**Background**

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 Goals**

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

**Control Group**  
n=196  

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

**Project Results & Impact**

**Conclusions, Next Steps, & Lessons Learned**

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

<table>
<thead>
<tr>
<th></th>
<th>Confident of STEDDI</th>
<th>P Value</th>
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<tbody>
<tr>
<td>ED revisits in 14 days</td>
<td>-0.10</td>
<td>0.004*</td>
</tr>
<tr>
<td>ED revisits in 30 days</td>
<td>-0.19</td>
<td>&lt;0.001*</td>
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<tr>
<td>Admissions in 30 days</td>
<td>-0.04</td>
<td>0.065</td>
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**Examples of short stay admissions avoided:**  
- Chest pain requiring outpatient cath, cardiology referral, PCP  
- Vertigo requiring vestibular rehab, ENT, audiology and PCP referrals  
- Social admissions for lack of support at home

**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

**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.