Address These Issues to Avoid Problems in Transitions

- Be sure patient can get meds (especially on weekends). Ask if meds need to be called-in (Some Walgreens open 24hrs)
- Ensure correct dose, time, generic vs. brand
- Compare previous (taken at home) & current meds/ review to avoid duplication; insure all meds listed on D/C plan
- Contact Primary MD(PCP) re hosp course, plan, home health care (HHC) orders, follow-up appts, med changes
- Consider cognitive screen on all older patients (3 item recall/clock draw) to help assess if patient able to follow plan.
- Discuss plans w/ caregiver (if avail) & ask about concerns
- Consider KELS eval w/ OT (Kohlman Evaluation of Living Skills) if uncertain about patient’s ability to live independently
- Determine if patient needs durable medical equipment (DME) before going home (hospital bed, commode, walker, etc.). Contact SW or case manager

### Required for Transfer to Acute Rehab

- Patient has a “rehab diagnosis”
- Able to tolerate 3 hrs/day combined therapies
- Tx w/ minimum of 2 therapy disciplines needed to qualify
- Transition plan to lower level of care is assured
- Medically stable and patient agrees w/plan
- **Note:** Medicare (Mcare) covers short-term skilled nursing/acute rehab care

### Required for Transfer to Skilled Nursing Facility (SNF)

- Minimum 72 hr acute hospitalization prior to transfer
- Must have skilled need: IV antibiotics, wound care, PT/OT/ST, pulmonary toilet, enteral
- MD must document therapy/nursing recommendations
- Transition plan to lower level of care is assured
- Medically stable and agrees w/ plan
- **Note:** NO heparin, flolan, chest tubes; wound vac & TPN determined on case by case basis

### Required for Referral to Home Health Care (HHC)

- Complex clinical course/continuing need at home for RN/PT/ST/OT (can’t be only OT) for Mcare/Mcal to cover
- **Also:** high risk for re-hosp; home safety eval; wound care; infusions; enterals; unexplained signif wt loss w/in 6 mo;
- **Also:** new DM; CHF; O2; cardio-pulmonary assess; other dx w/ need to assess, teach, and/or supervise pt/caregivers to facilitate independence or medical mgmt at home, and/or needs eval/ref for outside community resources
- MD (cannot be a resident) must sign new HHC orders even if pt previously had HHC
- Team must confirm plan/contact MD who will be signing the HHC orders before discharge
- When hospitalist/attending signs, team must also contact PCP & document name/tel. before discharge
- **Note:** Medicare does not cover personal care (home health aides) unless it is short term and associated with a skilled service.

### Required for Home Hospice

- 6 month prognosis plus agreement with program; end stage Alzheimer’s may qualify
- Patient must have a PCP to be hospice physician of record & sign orders; be sure to contact before the discharge
- **Note:** Medicare part A covers home hospice
- **Note:** Hospice referrals can also be made for nursing home & assisted living placements
**Assisted Living/Board and Care (Contact SW/Case Mgr)**
- Private pay (no Mcare/Mcal); state licensure
- Assistance w/ IADLs; may offer min/mod assist w/ADLs & meds; some specialize in mild/mod dementia; no skilled or medical services; can have HHC/Hospice if qualify
- Need PPD/CXR; MD complete form provided by facility
- Info on facilities at www.Elderlink.org; 800-613-5772

**Shelters/Homeless Resources (Contact SW/Case Mgr)**
- **Medical Respite** – Medically supported shelter for homeless patients who still need recuperative services or clinical coordination; E-referral through Dept. of Public Health (DPH) Lifetime Clinical Record (LCR)
- **SRO** – single room occupancy hotel; those run by DPH offer medical/social services & ensure tenants rights; privately run SRO’s vary in approach to tenants; SFGH discharges to Kean Hotel on Mission & 6th Sts.
- **Shelter** – temporary bed for 1 night at a time; most require clients to leave in am and return in pm

**Home Health Aides (Contact SW/Case Mgr)**
- Provide help w/ ADLs & IADLs
- In-home Supportive Services (IHSS) available if low income; eligibility determined by income and functional needs; may hire friend/family or use IHSS agency
- Many agencies provide private pay services, up to 24 hours/ day; some also offer care coordination/management
- Mcare does not cover; private pay services costly

**Abuse/Neglect Resources**
If elder abuse or self-neglect suspected, contact Adult Protective Services (APS) at 800-814-0009 or 415-557-5230

**Information on Community Resources**
- SF Dept. Aging/Adult Serv. Info/Ref: 355-6700
- Inst. on Aging (IOA) Info/Ref: 750-4111
- Family Caregiver Alliance: 434-3388
- Family Service Agency: 474-7310
- WebMD Little Blue Book (San Francisco): comprehensive contact info for local MDs & pharmacies: www.tlbb.com
- Curry Senior Center (PC & case mgmt): 885-2274

**SFFAMC Patient Transitions Information/Contacts:**
- Eligible Veterans covered for rehab, home health care, long term care, respite, assistance with personal care.
- All enrolled Veterans eligible for hospice care
- Care Management (Home Care: RN, IV, PT/OT/ST)
  - Eileen Kennedy 221-4810 x 2755
- Home O2/RT: Edwin White 221-4810 x 3047
- Respite Coordinator: 221-4810 x 4246
- Palliative Care Consult Pager: 739-1616
- Nursing Home placement (from inpatient):
  - Mary Hulme 221-4810 x 2801
  - 210-5558 (pager)
- Medical Practice Patients:
  - Karen Xavier 280-5103 (pager)

**Moffitt Patient Transitions Information/Contacts:**
- General Medicine Case Managers:
  - Anne Feingold: 443-6690; 3-1363
  - Penny Gonzalez: 443-8960; 3-7492
  - Betsy Denny: 443-8577; 3-4652
- General Medicine SW: Meher Singh 443-5476; 3-1504
- Geriatric CNS: Carla Graf 443-2709; 3-8791
- Palliative Care Pager: 443-4727
- UCSF Home Health Care Intake:
  - Gina Geoffrion 353-3100 x 33155
  - Pharmacist: Vicki Jue 443-9001; 3-1095

**SFVAMC Patient Transitions Information/Contacts:**
- Multidisciplinary Rounds: M-F 10:00 to 11:00
- Health at Home (SF County HHC for uninsured):
  - (Coordinate home care, order medical equipment, O2)
  - Inpatient referrals:
    - Contact SW (see medicine roster)
  - Outpatient referrals:
    - 682-1700
  - Weekend SW:
    - 327-9296 (pager)
  - ACE Unit SW:
    - 327-9253 (pager)
  - ED Case Management referrals (5 visits to ED in 1 yr):
    - 719-6102 (pager)
  - Bridge Clinic:
    - 206-3775
  - (if there are issues with scheduling timely follow-up appts.)
  - Palliative Care SW:
    - 327-0098 (pager)
  - Medical Respite Intake:
    - 734-4209
  - Laguna Honda Hospice: Dr. Kerr 831-4879 (pager)