County of Santa Clara
Santa Clara Valley Healthcare

County Government Center, East Wing
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Santa Clara County – Post-Acute Care Transitions (PACT) Program
Executive Summary 2024 CSAC Challenge Awards

Overview – SCVMC's Post-Acute Care Transitions (PACT) program provides safe hospital discharge for indigent patients with skilled nursing needs and facilitates their integration back to the community.

Challenge – The PACT program grew from the growing need to care for a vulnerable population - patients hospitalized for a severe medical condition but cannot be safely discharged when stabilized. Many of these patients require transition to a skilled nursing facility (SNF) but remain in the hospital due to no accepting facilities. This results in prolonging hospital access for those acutely sick, overcrowding of emergency services, compassion fatigue for healthcare providers, and higher morbidity and mortality once discharged to the community.

Solution – We developed the Post-Acute Care Transitions (PACT) team to serve as a bridge between hospital and high acuity outpatient care, focusing on providing continuity of care and seamless transitions from the hospital to a contracted nursing home facility. Beginning in the hospital, the PACT identifies patients stable for discharge to a nursing home but have no accepting SNF. We facilitate and coordinate their transition to a reserved nursing home bed. In the nursing home, the same PACT team provides medical care, facilitates safe discharge planning, and direct access to outpatient county services such as mental health support, primary care access, substance use treatment programs, wound care, county housing programs, and palliative services.

Innovation – The PACT program is built on the thinking that innovative solutions cannot be solved with conventional methods. By implementing an equity-driven care model, we cultivated a paradigm shift in caring for our county's most vulnerable patients. *"It can't be done"* was a common phrase in the beginning. Later it was, *"Why didn't we do this before?"* The innovation of the PACT initiative stems from multiple foundations: (1) diverse and collaborative efforts between inpatient and outpatient teams, and a dedicated PACT team with training in geriatric and homeless medicine. (2) PACT staff working in the nursing home. (3) Data-driven approach for patient selection of highest needs and data tracking to improve quality of care.

To date, unique accomplishments for the PACT patients include formal housing assessments resulting in permanent supportive housing, 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.

Results – From January 2018 to August 2024, the PACT program had 423 admissions and 396 discharges. PACT patients were noted to have vulnerable social determinants of health including over 50% unhoused or experiencing unstable housing, 34% with substance use disorders, 20% with serious mental illness, 21% requiring language interpreter services, and over 84% eligible for Medi-Cal health insurance. Effective hospital bed capacity was increased and allowed for an additional 1003 hospital admissions per year. The potential cost avoidance was over $13 million per year. Despite having a complex patient cohort, the 30-day hospital re-admission remains low at 14.4%, compared to 20-25% when matched with similar patient population.

Replicability – From the beginning, PACT protocols and workflows were designed and shared across multiple disciplines to improve transparency and efficiency. Key components include: (1) Identify leadership with a clear motivation to improve safe hospital discharges and patient outcomes. (2) Hire healthcare staff with a passion in serving this patient population.

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) has recognized the PACT program as a best practice for transitions of care. Other PACT awards include: 2019 HQI Duane Dauner Award and 2019 CAPH/SNI Award Winner for Innovation.

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