Keeping Patients Out Of The Emergency Department After Acute Hospitalization

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Project Description

Implement discharge bundle to improve patient experience with discharge process and reduce post discharge ED return.

Problem Statements:

In 2017, 1 in 4 patients going home from acute hospitalization at San Mateo Medical Center returned to Emergency Department within 30 days. HCAHPS surveys indicated that 54% of our patients did not feel prepared to manage their health at home, and 95% did not have follow up appointments within 30 days of discharge.

Discovery:

1. Interviewed 15 nurses, 9 providers, 10 patients, and 3 pharmacist to learn that our discharge process was complicated, roles and responsibilities were not clear, and patients felt overwhelmed and unprepared for discharge.
2. Less than 5% patients went home with follow up appointments.
3. Having hospital discharge summary available during the follow up visit in clinic was very important to PCPs.

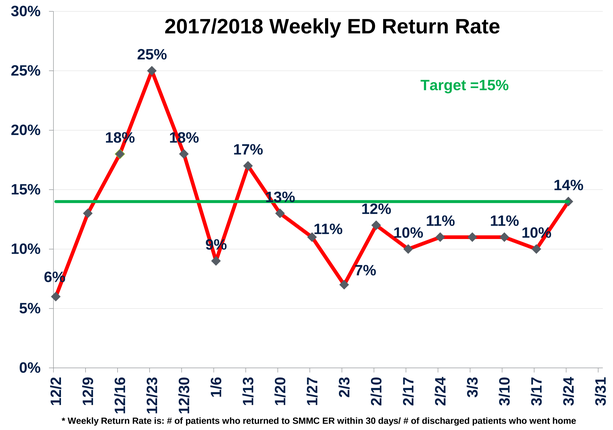
Goal:

Every patient going home after acute hospitalization will have all their needs met, will have follow up appointment scheduled, and San Mateo Medical Center will secure $500,000 in PRIME funding.

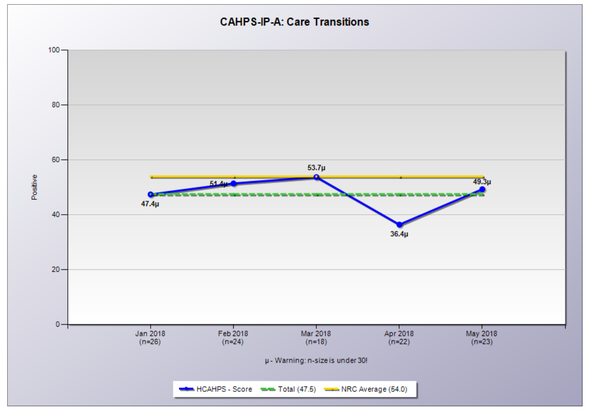
Outcome-oriented Objective:

By June 2018, we will improve our care transition section score on CAHPS surveys by 5% over 2017 baseline and reduce ED return rate from 25% to 15%.

Results



* Weekly Return Rate is: # of patients who returned to SMMC ER within 30 days/ # of discharged patients who went home



Lessons Learned

- Following scientific methods to run different experiments and creating clear target metrics for each experiment helped us understand which interventions were actually helpful in improving patient outcomes.
- Starting discharge education on the day of admission helped patient retain more information and created opportunity to ask questions.
- Multidisciplinary discharge huddle right before patient left the hospital and focusing on teach back created additional opportunity to include caregivers and reinforce teaching.
- Creating elaborate discharge checklist was a great idea, but it was not practical to implement.
- Engaging staff in identifying the problem and creating solutions worked really well, improvements stuck when ideas came from staff.

Next Steps:

- This project will be operationalized and future improvements will be led by local leaders.

Mission Model Canvas

Key Partners	Key Activities	Value Propositions	Buy-in & Support	Beneficiaries
Health Plan of San Mateo Care Coordinators, Care transitions nurses, New Patient Connection Center, SMMC satellite clinics.	Create Discharge bundle and workflow for post discharge follow up. **Key Resources** Care Transitions program coordinator, Street and Field Medicine team.	10% fewer patients returning to ED after acute discharge will lead to savings from unnecessary ED visits, and reduce overall readmission rate. 5% improvement in CAHPS care transition section score will help us get the PRIME funding.	Hospitalist, Primary Care leadership, Case Managers, staff nurses. **Deployment** Start with medical patients, and expand to surgical patients once successful.	All patients going home after acute hospital stay. ED staff will also benefit from having fewer patients returning for unnecessary visits.

Mission Budget/Cost	Mission Achievement/Impact Factors
$2,000 to purchase discharge folders.	Improvement in care transition score will help secure PRIME funding and improve hospital star rating.