Patient Centered Care: Beyond the Hospital

February 5, 2015

The San Diego Readmissions Summit
Presentation Objectives

• Identifying critical home based services that enable shorter hospital length of stay fluent discharges
• Identifying critical service gaps that delay hospital discharge
• Prioritizing home based care and discharge-home
Moderator

Gavin Ward

Regional Director of Strategy & Partnership

24Hr HomeCare
Expert Panelist

Tonya Soroosh

Director, Case Management

Clinical Social Work at Sharp Healthcare
Expert Panelist

Dr. Stephen Capon

Assistant Area Medical Director

Kaiser Permanente
Expert Panelist

Susan Erickson

Senior Director Patient Navigation

Scripps Health Care System
Question One

What is the primary challenge and cause of extended length of stay and delayed discharge as it pertains to securing necessary post acute services?
Beyond quality care, what are the top two characteristics your organization seeks in working with post acute providers?
Question Three

How should medical professions describe palliative care so that it differs from hospice?
Is your organization working toward the goal of physicians “ruling-out” home/assisted living-based care upon discharge before considering a SNF, LTACH or acute rehab?

Has this been a difficult transition for your hospital and physicians coming from a model where the first assumption upon discharge was SNF to limit physician liability?
Additional Questions

- How do we address the lack of communication between inpatient MDs and outpatient MDs to increase continuity of care?

- What diagnosis is your organization going to be looking at? Is the diagnosis with the highest readmission rate similar to what CMS sees?
Thank you!

Please sign in upon completion for BRN Contact Hours

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