help individual access IHSS services. However, for those individuals not enrolled or not eligible for Medi-Cal and IHSS, getting home care quickly is more of a problem. Many individuals are technically eligible for Medi-Cal and IHSS, but need to pay a "share of the cost" to access the benefit. Veterans, retired workers with small pensions, and others classified as the "upper poor" are disproportionately affected. The Community Living Fund can provide some assistance, but the solution is to reform the Medi-Cal Share of Cost Program.

Medicare beneficiaries receive a limited about of personal care services post discharge, but much of what is needed is not covered. Often home health agencies are the one consistent entity to provide care post-discharge and agencies could be looked to as another resource in alerting other community providers to individuals in need of additional help to stabilize at home. However these home health services are also significantly under-funded.

Recommendations:

- **Assure that the DAAS IHSS Discharge liaison unit remains fully staffed** and dedicated to this function.
- **Expand the IHSS Share of Cost Pilot Project** and target a portion of the resources to help patients being discharged from the hospital.
- **Work more proactively to enroll individuals in Medi-Cal prior to hospitalization** whenever possible to assure ready access to benefits at discharge.

Access to Funds for Immediate Needs and More Long Term needs

Most trips to the hospital are not planned, and patients or their caregivers may not have access to funds to pay for needed items at the point of discharge. Because most hospital discharge units have a very limited ability to pay for needed items, it generally falls to the community providers to help individuals and caregivers figure out how to pay for things. The Homecoming Services Network pilot has helped establish a small fund that can be accessed by case managers to pay for a range of items in coordination with the Community Living Fund. The Community Living Fund is a local initiative that provides flexible dollars to help individuals avoid placement and return home with adequate support.

Many patients do not have stable or accessible housing

San Francisco, like other urban areas, faces challenges due to the high number of homeless and inadequately housed individuals who need a place to go at discharge. Recently legislation was passed (A.B. 2745 – Jones) to deal with address issues related to "patient dumping" of homeless individuals. A series of local forums hosted by the Hospital Council, highlighted two things:

- San Francisco has initiated a number of specialized programs to address the needs of homeless and at risk individuals, but currently different hospitals do have different standards in terms of what they require at point of discharge.
- San Francisco still has a significant number of individuals for whom no suitable alternatives exist and patients are either discharged anyway or remain in the hospitals without a way to reimburse their care.

Increasing the number of respite beds in the City is a widely held goal for hospitals, homeless, veteran and disability groups.

It would be the hope that San Francisco could continue to develop programs and priorities that assure that no one is discharged inappropriately.

Recommendations:

- **Evaluate and work to expand the Homecoming Service Network Emergency Fund.**
- **Continue to develop policies and procedures that make the Community Living Fund** responsive to the needs of consumers being discharged from the hospitals.
- **Increase awareness of how to access other specialized funds**, like Season of Sharing, Fitschen Funds, and the like, to help in the transitional care process.

Access to Transportation

Arranging safe and affordable transportation for a patient to return home can also be a challenge. Consumers should not be discharged to a taxi without accompaniment. New resources to help with accompaniment through Little Brothers Friends of the Elderly was a needed addition, but still limited. Many individuals are too ill for regular transportation, but are forced to use a costly ambulance because gurney service is not available in San Francisco. Cost savings can be over $1,000 per ride to offer gurney service alternatives for non-medical transport.

Recommendations:

- **Work with the hospitals, para-transit program and taxi drivers to improve access to transportation** at the point of discharge
- **Change the policy to allow "gurney service" for non-medical transport.** San Francisco remains the only county in California that prohibits gurney service in favor of ambulance transport. The Advisory Council of the Aging and Adult Services Commission is supportive of the reinstatement of gurney service in San Francisco, but currently only ambulance transportation is available. Restoring Gurney Service in San Francisco would provide more cost-effective transportation to those who do not need (and cannot afford) an ambulance transport and would reduce the reliance on taxis for patients very ill at discharge.

Access to Surrogate Decision-makers

Many seniors and persons with disabilities in San Francisco live alone and have not formally designated anyone to help them with healthcare decisions or to have appropriate access to information from hospital and community caregivers to help in arranging support and assuring continuity in the transition process. In the extreme case, patients who can no longer make decisions for themselves sit in their hospital bed for days, weeks, sometimes months while the hospitals try to get the individual a legal conservator or guardian to help transition them out. More often, the patient has not planned ahead to designate someone to have power of attorney for health care or at the very least, to have access to basic information related to the care plan. The patient needs a designee to play a supporting role during the process and make sure the information about the patient's baseline abilities, housing accessibility, and access to social and practical support become a part of the planning process.

Recommendations:

- **Develop a much more active outreach and training effort** to help seniors, adults with disabilities and their hands-on care providers plan for their first trip to the hospital.

- **Promote the use of a durable power of attorney for health care** to designate a representative to help make decisions in line with the person's wishes as they relate to returning home vs. placement in a nursing facility.
- **Promote information about models for supported decision-making** that continue to involve the person in process despite reduced cognitive function.

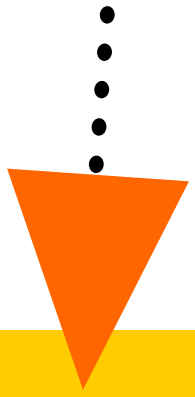
Coordination with Home Health Agencies and Hospice Programs

Home health care agencies and hospice providers can be a critical part of the safe transition home, providing a range of health and supportive services covered by Medicare, Medi-Cal or other insurance sources. However, referrals made on the day of discharge, particularly if it is a Friday or holiday, make it difficult for the agencies to appropriately respond. They can provide nursing services, medication reconciliation, physical therapy, and the like – depending on what the doctor orders.

Hospice is another resource in end of life transitions, but is often not involved early enough in the process to help substantially in end of life transitions.

Recommendations:

- Levels of staffing in the discharge units need to be adequate to facilitate more planning and to minimize last minute referrals.
- Physicans writing discharge orders need to give the discharge staff and the patient at least 24 hours advance notice.
- Insurance payment rates for Home Health Care need to increase to keep pace with the actual cost of providing quality care.
- Hospice and palliative care programs needs to be involved earlier in the process to help the patient and their family manage transitions, including hospital transitions, at the end of life.



Exercising your rights is tough when you're sick

Florence worked on helping people fight for their rights her whole life, but when she was sick or injured, she needed someone to help her fight.

Florence gave one close friend her medical power of attorney for healthcare and they had talked and documented her wishes. She designated another as her advocate to deal with services providers and the hospital, and a third to manage her finances. Unfortunately, only the first delegation was in writing.

Ideally, a person is empowered to make their own decisions, but also designates in writing who they would like to help them.

Florence wanted to leave Laguna Honda. She felt they had done as much for her as they could (and they probably did) and now she just wanted to go home. Staff at LHH did not agree and were recommending she transition to the long term care ward. Florence's advocates all worked to help her return home by helping arrange services and advocating in case conferences. Florence was able to transition back home with appropriate services, in large part because she had designated surrogate decision-makers and advocates who could help assure her wishes were carried out.

Access to on-going Physical Therapy and Support – A study by Planning for Elders and North and South of Market Adult Day Health Center examined discharge data and highlighted two key points in the discharge process. The first is when the person leaves the hospital and the second is when the person's Medicare or other health benefits run out, usually about 6 weeks after discharge. Programs like Adult Day Health Services can provide on-going access to physical therapy, occupational therapy, medical oversight, and the like through funding from Medi-Cal, Long Term Care Insurance, or through private pay on a sliding scale basis. Yet physician referral to these types of resources rarely happen at the point of discharge, and patients are not made aware of these options because the time allowed for hospital discharge planning tends to be too short. ADHC programs can even provide three transitional days in any 12 month period, without prior authorization, to assist individuals transitioning out of an institutional setting into ADHC.

Recommendations

- **Investigate current barriers** and facilitate improved referrals to programs that provide on-going physical therapy and support, including adult day health programs, On Lok and PACE programs.

Access to Volunteers and other Support

Hospital staff and patients alike report that if a patient has a support network - family members or friends who will be their advocate and help assure providers communicate with one another - the patient fares much better in the transition from hospital to home. Yet a disproportionate number of San Francisco residents live alone and report having a local support network that is limited or virtually non-existent. Long term solutions to helping improve transitional care in San Francisco are directly related to helping build those support networks that can produce the volunteers to help with the many things needed.

Recommendations:

- **Fund and promote programs that help rebuild social support networks for seniors and adults with disabilities** like those being developed by the PLAN Institute in partnership with the Community Living Campaign here in San Francisco. Another model just beginning is San Francisco Village – Northside being piloted in San Francisco's northwest neighborhoods with support from community churches, businesses, medical providers, neighborhood associations, etc.
- **Help expand existing peer support programs** like those developed by Family Service Agency, Planning for Elders, Independent Living Resource Center, the IHSS Public Authority and others.
- **Help train and expand the number of volunteers in other programs that provide practical support** – examples include Little Brothers Friends of the Elderly, Project Voice, Bernal Heights NEST Program, to name a few.

Access to Appropriate Housing

Many San Franciscans who want to return to their own homes face one major obstacle - stairs. San Francisco's housing stock is blessed (or cursed) with an overabundance of stairs, creating particular challenges for people with short term or long term physical disabilities that make traversing the stairs next to impossible. Short term solutions would be to increase the amount of respite beds or short term shared housing made available to help individuals recuperate in an accessible, supported environment. Long term solutions involve taking a hard look at the city's housing stock and increasing the amount of accessible housing, with more "universal design" principles, so that future housing stock is more practical for those seeking to age in place. Universal design, also called barrier-free design, focuses on making the house safe and accessible for everyone, regardless of age, physical ability, or stature.

Recommendations:

- **Assure a home assessment is part of the discharge plan** of high-risk patients, with information provided by family members, other caregivers, or hospital staff.
- **Increase the number of respite beds available in different settings** for those transitioning out of the hospital but unable to return home because of short term access issues.
- **Expand use of ramps, stair lifts, and other means to make housing more accessible,** especially to those individuals with chronic conditions where multiple hospitalizations might be expected.
- **Develop more housing to be fully ADA accessible and build with universal design principles** so as to be more flexible when health conditions and needs change.
- **Increase the amount of accessible, affordable, supportive housing,** especially for adults with disabilities under 62, who have few or no options now for this type of housing.

Access to Training and Support

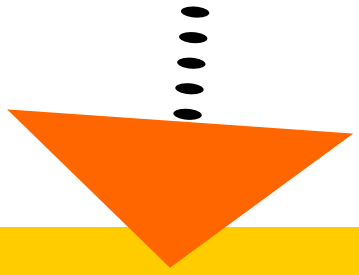
Professionals and Para-professionals serving seniors and persons with disabilities who play a role somewhere in the transitional care process need additional and on-going training and support to increase their effectiveness in discharge planning, arranging post discharge care and support, and working with patients and their hands-on care providers to delay or prevent future hospitalizations.

Recommendation

- **Support the systematic development of training on transitional care for all professionals and para-professionals in the care continuum –** including primary care physicians, hospitalists, discharge nurses and social workers, home health aides, homecare providers, and community health workers – with incentives such as Continuing Education credits where appropriate.
- **Support and expand programs that train future clinicians in providing needed in-home medical services,** like the UCSF Mt. Zion Housecalls Program.
- **Support the systematic development and training of community case managers and care coordinators** by making the Homecoming Services Network Case Manager training an on-going practice.
- **Promote existing training opportunities widely and enthusiastically**, including the opportunities for cross-disciplinary and cross-education provided by groups like

Lumetra, California American Geriatric Society, California Association of Long Term Care Medicine, and so forth.

- **Expand initial and on-going in-service training for IHSS Para-professionals** so that they can perform the increasingly more complex tasks for individuals being discharged back home.
- **Promulgate tools that help both professional and Para-professionals understand and communicate information,** like resource information that can be downloaded from sites like Family Caregiver Alliance and Senior Survival School or the information being developed by Eric Coleman's Transition Coach model.
- **Encourage broader adoption of financial incentives for physicians** who demonstrate successful, long-term reductions in re-hospitalization for specific high-cost diagnoses by promoting effective transitional and in-home care.



Lack of a Support Network Has Real Costs

Florence had a wonderful homecare worker, who Florence's local friends and far-away family came to depend on, to the point where there wasn't a good back-up plan. When her homecare worker had to be off for a few days for minor surgery, the replacement worker did not know how to get Florence to cooperate in her own care, and when a whole day's efforts had resulted in Florence refusing any care, in desperation she called 911. The ambulance took Florence to the hospital, took care of her personal care needs, helped medicate for the pain, ran tests, and decided she was fine to go home—except there was no one available to provide trusted care until her regular provider returned in two days. At the urging of her advocates, the hospital agreed to let her stay through the weekend.

The cost was $900 for an unnecessary ambulance trip and over $10,000 for the hospital stay, much of which was not reimbursed because all that was really needed was custodial, not skilled, care. But Florence was happy, her friends were relieved, her caregiver was able to continue and life resumed as before when she returned home.

A stronger personal support network and more adequate back-up plan would have avoided this unnecessary cost and hospitalization, which always increases the risk of complications due to hospital borne infection, the overuse of catheters, and similar problems.

ATTENTION INFORMAL (UNPAID) CAREGIVERS

Caregivers are often left out of discharge planning process

While much of the focus so far in this report has been on those without available caregivers, many seniors and persons with disabilities live with or near spouses, partners, children, parents, siblings and other close family and friends. Yet the medical system does not substantially consider or support the critical role of informal (unpaid) caregivers. Individual discharge planners and even some hospitals have put more focus on engaging and supporting the caregiver, but the numbers of patients and expectations on the hospital discharge staff leave little time to really engage caregivers in a meaningful way. Information provided is often too general and does not help caregivers or the patient really understand what to expect with their specific condition when they return home. And too often, the available caregivers themselves are not in good health and may have real physical or mental issues that limit their ability to provide the kind of support needed. As patients go home sicker and quicker, with little time to put together a workable plan, issues can be emotionally charged and confusing. While most post- discharge services funded by insurance providers are tied to skilled health services, what is most often lacking is the practical support that can be effectively pulled together by community-based case management and transitional care programs.

Transitional Care can help mobilize the support network
Florence's declining health resulted in a number of hospital stays in her 80's, and a loose network of friends helped her with shopping, paying bills, transportation to the doctor and social activities. Had there been a transitional care program like Homecoming Services in place during some of those initial hospitalizations, Florence and her friends and family could have more deliberatively organized into a social support network to mobilize formal and informal support to help maintain Florence's qualify of life until the end of life.

The days and sometimes weeks immediately following discharge are the most stressed, causing the caregiver to risk their own health and sometimes their job to provide needed care.

Recommendations

- **Enhance caregiver support before, during and after discharge** by
  - **Training staff to better recognize and integrate caregiver support** as part of the unit of care and as an integral part of the care team.
  - **Encourage development and evaluation of innovative models in team caregiving** (e.g. tools by Share The Care (sharethecare.org) and PeaceHealth's Shared Care Plan.
  - **Increase the awareness and expand the availability of caregiver resources and support groups** and other support services to provide emotional assistance and respite for caregivers and information on providing and obtaining care. Agencies

like the Family Caregiver Alliance have a wealth of information available by calling the office, participating in a support group, or accessing disease and condition-specific information related to what to expect when you get home at www.caregiver.org.

- **Encourage patient assessment protocols in hospitals include a realistic assessments of caregiver strengths and abilities**, as well as the level of additional support available.

- **Encourage local employers to adopt policies and procedures** that give primary caregivers more leeway and flexibility to support their caregiving roles. Action by San Francisco to require employers to provide paid sick leave also allows employees to use that paid leave not just for themselves and family members, but also to allow employees with no spouse or partner to use leave to care for a "designated person" such as a neighbor or roommate.

- **Encourage local employee and labor organizations to push for policies and procedures that support caregivers** with expanded flex time, financial support, etc. One example is the Child and Elder Care Fund at Unite HERE Local 2. The Fund helps offset non-reimbursed expenses incurred by workers in caring for a spouse, parent, parent-in-law, grandparent, or domestic partner. Unions like the UAW, IBEW and CWA have successfully negotiated elder care resource and referral services for their members. Other unions have bargained for family leave (paid or unpaid) and flexible work options for members who provide dependent care.

Labor Project for Working Families
ELDER AND DEPENDENT CARE IN UNION CONTRACTS
Here are some types of contract provisions unions have negotiated to help members address the demands of caregiver:

- **Resource and Referral Services:** Match care providers with appropriate elder care resource and services.
- **Pre-Tax Programs:** Establish a tax-free flexible spending account for dependent/elder care expenses.
- **Elder Care Fund:** Provide direct cash payments or reimbursement for elder care expenses.
- **Support Services:** Provide information and support services for retired members and their families.
- **Long Term Care Insurance:** Help workers pay for long-term care for self or dependents including spouse or parent.
- **Sick Time for Family Members:** Enable workers to use their accumulated sick leave to care for sick dependents.
- **Flextime Options:** Enable workers to use their accumulated sick leave to care for sick dependents.

Sample contract language available at http://www.working-families.org/contractlanguage/index.html.

ATTENTION - INFORMATION AND COMMUNICATION SPECIALISTS

The systems to share both patient and resource information across settings are, with some notable exceptions, badly fragmented and outdated.

Complications arise when patients are transferred from hospital to hospital, hospital to nursing home, and particularly from hospital to home without full communication between location of departure and arrival. Patients, their hands-on caregivers, and other providers are put at risk unnecessarily when the communication of important care information is neglected. And the risk is only increased by high caseloads, the prevalence of Friday and weekend discharges, the slow pace of adoption of electronic records, lack of understanding of HIPAA regulations, and the lack of simple tools that consumers and caregivers can use to track and share information.

Patient Information

There is a need for increased information sharing among hospitals and between hospitals and other care providers to make sure that patient discharge needs are assessed. All too often, when patients enter the hospital via the emergency room, little or no information is readily available about medications they are taking, nor is there information about medical decision-makers and caregivers who could provide information about base-line conditions and help inform care and discharge planning.

- **Encourage increased development and appropriate use of the Electronic Health Record pilot** that encompasses the hospitalization, discharge planning and hospital-to-home periods. Organizations like the Veterans Administration lead the way in this regard, but the City-funded health providers have made significant progress in developing a more integrated patient information system.
- **Encourage the development of appropriate information sharing between hospital and community providers**. Projects like the newly initiated Case Management Connect are beginning to bridge the gap between health systems and community-based services and support.
- **Encourage consumers and their caregivers to use existing tools to manage their own health information.** There are proficient means, both low and high tech, to summarize important health care information, like allergies, current medications, and names of individuals they would like involved in their care planning with appropriate signed authorization. On the low tech end is a simple card that they carry and that is posted on the refrigerator that lists who to call for needed information. Some non-profit housing providers use the VIAL for Life model, where basic health information is kept in a medicine bottle in the refrigerator with a notice on the refrigerator door to alert medical professionals in an emergency. On the other end is the growing movement for consumers to gather, store and appropriately share their medical information themselves, either by keeping and making copies, or by posting it on-line in one of the many secure sites where individuals can designate full or limited access. They can even make it available on a flash drive or electronic “key fob” with an individual’s entire history available to anyone with a computer.

- **Encourage hospitals to provide simple checklist and discharge instructions**, written in multiple languages and at literacy levels patients can understand.

Eligibility Information

With hospital stays getting shorter and shorter, there is less time to assess, let alone enroll, eligible patients in programs and services. Community-based service providers and agencies like IHSS, hospice and adult day care are increasingly posting screening and enrollment information on-line, but hospital staff and patients don't usually have the information or time needed to begin the process in the hospital. San Francisco has initiated Healthy San Francisco to assure all San Francisco residents have access to health care, which involves assessing potential eligibility for Medi-Cal, Medicare and other health care coverage. This will help individuals access health coverage before they have need for a hospital stay.

Lack of Patient Information Puts Individuals at Increased Risk During Transitions

When Florence arrived at SF General, she had no information on her about what medications she regularly took, how to reach her primary care doctor, or any allergies or special issues she had. Like most SF residents with Medicare, SF General was not her regular hospital and so did not have access to her medical records, nor was there any way to access patient information on-line. Emergency treatment decisions and early planning for discharge would be greatly enhanced by ready access to patient information.

Recommendations:

- **Evaluate the One-e-App process** being developed to streamline enrollment in a range of publicly funded health and human service programs. One-e-App is an on-line, unified application form is currently being used to handle enrollment to the Health Access Program in San Francisco and provide access to Medi-Cal and other services.
- **Engage the San Francisco Clinic Consortium and the San Francisco Health Plan** in efforts to identify and to enroll members in programs and activities that would prevent hospitalization as well as help manage care and provide post-discharge support.
- **Support California's acute and long-term care integration efforts, which include streamlining eligibility criteria and application processes** for home and community-based services.
- **Work with the Departments of Health and Aging and Adult Services to develop and to implement a county-wide Medi-Cal strategy** to enroll eligible individuals in existing Medi-Cal waiver programs that could provide continuity of care. These programs have at least 500 slots potentially available for San Francisco residents, many of whom could be accessed on discharge from Laguna Honda, SF General or other acute and long term care facilities in San Francisco to provide an array of services and post-discharge support.

Service and Support Resource Information

Previous sections have highlighted the need to make information about resources, services and support more available to all those involve in the process, including hospital staff, patients, caregivers, community-based health and service providers, and others. At this point, this type of information does not exist in a centralized place anywhere.

Recommendations:

- **Develop a centralized Transitional Care Resources website**, with funding to provide on-going updates and the capacity to alert "subscribers" to training opportunities, new resources, changes in Medi-Cal, Medicare or other regulations, links for the hospitals to make referrals to community providers, and the like.
- **Work with existing I&R providers** like 211, 311, United Way Helplink, DAAS Central In-take , Neighborhood Resource Centers and others to increase their awareness of this emerging discipline and the resources available.

ATTENTION: FINANCIAL MANAGERS AND RESOURCE DEVELOPERS

All too often, insurance coverage, not patient need, drives the discharge decisions

As noted in repeatedly in this report, the funding for services and support to help an individual transition safely from hospital, nursing home, and other settings is sorely lacking. Fragmented and complex funding sources, complex eligibility regulations, lack of funding for home and community-based long term care services, and lack of financial incentives to hospitals to improve discharge planning and services **all** put patients, family members and caregivers at risk. The following section highlights some of the ways that policy-makers could begin to address these issues in a more systemic way.

Promote Long Term Care Insurance Plans that Cover Transitional Care: An increasing number of individuals are purchasing long term care insurance or are offered access to plans through their employers. But some plans have features that limit access to services within a certain period of time post-discharge. Plans endorsed by the California Partnership for Long Term Care provide additional counseling and information to purchasing insurance and can help individuals assess how to purchase a plan that maximizes support post-hospitalization.

Promote Financial Planning that includes anticipating future hospital and nursing home stays. Odds are that all San Francisco residents will be hospitalized at some point in their lives, and if they are lucky, they will be discharged. Helping individuals understand rules related to Medi-Cal eligibility, long term care insurance, reverse mortgages, medical savings accounts, special needs trusts and the like can help consumers be more in charge of their futures.

Restoring Fairness to the Share of Cost Medi-Cal Program

Many low-income seniors and adults with disabilities are willing and able to contribute to the cost of transitional and long term care, but the current program places an undue and unequal burden on them. For example, the current SSI income limit is $870 per month for an individual (and $1,524 for a married couple). Folks are allowed an additional $20 in monthly income beyond that. In the Aged, Blind and Disabled Medi-Cal Program, individuals and couples are allowed to retain up to 133% of those amounts to receive Medi-Cal and IHSS without a share of cost ($1101 per individual and $1544 per couple). However, if they earn even one dollar over, their share of cost is not $1 dollar, but $482 ($591 per couple) and it goes up from there – a huge jump since these calculations don't take into account what an individual has to pay for food, housing and other expenses. All too often, individuals do not have the money to pay their "out of pocket" share after paying for these necessities.

San Francisco has undertaken several special programs to over-come this problem on a very limited basis:

- The IHSS Share of Cost Pilot Project, through which the county helps pay a portion of an individual's "share-of-cost", allowing them to enroll in Medi-Cal and to access needed health and long term care services.
- The Community Living Fund, which can provide funds to help individuals pay the share of cost and other expenses to help them return home as quickly as possible rather than be placed in a nursing facility.

However, the long term solution for San Francisco and for other communities in California is to change the share of cost calculations for Medi-Cal.

ATTENTION - POLICY-MAKERS

Time to Promote Universal Access to Transitional and Long Term Care in San Francisco

Encouraging San Francisco policymakers to move toward universal access to transitional and long term care will help assure that all individuals, regardless of income, are equitably supported when they need to be. In the end, this attention to transitional and long term care is a preventive measure that can minimize hospitalizations and improve quality of life while reducing over-all cost. Models like On Lok and its PACE replications have demonstrated the cost-effectiveness of this approach.

- **Promote policy changes that support efforts already under way to improve the transitional care process and the accessibility and quality of community services.** Expand the participation of providers in these efforts. Evaluate and recommend expanded implementation of legislative initiatives that improve care and services relevant to transitions, like A.B. 364 (Berg).
- **Create a San Francisco Discharge Planning Ordinance** (modeled after the Charity Care Ordinance) to make hospitals accountable for providing safe and adequate discharge options regardless of the patient's insurance status. Hospitals would be required to inform patients of their rights and options and they would report to the Health Commission periodically to insure compliance.
- **Promote major Medicare, Medicaid/Medi-Cal and Older Americans Act policy and program changes to support and adequately fund effective discharge planning and transitional care and to encourage in-home rather than institutional care.**
    - Expand funding under the Older Americans Act for services provided to seniors in the home.
    - Change Medicare's "75%" rule to cover rehabilitation in acute

Unrealistic and outdated Medi-Cal Asset limits biggest single barrier to transitional and long term care.

The asset limit for the Medicaid program in California (Medi-Cal) was set unrealistically low at $2,000 for an individual and $3,000 for a couple in 1989, and has not been increased even once in the 18 years that followed.

San Francisco leads the state in efforts to develop a quality IHSS homecare program with a solid collaboration between the Department of Aging and Adults Services that administers the program, the IHSS Consortium and IHSS Public Authority that help recruit, train and support IHSS providers with the highest level of wages and benefits in the state. Previous efforts to improve transitional care even created a special unit, the discharge liaison unit, to perform assessments and authorize homecare before the patient even leaves the hospital.
Yet those seniors and adults with disabilities who have the smallest amount of funds in the bank are locked out of the program until they impoverish themselves.

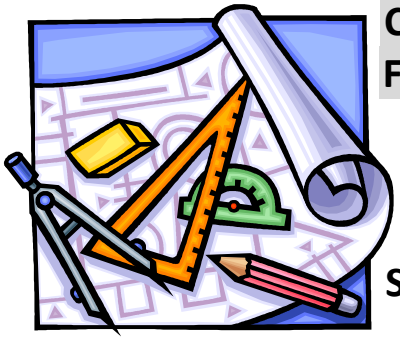
Does it have to be this way? No. Many states have adopted much more realistic asset limits, often as part of waiver programs. By comparison, the limit in Connecticut is $18,132, Illinois $10,000, New Jersey $40,000, South Dakota ($40,000) and Minnesota ($22,819) either as a part of their state plan or because of specific Medi-Cal waivers.

inpatient facilities for a wider range of conditions.
    - Strengthen IHSS policies, procedures and funding to train IHSS representatives to conduct pre-discharge determination of eligibility and home assessments so they can provide IHSS services in the home immediately after discharge.
    - To implement the Olmstead decision effectively, eliminate/minimize reimbursement policies that create a bias toward putting patients in institutions after hospital discharge.
    - Cover the cost of home modifications as well as durable medical equipment.
    - Pay for in-hospital visits for home health workers (use cost savings generated by reduced post-hospital visits) so that workers could be oriented to new prescription routines, side effects to watch out for, and any other post-discharge concerns.
    - Explicitly cover transitional care as a part of the benefits provided under private insurance plans, such as Medicare Advantage plans. Insurers can save money by avoiding preventable hospitalizations.

- **Support demonstration projects and other initiatives in transitional care.**
    - Adopt the hospice care model of family-focused and community-based care to transitional care.
    - Fund and evaluate other local demonstration projects for care coordination and early-support discharge, home-based caregiver training, and team caregiving models such as "Share the Care" (www.sharethecare.org).
    - Design and fund evaluations that can more clearly document outcomes.
    - Monitor evaluation results of a pilot program under Medicare which funds adult day health care services to enhance in-home recovery after hospitalization.
    - Encourage a major funder, like the Robert Wood Johnson Foundation, to help disseminate findings of promising interventions to promote implementation using a centralized website and local listserv.

- **Expand eligibility for public programs to meet the needs of the growing number of seniors and persons with disabilities.**
    - Raise the income threshold and assets threshold for Medi-Cal, particularly for Medi-Cal home and community-based long term care services like IHSS and Adult Day Health Care.
    - Modify the Medicare hospice benefit to cover serious chronic conditions, even if they are not diagnosed as terminal, and extend coverage of palliative care.
    - Make care/case managers a reimbursable benefit under Medicare regardless of whether the patient is eligible for nursing home care.
    - Expand Medicare coverage so that home care benefits are available for both short term transitional care and chronic conditions.

- **Amend the federal and California family and medical leave laws** to require employers to allow workers more flexibility in their schedules and other conditions of employment in order to provide care for a family member while continuing to work. Promote understanding of this benefit.



CAN SAN FRANCISCO BE THE MODEL COMMUNITY FOR TRANSITIONAL CARE?

With your help, we can!

So now what?

Hopefully, the reader has learned more about the issue.

Those interviews have seen some of their recommendations included.

We've highlighted a few of the programs and policies that are working to improve transitional care in San Francisco that could inform efforts in other communities.

We've identified lots more things we could do – some would just take a few phone calls, others would require a major shift in policy and funding.

So here are two final recommendations:

- **First,** convene key stakeholders to make a commitment to do better.
- **Second,** host a second Transitional Care Summit in San Francisco, focusing this time on setting priorities and commiting to take action.

What ideas to you have?

If you have comments, critiques or best practices which should be included in plans to implement this report, let us know by contacting

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Attachment A. – Planning Project Overview

Help Shape the Future of Transitional Care Services in San Francisco

The **Transitional Care Management and Support Planning Project** will provide a "blueprint" for establishing a model transitional care services delivery system in San Francisco, while involving a cross-section of community agencies and hospitals in a planning process. At the heart of the process is a commitment to train community-based case managers on the goals and objectives of the Homecoming Services Program model (described below) and improve the communication and referral process from participating hospitals. The target groups are isolated seniors and people with disabilities who are being discharged from acute care hospitals and who could benefit from more community-based care and support as they transition home. The project is funded by the Department of Aging and Adult Services, and includes funding for direct services. The initial plans and recommendations will be completed by July 2007.

San Francisco Senior Center (SFSC) is the lead agency to undertake this planning process. Currently, SFSC is sub-contracting for case management services with agencies whose staff will complete the training process and be available to help local hospitals to safely discharge at-risk seniors and adults with disabilities. SFSC is also working with Planning for Elders to develop training and material to help family members and peers better support the hospital discharge process.

The over-all goal is to develop a Transitional Care Services Plan that:

- Builds on the nationally recognized, locally developed "best practices" model, the Homecoming Services Program, for improving transitional care management services;
- Details successful methods to engage hospitals and community-based agencies in efforts to establish policies and practices that improve coordination and communication;
- Promotes expedited referrals to services needed for a safe transition from hospital to home, including IHSS and homecare, home delivered meals, physical and occupational therapy and the range of services available through the community living fund;
- Identifies ways patients, their families, and community volunteers can become "trained partners" to professional case managers, increasing their reach and cost-effectiveness;
- Outlines a strategy to strengthen funding for transitional care services in San Francisco.

The key components of the project include the following:

Lead Agency: San Francisco Senior Centers (SFSC) is the lead agency and has engaged a consultant specialist, Marie Jobling, to carry the organizational development responsibilities and draft the final "blueprint." SFSC first established the Homecoming Services Program to respond to the critical hospital-to-home needs of isolated seniors who lacked transitional support. In partnership with eight community based agencies, Homecoming Services Program provides immediate comprehensive services for medically at-risk low income seniors after hospital, rehabilitation or convalescent facilities. Homecoming Services Program is an intensive service provided on a short-term basis until permanent at-home services are arranged or no longer needed.

Expand and Replicate the Homecoming Services Model: The current program serves each client for an average of 4-6 weeks using a full intensive case management model in coordination with discharge planners through established relationships at designated hospitals. Medical escorts are provided, dwelling preparation is put in place including fresh food stuffs, and light housekeeping. Homecare assistance is arranged and hot meals are delivered if necessary. A care plan is established and implemented and daily contact is offered until patient is stabilized at-home.

Develop Training to Expand the Homecoming Program Model

- Host Trainings of Case Managers: Develop an initial training program model to expand the "Homecoming" model across the City. This training could then be integrated into the on-going Department of Aging and Adult Services (DAAS) case management training process.
- Host Training of Peer Advocates/Transition Coaches: Develop a training program for seniors, family members, persons with disabilities and community volunteers to serve as peer "transition coaches" to support the efforts of the case managers.

Improve the Partnership between Hospital Staff and Community-based Case Managers

- Hold Meetings with Key Hospital Staff: Come together at least twice to solicit input and encourage participation in ways that meet the needs of the hospitals. Overall, the planning process would commit to secure the hospitals' feedback and recommendations as they relate to the case management and transitional care services.
- Encourage hospitals to make referrals. Work to get specific commitments from participating hospitals to make referrals for transitional care services during this planning process and into the future.
- Increase public awareness of the Homecoming Services model and expanding services: Raise the visibility of participating agencies and cooperating hospitals through a focused media outreach utilizing the S.F. Examiner and local neighborhood and ethnic media. The project will also distribute a simple consumer handout in different languages to re-enforce the referral process.

Provide Additional Transitional Care Services

- Provide transitional care management: Support clients with case managers trained in the Homecoming Program model. Case managers would facilitate access to a continuum of services to provide for a smooth and safe transition from hospital to home.
- Assure needed services can be readily accessed: Establish protocols to assure the following types of services will be available in this expanded model: IHSS and homecare, home delivered meals, escort to medical appointments, and other purchased services through the new $3 million Community Living Fund.
- Document "what works": Highlight opportunities and barriers in terms of providing a safe transition from hospital to home. Trainings and debriefings will yield important insights to ensure the "blueprint" developed takes into account the existing landscape of services and relationships.

Craft a Strategy to Expand Funding for Transitional Care

- Develop a series of recommendations aimed at improving the financial support: Make transitional care more of a priority for San Francisco. Conversations with stakeholders and experts in the field will yield a better understanding of the opportunities now and into the future for more stable funding for transitional care.
- Support efforts to garner more foundation support for transitional care: Outline a strategy to bring stakeholders together to secure additional funding from both public and private sources.

We look forward to working hard to bring these new services and resources to seniors and adults with disabilities who could benefit from additional help and support in the transition from hospital to home.

For more information or to be involved, please contact Bob Trevorrow, San Francisco Senior Center Executive Director at (415) 775-2562 or Marie Jobling, Planning Project Coordinator at (415) 821-1003.

Attachment B – Consumer Handout

PREPARING TO LEAVE THE HOSPITAL

To make sure you'll have the care you need when you leave,
here's what you need to do **NOW** while you're staying in the hospital.

1. **Think about what you will need** at home and whether anyone at home can take care of your needs. You may need help with:

- ACTIVITIES – Will you have to change your daily activities when you get home?
- STEPS – Are there stairs going up to your home or to get to the bathroom?
- MEDICATION – Do you have the information you need about your medications?
- ERRANDS – How will you pick up prescription drugs and groceries?
- TRANSPORTATION – How will you get home from the hospital? How will you get to your doctors' appointments and other activities once you are home?
- FOOD – Can you prepare meals? Do you have food? Will your diet change?
- PERSONAL CARE – Will you need help showering, in the bathroom, or eating?
- HOUSEHOLD CHORES – Will you need help with cooking, cleaning or laundry?
- EQUIPMENT - Will you need commode or shower chair?

2. A **Hospital Discharge Planner, Case Manager or Social Worker** is available to help you plan for care when you are leaving the hospital. This person can help you arrange for services for which you may be eligible.

3. Find out from your doctor when you are likely to leave the hospital so you can plan for what will happen when you leave. Your **Hospital Doctor** is the leader of the Hospital Health Care Team.

4. Your **Social Worker / Discharge Planner / Case Manager** will work with you or your representative to develop a plan of care. If you can, involve family or friends in making decisions and arrangements. A **discharge instruction sheet** will be given to you at the time of discharge from the hospital.

5. If you have **questions or concerns** about your discharge tell your doctor, or Discharge Planner / Social Worker / Case Manager as soon as possible.

   If you disagree with your discharge, contact your insurance company or the number provided to you by the hospital. Every type of insurance has an appeal process. Appeal rights vary based on the type of insurance you have. Talk to the Social Worker / Discharge Planner / Case Manager to understand these appeal rights, and look at the information on this sheet.

6. If you're sent somewhere besides your home when you leave the hospital, tell the important **people in your life** so they can reach you.

IF YOU HAVE PROBLEMS AT THE HOSPITAL OR WITH YOUR DISCHARGE PLAN, a **Patient Advocate** can investigate complaints – **ask your hospital!**

COMMUNITY SERVICES YOU MAY BE ELIGIBLE FOR:

- Homecoming Services Network – **415-923-4490**
- Aging and Adult Services Information and Referral –**1-800-510-2020**
- In-Home Supportive Services (IHSS) – **415-557-5251**
- IHSS Public Authority (on-call care/private pay) – **415-243-4477**
- Elder Care at Home (emergency homecare) – **415-677-7595**
- San Francisco Paratransit – **415-351-7000**
- MV transportation (lift vans) – **415-468-4300**
- Home Delivered Meals – **415-648-5592**
- Friendship Line for the Elderly – **415-752-3778**
- Retired Senior Volunteer Program Tele/Friend Program – **415-731-3335**
- Adult Day Health Services – **415- 808-4357**
- Social Service Referral Hotline – **211**

IF YOUR NEEDS ARE NOT BEING MET AND YOU WANT TO APPEAL YOUR DISCHARGE, FOLLOW THESE GUIDELINES:

If you have **MEDICARE** (With or without Medi-Cal or other coverage)…

- Insist on a written notice.
- Call Lumetra *(Formerly CMRI)* California's Medicare **Q**uality **I**mprovement **O**rganization or **QIO**) – **1-800-841-1602.**
- Call HICAP (**H**ealth **I**nsurance **C**ounseling & **A**dvocacy **P**rogram) – **1-800-434-0222.**
- You may have the right to an expedited appeal.
- For more information call 1-800-Medicare or visit www.medicare.gov.

If you have **MEDI-CAL,** but **NOT** Medicare…

- Call Bay Area Legal Aid – **415-982-1300.**
- For automated information you may call the California Department of Social Services – **1-800-952-5253.**

If you have **PRIVATE INSURANCE,** but **NOT** Medicare, call your insurance company or HMO to find out about its rules and what you can do. They still have to give you a written notice 48 hours before your *"LAST COVERED DAY."*

Attachment C - Homecoming Services Network Short Contact List

Homecoming Services Network

Homecoming Services Program	***Kathleen or Sandy - 923-4490***
Catholic Charities CYO	*Christian Irizarry - 406-1150*
Self Help for the Elderly	*Angel Yuen – 677-7593*
Curry Senior Center	*Mike McGinley – 292-1042*
Kimochi Inc.	*Anna Sawamura – 931-2294*
Swords to Plowshares	*Johnny Baskerville – 252-4787 ex 334*
NEST/Bernal Heights Center	*Karen Garrison – 206-2140 ex 131*
Episcopal Community Services	*Lolita Kintanar – 487-3786*

IHSS Intake and Referral

- Central Intake - 557-5251
- IHSS Discharge Liaison – 557-5534
    - Referral – use HSP form or download from http://www.sfgov.org/site/frame.asp?u=http://www.sfhsa.org/ and write "hospital discharge" in big letters on form and FAX to: 415-557-5271

IHSS Services *(See attached sheet for more information re: IHSS Referrals)*

- IHSS Consortium – 255-2079
- IHSS Public Authority – 243-4477
- Self-Help for the Elderly- 677-7595

Homecare for Non-IHSS Eligible Clients

- Catholic Charities CYO- 587-1443
- Jewish Family and Children's Services
- IHSS Public Authority - Registry – 243-4477

Home Health Agencies

- West Bay (650) 991-6680
- Tender Loving Care – 650-653-9128
- Visiting Nurses and Hospice 600-7500

Hospice

- Hospice by the Bay (415) 626-5900
- Zen Hospice (415) 863-2910

Transportation

- Medical Escort – Little Brothers Friends of the Elderly –771-7957

- Para transit
    - Eligibility: contact Para transit Broker's office at 351-7000
    - Down-load the application form from the web site at www.sfpartransit.com.

Linkages to ADHC Services and PACE Program
- San Francisco Adult Day Health Network -808-7371
- On Lok / PACE Programs – 886-6565

SSI Medi-Cal and Share of Cost Issues:
- Medi-Cal field office - 863-9892

Meals:
- Home Delivered Meals Clearinghouse - 648-5592
- Project Open Hand - 447-2480

Community-Living Skills/Peer Support: If your client needs help with managing life in the community, you might contact
- Family Service Agency, 474-7310, Ext 326;
- ILRC, the Independent Living Resource Center, at 543-6222;
- IHSS Public Authority, 243-4477, ext 310.

Money Management:
- Conard House – 346-6380
- Lutheran Social Services - 581-0891 ext 107.
- Coming Home – 447-2250

Primary care (Referrals for services, prescriptions, and DME require PCP referral):
Identify hospital or regular primary care physician

Case management: Referrals for on-going case management
- I & R for Case Management – 626-1033
- Central In-take - CLF Intensive Case management – 557-5251
- MSSP/Linkages – 750-4150

Minor Home Modifications: For grab bars and other immediate repairs,
- Rebuilding Together – 905-1611

Supplies:
- If your client needs health care supplies (oxygen, diapers, etc)

the service should be set up before the move whenever possible.

Financial Resources - Emergency Purchase of Supplies
- Community Living Fund – 355-3570
- Fitschen Fund – See attached list of agencies
- Campos Estate – Episcopal Community Services (Lolita) at 487-3786