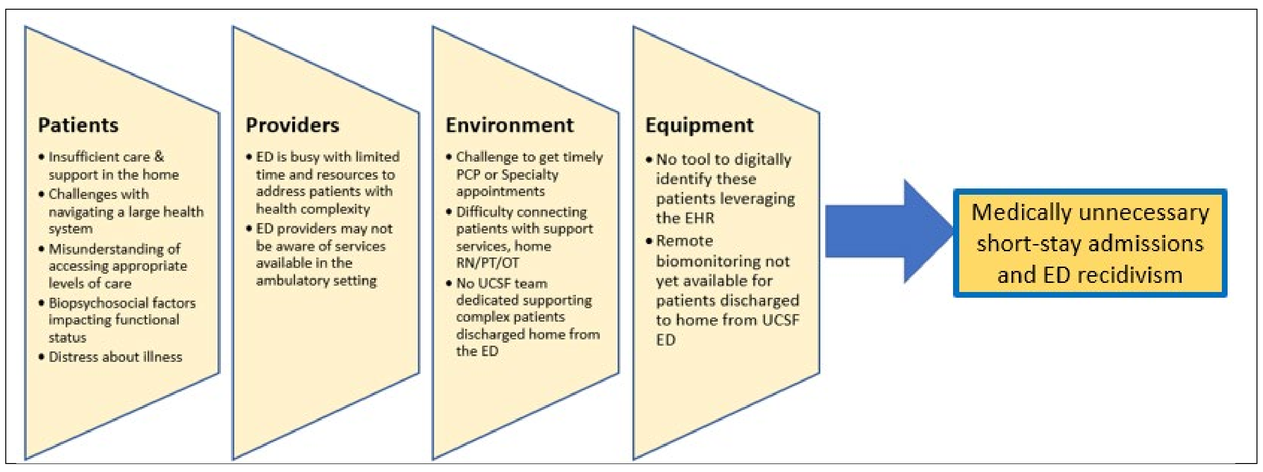
STEDDI (Short-Term ED Discharge Intervention)

OPH Care Support Team: Robin Andersen, Jillian Clark, Sam Desrochers, Martha French, Makda Gebrezghi, Laura Salcido, Richard Sherwin
Medical Directors: Dr. Jahan Fahimi & Dr. Timothy Judson

Background



Project Goals

Mission #1: Decrease medically unnecessary short stay admissions.
Mission #2: Decrease ED recidivism in complex ED discharges.

Strategy employed:
- Patient assessment and high-touch care management by LCSW and Advanced Nurse Specialist for 1-2 weeks to meet clinical and social needs
- Completion of educational milestones and coordination of ED discharge care plan

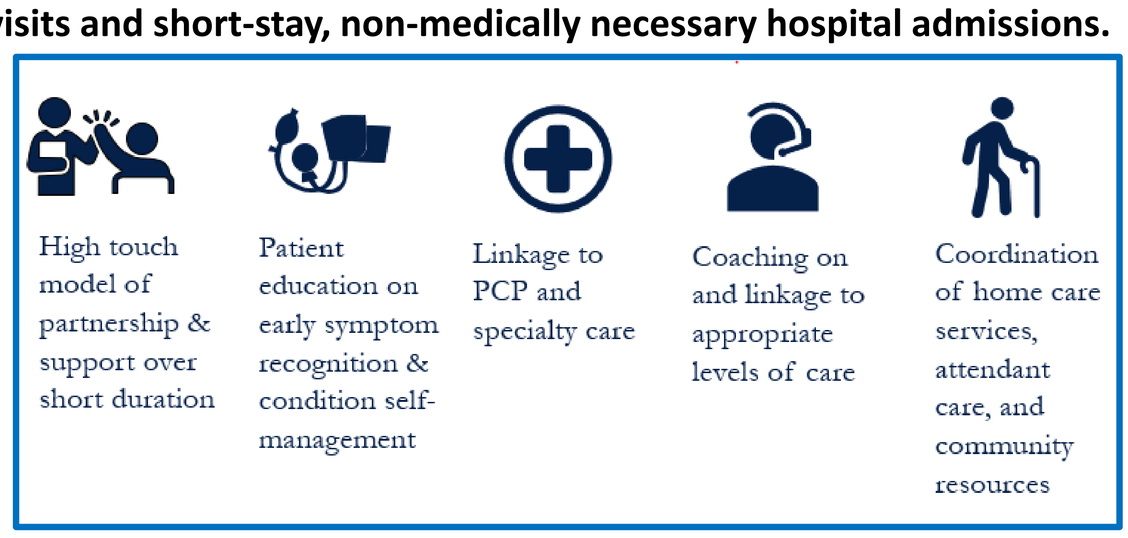
GOAL: Of the patients admitted to STEDDI, fewer than 30% return to the ED within 14-days and fewer than 10% get admitted to the hospital within 30-days.

PROBLEM STATEMENT:
- Between 2-5 patients are admitted to the hospital daily from the Parnassus Emergency Department with an inpatient length of stay (LOS) <2 days; some are socially driven.
- For all ED disposition types, the typical 30 day return rate is 17%
- ED bounce-backs and unnecessary hospital admissions divert resources away from other patients who require tertiary or quaternary (T/Q) levels of care.
- There was no UCSF team dedicated to supporting complex patients discharged from the ED.

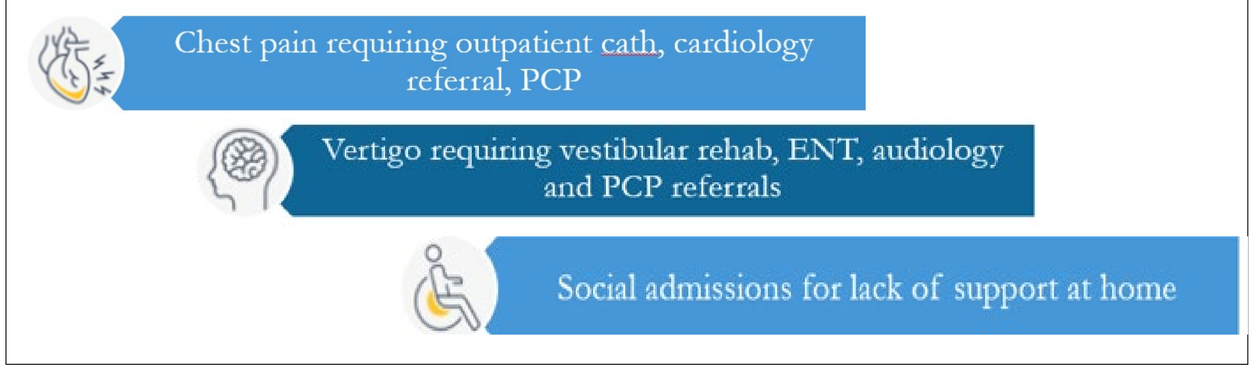
WE ACHIEVED A 20% REDUCTION IN 30-DAY ED RE-VISIT RATE TO UCSF PARNASSUS EMPLOYING A 2-WEEK INTERVENTION OF HIGH-TOUCH COMPLEX CARE MANAGEMENT!

Project Plan and Intervention(s)

Hypothesis: Ambulatory care management may be effective to avoid ED revisits and short-stay, non-medically necessary hospital admissions.



Examples of short stay admissions avoided:



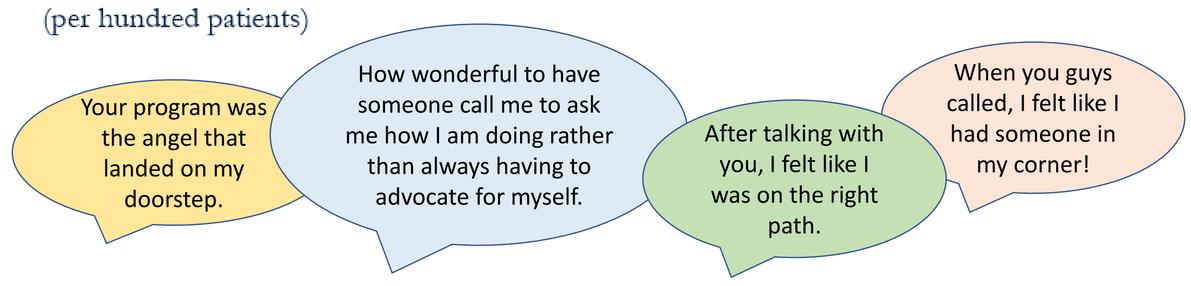
Project Results & Impact

Multiple Regression
N= 13,756; Controlled for age, medical complexity and past utilization

	Coefficient of STEDDI	P value
ED revisits in 14 days	-0.10	0.004*
ED revisits in 30 days	-0.19	<0.001*
Admissions in 30 days	-0.04	0.065

Control Group
Comparison to a control group of ED encounters
Matched on age, prior utilization, and medical complexity

	STEDDI n=192	Controls n=1068	P value	NNT
ED revisits in 14 days (per hundred patients)	12.7	23.4	0.070	9.3
ED revisits in 30 days (per hundred patients)	22.4	42.4	0.052	5.0
Admissions in 30 days (per hundred patients)	11.7	18.4	0.075	14.9



Conclusions, Next Steps, & Lessons Learned

Lessons Learned:
- Following ED discharge, a gap in care existed for patients with high health complexity leaving them at risk for return to the ED.
- Complex patients transitioning to home from the ED benefit from high touch support for safe and successful follow through on medical treatment plans.
- A multidisciplinary team is required to meet the needs of these high-risk patients with an emphasis on social work interventions.
- Identifying patients for whom this type of program could serve as an alternative to admission has proved challenging.
- Patients receiving outreach and support following an ED visit have readily engaged with our team and are overwhelmingly grateful for these services.

Next Steps:
- Initiate framework for expansion including the following considerations:
  - Address barriers to scale
  - Continue to explore most effective means of generating referrals
  - Automate identification of eligible patients
  - Pilot the use of home monitoring devices
- Track data on barriers to care (e.g., PC and Specialty Practice access issues) for operational leaders' awareness

UCSF Health Improvement Symposium 2022