Success Snapshot:

How UCSF Health is improving patient outcomes through timely access to high-quality post-acute care

Today's Speaker

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Educational Webinar Series

Learning Objectives

UCSF Transitional Care Program

- Describe San Francisco Bay Area healthcare market conditions
- Review the foundation of the transitional care program
- Evaluate the methods
- Summarize the outcomes
- Report the impact of the program
- Forecast the future state of the program

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Background

In the late spring of 2020, UCSF Health realigned its operations to support the Bay Area community during the COVID-19 pandemic.

Many programs, including the SNF/HHA Collaborative, were paused to focus on testing, prioritizing urgent visits/procedures, and shifting to a telehealth model of care.

San Francisco Bay Area Healthcare Market

Mid-pandemic

Hospital capacity rising

- Overwhelming emergency services

Growing healthcare disparities

- People of Color
- Poverty
- Homelessness
- Medi-Cal
- Inability to access or use technology

COVID-19 regulations and restrictions

- Admissions impacted by positive COVID-19 cases
- Testing and Isolation requirements delaying transfers
- Visitor restrictions
- Office space and remote work

Staffing shortages

- Healthcare workers leaving the profession
- COVID-19 leave of absence
- Increase stress and burnout

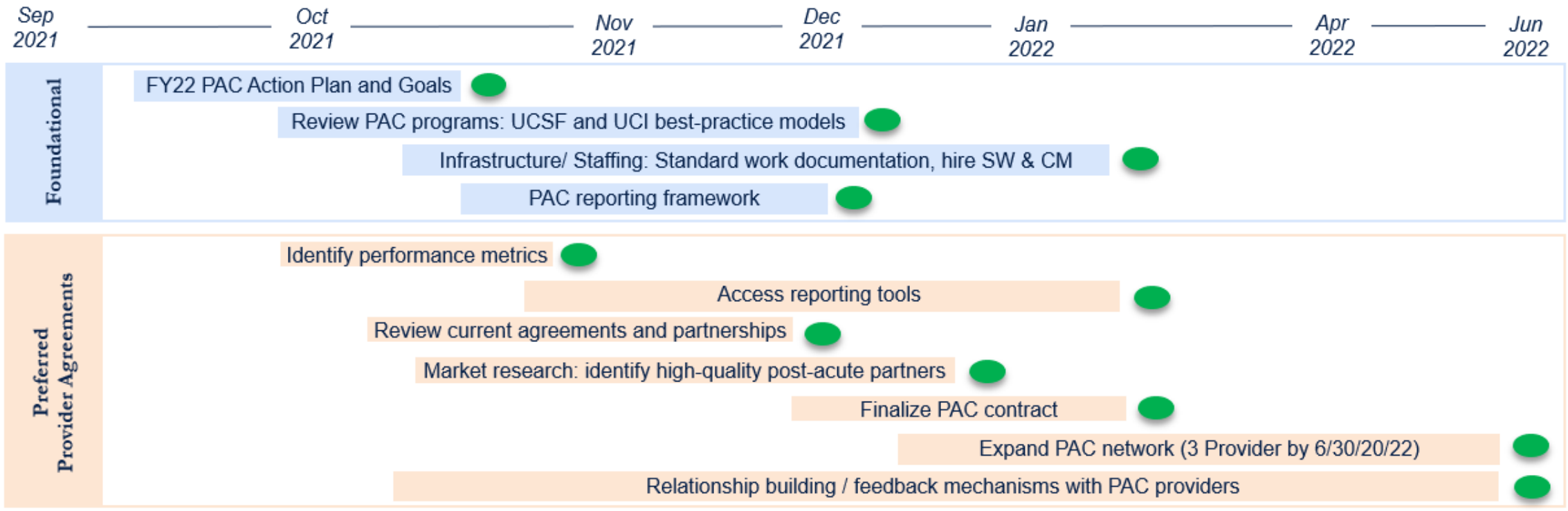
Transitional Care Program

Foundation

- **Vision:** promotes better health outcomes for UCSF patients by increasing timely access to high-quality post-acute care.
- **Goals:**
  - Improve patient outcomes through timely access to care
  - Streamline workflows and align with best practices
  - Reduce healthcare disparities for our Medi-Cal and underfunded patients by bridging gaps in care
  - Decrease unnecessary ED and hospitalization utilization

Transitional Care Program

Timeline



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UCSF Transitional Care Program

Methods

Complex Case Management

Outpatients

- **Community-based support for adult patients that**
  - Have two or more comorbid conditions
  - Are at high risk for rehospitalization
  - Have no identified support system
- **Patient-specific care plan and outcome goals**
  - Minimum of three goals

Inpatients

- **Hospital Medicine Outliers**

All Patients (Outpatient/Inpatient) 20+ Patients

- **Weekly multidisciplinary meeting**
  - Track census & patient progress
- **Standardized Documentation Templates**
- **Staffing**
  - Assistant Director of Post-Acute Care
  - Nurse Case Manager
  - Medical Social Worker

Post-Acute Partnership

- **9 Post-Acute Agencies and Facilities (SNF/HHA/DME)**
- **Developed a service-level agreement: Expectations and target metrics**
  - 30-day unplanned readmissions
  - Medi-Cal acceptance rates
  - Star Ratings
- **Review target metrics monthly**
  - CarePort Insight Analytics
- **Member list in CarePort Guide**
- **Host quarterly conferences for in-services and discussion forums**
- **Managed by Complex Case Management staff**

Intra-organizational Partnerships

- **Align goals and strategy**
  - PAC within affiliate service area
  - Preparing for Discharge brochures
- **Knowledge Sharing**
  - Wiki page
    - CHA policy updates
    - PAC contacts
    - Community programs
  - Lunch and Learns
    - Augmented and Alternative Communication
    - ASL and HCBA waivers

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Complex Case Management

Outcomes

Quantitative

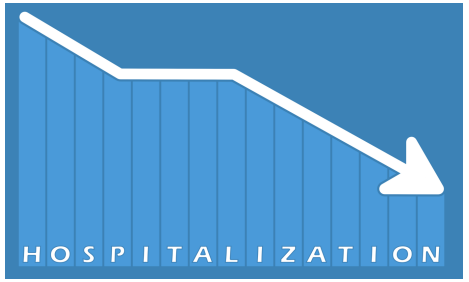
Outpatients

- 85% reduction in unnecessary hospitalizations
- 92% Reduction in unnecessary ED visits
- Achieved 90% of the patient-specific outcome goals

  Measured at 6 months following enrollment

Inpatients

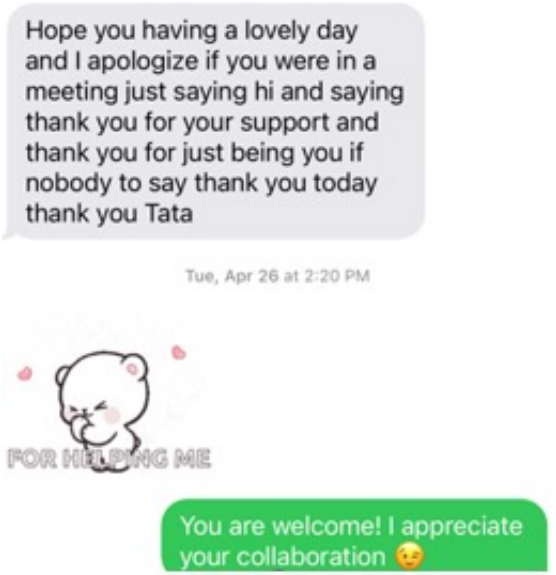
- Hospital Medicine Outlier LOS index decreased from 5.22 in FY22 to 4.62 FY23 YTD



Qualitative

"I have to say, you and your team saved Mr. S's life. I saw him recently right before his birthday, and I reflected on how unbelievably far he's come in the past 2 years. This is due to the work of his case managers and social workers (in addition to his family)"

– Dr. E. Askin, UCSF Primary Care



Post-Acute Partnership

Outcomes

Quantitative

Q1 & Q2 of FY23 compared to Q1 & Q2 FY22

- SNF unplanned 30-day readmissions decreased by 8%
- HHA unplanned 30-day readmissions decreased by 5%
- HHA Medi-Cal acceptance rates increased by 7%
- SNF Medi-Cal acceptance rates decreased by 2%

Average CMS Star Rating

- SNF CMS Star Rating = 5
- HHA CMS Star Ratings = 4.5

Qualitative

Post-Discharge Assistance

- Order clarification and updates
- Scheduling appointments and transportation
- Provider communication
- Customer-service recovery

Expanding Network

- Managed Care Plans
- Community partnerships

Quarterly Conference Survey Feedback

- “Great speakers, lots of good information”
- “Organized and interactive”

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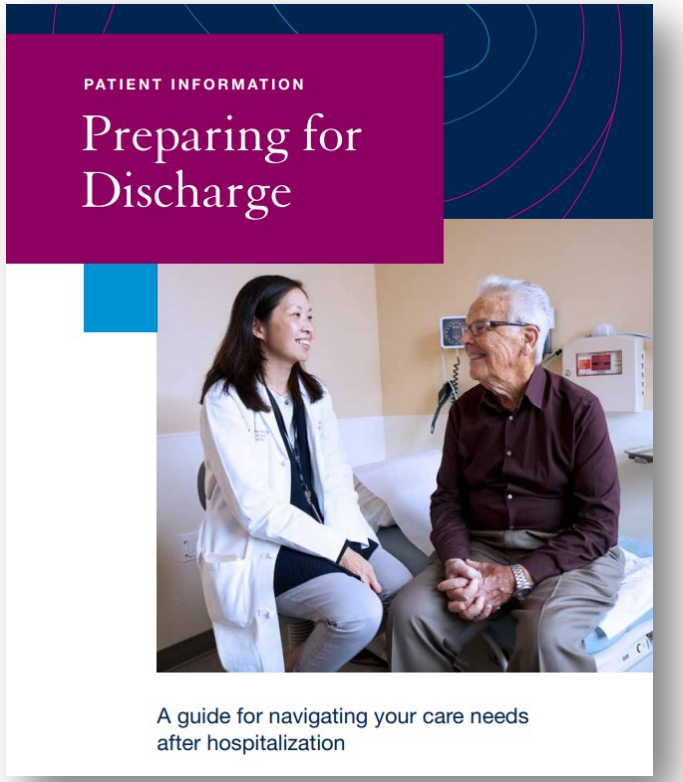
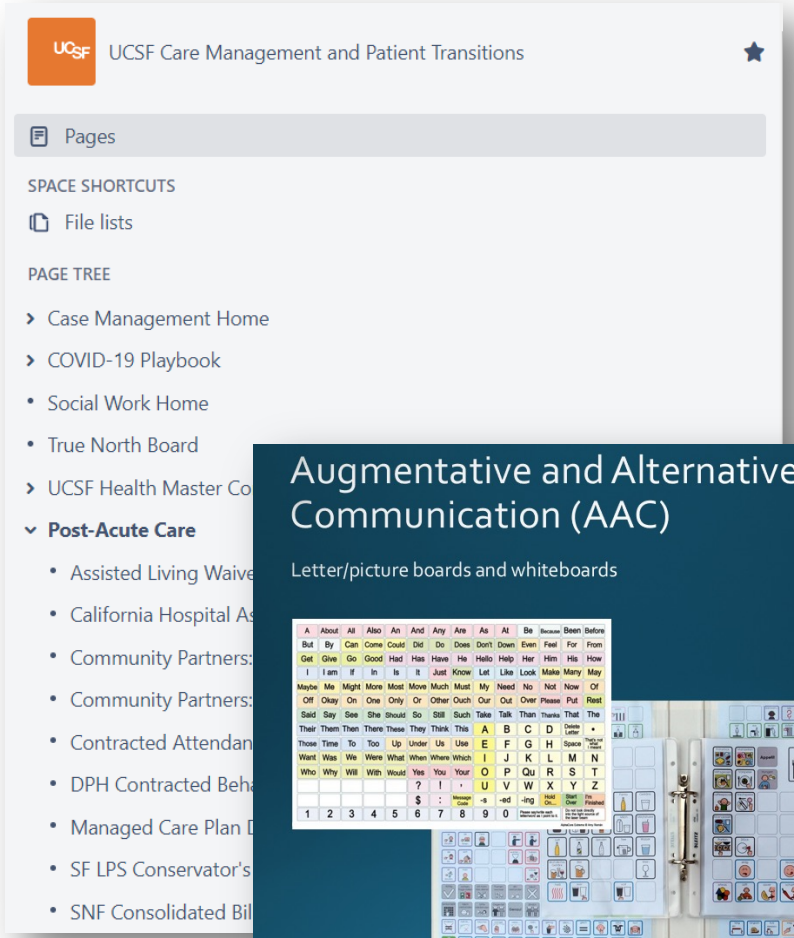
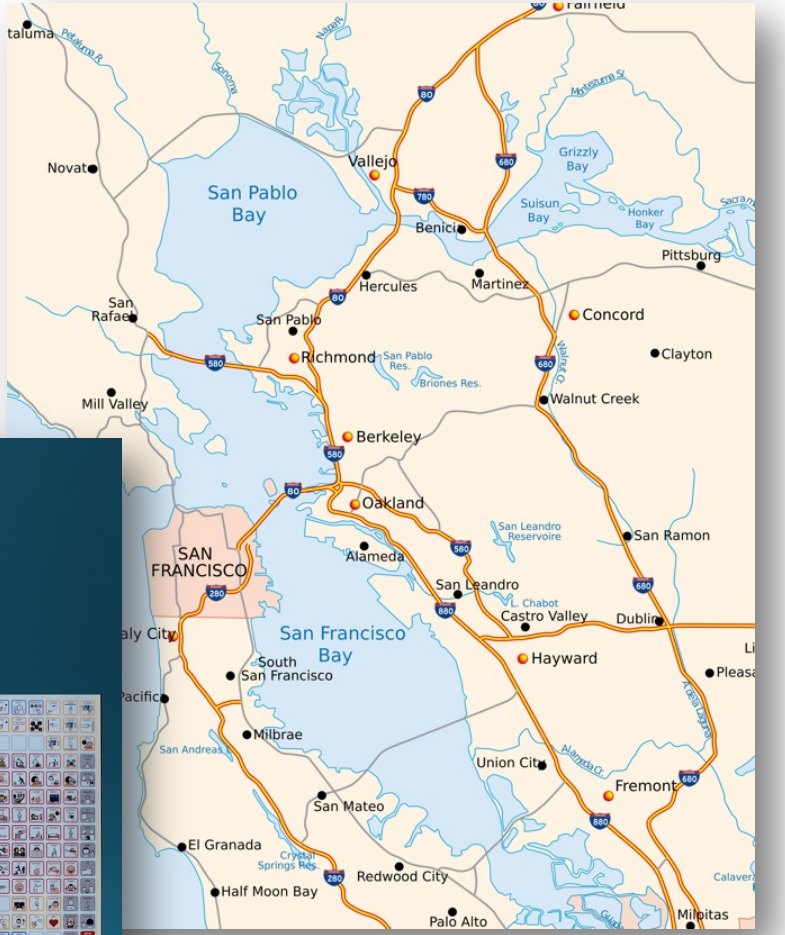
Intra-organizational Partnerships

Outcomes







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Impact

Currently, the complex case management team manages a caseload of 20+ active patients and an inpatient consult service for medically active patients with a limited support network or who are being evaluated for medical probate or LPS conservatorship.

The program hosts quarterly in-services with organizational, PAC providers, and other community members where they share community resources and best practices in transitional care.

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Future State

Complex Case Management

- Grow caseload to 30+ patients

Post-Acute Partnership

- Expand the network to include LTACH and Home Infusion in FY24

Intra-organizational Partnerships

- Establish the UCSF Post-Acute Strategy Steering Committee by Q4 FY23
  - Care Management and Patient Transitions
  - Office of Population Health
  - Ambulatory Care Services
  - Inpatient Services
  - Strategy

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Q&A

[Visit the CarePort exhibit booth]

Thank you

Contact us

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