



**Re: 2019 Hospital Quality Institute C. Duane Dauner Quality Award**

Santa Clara Valley Medical Center  
751 South Bascom Avenue  
San Jose, CA 95128  
[www.scvmc.org](http://www.scvmc.org)

Contact:

Pamela Sebastian, MBBS  
Program Manager, Post-Acute Care Transitions  
Santa Clara Valley Medical Center  
[pamela.sebastian@hhs.sccgov.org](mailto:pamela.sebastian@hhs.sccgov.org)  
669.287.8253

Alternates:

Huy Ngo, MD  
Program Director, Post-Acute Care Transitions  
Santa Clara Valley Medical Center  
[huy.ngo@hhs.sccgov.org](mailto:huy.ngo@hhs.sccgov.org)  
408.318.4679

Raymond Chan, MD  
Program Co-Director, Post-Acute Care Transitions  
Santa Clara Valley Medical Center  
[raymond.chan@hhs.sccgov.org](mailto:raymond.chan@hhs.sccgov.org)

Sanjay Kurani, MD  
Hospital Medical Director  
Santa Clara Valley Medical Center  
[sanjay.kurani@hhs.sccgov.org](mailto:sanjay.kurani@hhs.sccgov.org)  
408.885.7744

**Brief Statement by an executive leader in support of the application**

Dear C. Duane Dauner Quality Award Application Review Committee:

We are proud and enthusiastic to submit our post-acute transitions care model to the Hospital Quality Institute to consider for the 2019 C. Duane Dauner Quality Award. The Post-Acute Care Transitions (PACT) program evolved from the coordinated collaborative effort between both inpatient and outpatient teams including hospitalists, care management staff, and a dedicated team with training in geriatric and homeless medicine. The focus on strengthening transitions of care for some of our most vulnerable hospitalized patients led to significant improvement in patient safety and quality.

The foundation of the PACT initiative grew out of a growing need to care for a challenging population - patients hospitalized for a severe medical condition but cannot be safely discharged when stabilized. These patients can have extensive barriers in long term care and care management planning. They can also be some of the highest utilizers of our medical system and often need a multi-disciplinary effort to appropriately address their psychosocial needs, medical complexities, and care coordination.

Santa Clara Valley Medical Center is the second largest public health care system in California and in the heart of Silicon Valley. Yet the county has a large disparity between the wealthy and the poor. Despite limited resources, including a shortage of hospital beds, *we recognize our responsibility to be the safety net for our patients.* The need for innovative programs and thinking stimulated our passionate staff to create a program that would focus on high quality care and improve coordinated team efforts across multiple county resources to effectively care for our indigent and vulnerable patients.

I believe this model can serve as a great valuable resource to all hospitals that want to improve their transitions of care for patients that traditionally have significant barriers for safe discharge. We are proud to support the PACT initiative and are inspired by the Hospital Quality to collaborate and share our methodology with other medical centers.

Respectively Submitted,



Sanjay Kurani, MD  
Hospital Medical Director  
Santa Clara Valley Medical Center

**Title:** An Integrated Healthcare Model for our County’s Most Vulnerable Patients: Making an Impact with PACT (Post-Acute Care Transitions)

**Topical Areas:** Patient Safety: Providing safe transitions post hospital discharge  
Quality Improvement: Reduction in readmission rates, improve cost avoidance, and increasing hospital bed capacity  
Patient Experience: To provide, manage, and connect patients effectively to existing county resources

### **Executive Summary**

Safe hospital discharge remains a high priority for maintaining quality of care in medical systems. Vulnerable populations including the indigent, medically uninsured, and homeless patients can require extensive care coordination upon hospitalization. We designed and developed the Post-Acute Care Transitions (PACT) initiative to improve safety and care of patients discharged from the hospital by facilitating their integration back to the community.

Our program focuses on patient transitions to a nursing home where we provide, manage, and connect them to existing county resources related to and including: mental health support, homeless medicine, substance dependence, wound care, county housing programs, and palliative services.

The PACT program began in early 2018. Since then, our hospital length of stay for non-acute patients decreased by approximately 50%, from 70 days to 35 days. Increased hospital bed capacity from resulting discharges allowed for over 5,000 hospital bed days. In addition, patients in the PACT program had a 30-day readmission rates of 5.5% and improved access to follow-up care.

### **Background and Relevance**

At any one time, there can be 20 to 50 non-acute patients in our county hospital. They do not need hospital level of care but cannot be safely discharged. Hospitals refer to these as non-acute patients. Many are chronically homeless or do not have adequate insurance for care outside the hospital.

Nursing homes often do not accept these patients due to their challenging management with respect to multiple chronic medical conditions, behavioral disturbances, dual diagnoses, wound care, complicated social situations, and limited medical insurance status. These patients are especially vulnerable with respect to their social determinants of health.

Consequently, these patients often stay in the hospital longer despite having no acute medical needs. From a systems perspective, this results in high bed occupancy rates, compassion fatigue for healthcare

providers, overcrowding of emergency services, and higher morbidity and mortality once discharged to the community.

One of our sage hospitalists is known for this quote, *“We can’t just make this society’s problem.”* Safe discharge for the indigent population remains a challenge for resource-constrained health systems. Traditional solutions can feel like fitting a square into a circular peg. Our program is built on the thinking that innovative solutions cannot be solved with conventional methods.

### **Challenges, Effort, and Scope**

Extensivist/Transitionist is a new genre of primary care specialist that is a bridge between inpatient acute care and high acuity outpatient care. We developed a Post-Acute Care Transitions (PACT) team focused on providing continuity of care and seamless transitions from the hospital to the nursing home. We identify patients in the hospital that are medically stable but cannot be discharged safely. The PACT team is an integration of the Extensivist role with a multidisciplinary team adapted to focus on post-acute transitions, care coordination, and complex care management. *The innovation stems from building a dedicated team that integrates patient care directly with the inpatient staff, the nursing home facility, and outpatient services.*

The PACT team consists of a physician-led multi-disciplinary team including social worker, case manager, physician assistant (PA), and licensed vocational nurse (LVN). In this model, the inpatient PACT physician identifies potential patients and provides consult recommendations for their safe transition to a reserved nursing home bed. Once accepted, the case manager works closely with the patient’s primary team and the nursing home staff to facilitate a coordinated transfer.

At the nursing home, the PACT team begins the critical process of building patient trust and rapport. The physician and PA conduct team rounds for medical management. The PACT team performs a team-based assessment to design a care coordination plan for patient integration back to the community. Our LVN provides patient education about their medical conditions and serves as a liaison between the nursing facility support staff and our PACT providers. The social worker leads the discharge planning coordination and follows up after nursing home discharge for any anticipated issues. The social worker is directly accessible to the patient, even upon discharge, and relays any patient concerns to the PACT team for problem-solving.

Medically, the goal is to meet the complex and long-term needs of vulnerable patients including complex wound care, behavior issues often related to history of trauma and mental illness, homelessness, pain management, intravenous medication, palliative care, and peri-operative care. A secondary goal is to provide a safe place for healing and design effective ways to help the patient integrate back into the community. Our team also focuses on educating and empowering patients with resources and knowledge to maximize their ability for self-care.

This model offers multiple benefits including improving patient outcomes, increasing available hospital beds for acutely sick patients, and decreasing high utilization of emergency services. In turn, this also

helps to decrease hospital readmissions and improve cost avoidance. It would also generate revenue through billable encounters at the nursing home and improve hospital flow.

One challenge was to develop a robust transitions of care model for the underserved while working effectively within a unionized county system that is resource-limited. Considered the second largest public health system in California, we proposed our PACT initiative as a model for post-acute care. We identified leaders in our hospital and outpatient organization with a clear motivation to improve safe discharge. Their belief and support in this mission set the foundation for multiple disciplines to work together. As a result, we became more unified addressing a gap once thought too challenging to improve.

Another challenge was: How do we avoid moving the bottleneck of patient flow from the hospital to nursing homes? Understandably, most nursing homes have been resistant to accepting patients with no discharge plans. We resolved this by reaching out to nursing homes with the mindset of transparency and honesty to form a partnership. We offered our dedicated PACT team to care for and to design safe discharge planning. As a result, a contract was established between the county and the nursing home for dedicated beds. To date, we have maintained a discharge rate of over 80% in our mission to create safer discharge plans for our most vulnerable patients and their integration back to the community.

Collectively, we worked to develop integration of various “silos” in our community to serve the county’s mission statement of caring for the underserved. A patient-centered approach guided the PACT team on how to implement direct patient care. We served as advocate for the patients in coordinating their care across multiple agencies and departments. In addition, safety and quality metrics were identified and protocols established to track outcomes.

## **Results**

From January 2018 to March 2019, the PACT program had a total of 73 admissions and 61 discharges.

Patient demographics and characteristics were collected to better understand patterns for future predictive analytics. In particular, the PACT had a complexity score of 9.2 (high complexity), high rates of homelessness (67%), high rates of substance use (47%), and high rates of mental illness (50%). For the PACT patients, the average length of stay in the hospital prior to hospital admission was 26 days, significantly higher than average length of hospital stay of 5.5 days.

Inpatient flow improved prior to PACT vs post PACT implementation. The non-acute patient census in the hospital decreased from 36 patients to 17 patients in the first seven months – a 53% reduction. Overall, the hospital census for non-acute patients in the 14 months prior versus 14 months after PACT implementation showed a significant reduction of 25%. The potential cost avoidance averaged to approximately \$11 million dollars (Table 1). Effective hospital bed capacity was increased and resulted in 5,000 hospital bed days saved over the first 15 months of PACT implementation.

To date, the average 30-day readmission rate for PACT patients was 5.5 % (Table 1). The PACT program assisted in helping to decrease the readmission rate for our hospital from approximately 19% to 15% (Table 2).

## **Significance**

Safe discharge of patients from hospitals is essential to the health of communities. Like many safety net hospitals, SCVMC operates under constrained resources and does not have the ability to expand hospital beds quickly. Hospitals are also measured by quality metrics including 30-day readmission rates and high utilization of emergency services. This can be especially challenging for indigent populations including the homeless and those with serious mental health disparities.

In Santa Clara County, the number of homeless patient discharges from hospitals jumped 42% from 2015 to 2017, according to data from the Office of Statewide Health Planning and Development. Statewide, hospitals discharged homeless patients nearly 100,000 times in 2017, a 28% increase over 2015. The discharges include 2,608 deaths in hospitals from 2015 to 2017.

The PACT program implemented a model of transitions of care focusing on the vulnerable populations of the county. Three areas of outstanding achievements were recognized including the dramatic reduction of non-acute inpatient length of stay by half, increasing effective bed flow to increase hospital admissions by an estimated 10% for the medicine service, and maintaining a low 30-day readmission rate of 5.5%.

Most importantly a new culture of interdisciplinary collaboration has emerged regarding post-acute care for the indigent population. Hospitalists, care management staff, and safe discharge planning committees have expressed a notable change in flow. Similarly, transitions to outpatient primary care services have improved for the PACT patients through protocols of warm hand-off and public health agencies integration. By leveraging existing county resources, the PACT program serves as a care coordination team to connect public services such as the Office of Supportive Housing, Valley Healthcare for the Homeless Program, and the Valley Health Clinics for primary care.

To date, unique accomplishments for the PACT patients include formal housing assessments resulting in permanent supportive housing for five patients, direct appointment scheduling for primary care visits prior to nursing home discharge, direct pathways established for services including substance use rehabilitation, and access to buprenorphine-based therapy for chronic opioid use. The successful care coordination of the PACT patients resulted without creating new resources or programs but by improving the communications and path for patients to access existing resources.

## **Sustainability and Scalability**

The PACT initiative started from a mindset of sustainability and scalability. Since the introduction of the PACT program in January 2018, the reduction of non-acute inpatient length of stay and census remain significantly lower. In addition, the flow of PACT patients admitted and discharged from the nursing home continue to be maintained with an 83% discharge rate over the 15 months of operations. Over the same period, the 30-day readmission rate continues at less than 6%, compared to the average of 16% -

19% of regional and state rates. We believe this post-acute transition model can be replicated and adapted for other health systems.

Regarding scalability, protocols were established from the beginning to formally integrate the consultation model inpatient, hospital discharge, and nursing home admission. Inpatient meetings and nursing home staff integration protocols were introduced to maintain quality of communication. We continue to grow the PACT program and have established a staffing to patient ratio for better replication at future nursing homes. Due to the program's success, Santa Clara County has adopted this model of post-acute care transitions for future expansion. In addition, the Health Services Advisory Group (HSAG), which serves as the Medicare Quality Improvement Organization (QIO) in California has recognized the PACT program as a best practice for transitions of care. The PACT team has also been invited by other programs nationwide to share its experience.

### **Key Lessons and Advice**

1. Establish a strong multi-disciplinary team with a passion for working with vulnerable populations. Because hurdles can arise in any new project, challenge the team to be creative and instill a culture of "getting things done" for patient care.
2. Identify the inpatient leaders in care management, admitting hospitalists, and executive administration who have a clear motivation to improve safe discharges. Engage their commitment to build a post-acute care team. *"It can't be done" was a common phrase in the beginning. Later it was, "Why didn't we do this before?"*
3. Identify a nursing home and establish a contract for dedicated beds. Be honest and transparent in the relationship.
4. Build a direct path of communication between the post-acute care team, inpatient staff including hospitalists and care management teams, and the nursing home staff. *For example, the PACT team communicates daily with inpatient staff to facilitate patient transitions and coordinate care across multiple disciplines.*
5. Identify the needs of the patient population and establish a formal path for patients to navigate between existing services to facilitate integration back into the community. *For example, the PACT patients have a direct path to receive substance use treatment such as MAT, vivitrol, and/or rehabilitation services due to formal linkages with existing county programs.*
6. Have a sense of urgency in anticipating the challenges and needs of care coordination. Even in a unionized and regulated environment we were able to connect patients to multiple services by acknowledging their high priority of care.
7. Recognize the importance of work balance to minimize provider burnout and compassion fatigue. Find the carrots and sticks to motivate the staff.
8. Embrace transparency using a data driven approach. Set goals that reflect quality of care metrics and establish a method of data tracking to show progress.
9. Build trust and rapport with patients. This is critical for establishing long term care and follow-up.

10. Design innovative solutions to address gaps that cannot be solved with conventional methods.  
*“We can’t just make this society’s problem.”*
11. Recognize the importance of relationship building within the nursing home. *Having a dedicated post-acute care team in the nursing home can improve both patient care and cultivate a nursing home culture of caring for indigent and complex patients.*

“Never underestimate the ability of a small group of committed individuals to change the world. Indeed, they are the only ones who ever have” – Margaret Mead