

Short-Term Emergency Department Discharge Intervention (STEDDI)



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Care Support Program

Office of Population Health

Background

- Analysis involving an 18 month look back found that between 2-5 patients are admitted to the hospital every day from the Parnassus Emergency Department with an inpatient length of stay (LOS) <2 days. A subset of these admissions may not be medically necessary.
- Chart reviews by Parnassus Emergency Department leadership identified opportunities to avoid admissions for patients presenting with conditions including falls/weakness, DVT, palliative care needs, and conditions requiring IV medication infusions.
- These unnecessary hospital admissions divert resources away from other patients who require tertiary or quaternary (T/Q) levels of care.
- Measures to increase availability of beds for higher complexity levels of care (T/Q) aligns with the UCSF Health efforts for financial recovery from the COVID-19 pandemic.
- Patients prefer to avoid hospitalization if at all possible.

Project Goals

Financial Strength
Quality & Safety
Patient Experience

Strategic Alignment

- This project supports the UCSF Health goal of increasing tertiary and quaternary bed capacity to support financial recovery. It also addresses the True North pillars of improving quality and safety for our patients and patient satisfaction.

Overall Aim

- This collaboration between Population Health Care Support and UCSF Emergency Department originally aimed to avoid short-stay hospital admissions that are not medically necessary.

Project SMART 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.

Gap Analysis

Patients

- Insufficient care & support in the home
- Challenges with navigating a large health system
- Misunderstanding of accessing appropriate levels of care
- Biopsychosocial factors impacting functional status
- Distress about illness

Providers

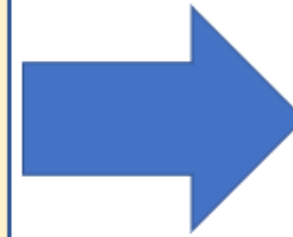
- ED is busy with limited time and resources to address patients with health complexity
- ED providers may not be aware of services available in the ambulatory setting

Environment

- Challenge to get timely PCP or Specialty appointments
- Difficulty connecting patients with support services, home RN/PT/OT
- No UCSF team dedicated supporting complex patients discharged home from the ED

Equipment

- No tool to digitally identify these patients leveraging the EHR
- Remote biomonitors not yet available for patients discharged to home from UCSF ED



Medically unnecessary short-stay admissions

Project Plan & Interventions

Enrollment in STEDDI is an alternative to admission for medically stable patients. The multidisciplinary STEDDI team of Licensed Clinical Social Workers and Advanced Nurse Specialists provides two weeks of intensive care management after discharge to home from the ED.

The project has included three major categories of work:

Workflow Innovations

- Virtual Zoom rounding with the ED teams
- Virtual warm hand-offs with patients
- Voalte availability throughout the day for collaboration and referrals

Partnerships

- SACC for “PCP Bridge” appointments
- Community Home Health agency for next day guaranteed start of care
- New Patient Navigator exclusive phone line established
- Outpatient Palliative Care for visit within 3 business days
- VAST (Vascular Access Team) for expedited PICC placement in CDU
- Physical Therapy for priority evaluations in the ED/CDU
- ED Care Management collaboration with SWs & RNs for patient identification and discharge planning

Care Pathways

- DVT
- Falls
- IV Infusion at Home
- Palliative Care/Hospice

Project Evaluation & Impact

Phase I (Nov-March 18)

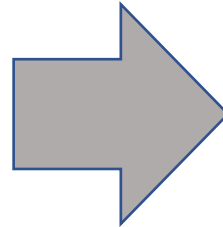
Mission: Prevent unnecessary admissions

KPI's

- 35 patients enrolled
- 5 (14%) returned to the ED within 14 days
- 5 (14%) were admitted to the hospital within 30 days
 - **Up to 30 potential admissions prevented!**

Operational metrics

- 28 PCP appointments made within 14 days of ED visit (80%)
- 22 Nursing interventions done
- 32 social service referrals made
- 19 specialty or testing appointments made



Phase II (March 18-present)

Expansion of mission to include preventing return to ED for patients at high risk

KPI's

- 49 patients enrolled
- KPI's and operational metrics pending further chart review

Next Steps & Lessons Learned

- **Lessons Learned:**

- Identifying patients for whom this type of program could serve as an alternative to admission has proved challenging.
- 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.
- Patients receiving outreach and support following an ED visit have readily engaged with our team and are overwhelmingly grateful for these services.

- **Next Steps**

- Build an automated reporting workbench report to identify patients in real time without need for time intensive chart review.
- Compare ED return rates and admission rates between STEDDI patients and control patients (high risk based on other criteria but not enrolled in STEDDI).
- Test and refine Care Pathways.
- Optimize workflows with clinical partners and create channels for sustaining collaboration (e.g. PT, Vascular Access).