Better Health for All

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

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September 25, 2018

TO: Honorable Members of the Board of Supervisors
Jeffrey V. Smith, M.D., J.D., County Executive

FROM: Rene G. Santiago, Deputy County Executive/Director, SCVHHS
Paul E. Lorenz, Chief Executive Officer, SCVMC

SUBJECT: Board Referral from July 3, 2018 Board of Supervisors meeting regarding discussions with the Valley Homeless Healthcare Program and patient discharge practices

Under advisement from the Board of Supervisors (Board) meeting of July 3, 2018, (per agenda item no. 12), the Board requested that Administration provide an off agenda report regarding discharge practices of homeless patients receiving care at Santa Clara Valley Medical Center (SCVMC). Below is the information requested by the Board of Supervisors.

The discharge process involves a multi-faceted care coordination plan requiring continuing planning and adjustments, coordination and communication amongst care teams and the patient. In accordance with regulatory requirements and accreditation standards, the discharge planning policy of Santa Clara Valley Medical Center (SCVMC) aims to "provide a comprehensive, multi-disciplinary discharge planning program to all patients, as needed, to ensure a safe plan for continuity and transition to the community or to the next level of care."

Based on the homeless population who had an outpatient visit, HealthLink data revealed that in FY17, a total of 2,286 homeless patients were discharged from SCVMC. In FY18, the number of discharges dropped to 1,851 as compared to FY17. Eighty percent of the patients were discharged between 0-5 days in FY17 and similarly, 77% in FY18.

In FY18, the majority of patients (71%) were discharged to the patient's home or previous living arrangements. At times, patients chose not to complete their stay at SCVMC accounting for 8% of patients who left against medical advice. Over 6% of patients were discharged to a Skilled Nursing Facility; 3% of patients were discharged back to custody; and 2% were discharged to a residential care or board and care home. The remaining 10% of patients were discharged to Emergency Psychiatric Service,

Barbara Arons Pavilion, hospice facility, another health care facility, court, or had eloped after treatment was initiated. Additionally, 86% were between the ages of 18-64 years; 9% were 65 years or older and 5% were ages 17 years and younger.

The discharge planning process for these homeless patients begins when a physician makes a referral to either a Nurse Case Manager (NCM) or a Medical Social Worker (MSW). In addition to physicians, other members of the care management team may also make referrals to the NCM or MSW.

In collaboration with the care team, the NCM would develop and coordinate the medically complex discharge plans such as respite care, skilled nursing facility placement, discharges to home with home health services, and/or hospice and acute care facilities. The discharge plan may include addressing psychosocial needs, identifying board and care facilities, shelters, and medical respite.

Both the NCM and MSW would complete an initial assessment of patients which include an evaluation for possible post-hospital services, availability of the services, as well as capacity for self-care. The NCM and MSW will make their best efforts to complete the initial assessment within 24-48 hours but no later than 72 hours from admission. The assessment will be documented in the patient's electronic health record.

Because patients are more likely to be compliant in the implementation of a discharge plan that reflect their preferences, the NCM and MSW engage patients in the development of the discharge plan which incorporates the patient's goals and preferences and results of the discharge planning assessment. This collaboration would increase the likelihood of successful care transition and better health outcomes.

For example, for a homeless patient being discharged from the hospital who require respite care, the MSW will work with the Medical Respite Program (MRP) to ensure the patient meets the requirements for respite care. Once the determination has been made that the patient qualifies for respite, the MSW will arrange transportation, address any concerns the patient may have about their medical coverage at respite and provide the MRP with necessary medical information for patient to be followed after discharge from SCVMC.

One of the major challenges in discharging homeless patients is the lack of downstream discharge locations such as board and cares, room rentals and permanent housing. Permanent housing is the optimal discharge location for these highly vulnerable patients, but the scarcity of housing vouchers prevents many homeless patients from obtaining housing upon discharge. Inpatient care teams, especially the NCM and MSW, continue to work closely with Office of Supportive Housing and other local agencies to ensure patients are discharged to an environment conducive to their recovery.