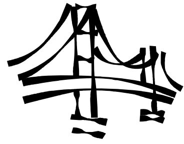
UCSF, SFVAMC, and SFGH
Patient Transitions Planning Card



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For changes, please contact
jabrams@medicine.ucsf.edu

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, enterals
- 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
- **Note: Mcare pays up to 100 days w/skilled needs**; SNF long-term (custodial) care is paid by MediCal (Medicaid) or pvt pay
- **Note:** Consider **alternatives to SNF** if no skilled needs: assisted living, B & C home, life care facilities are pvt pay; PACE (On-Lok) & Adult Day Health Care (ADHC) paid by Mcare/Mcal; however pts may not qualify because of $$. Contact SW or case manager
- Remember **PPD/CXR** before discharge

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; O^2 ; 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

*Web*MD Little Blue Book (San Francisco): comprehensive contact info for local MDs & pharmacies: www.tlbb.com

Curry Senior Center (PC & case mgmt): 885-2274

SFVAMC 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 O^2/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

SFGH 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, O^2**)
  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)
  M-F 8:00—5:00
- Bridge Clinic: 206-3775
  327-0287 (pager)
  (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)