



ED PAUSE

Meadowview Regional Medical
Center
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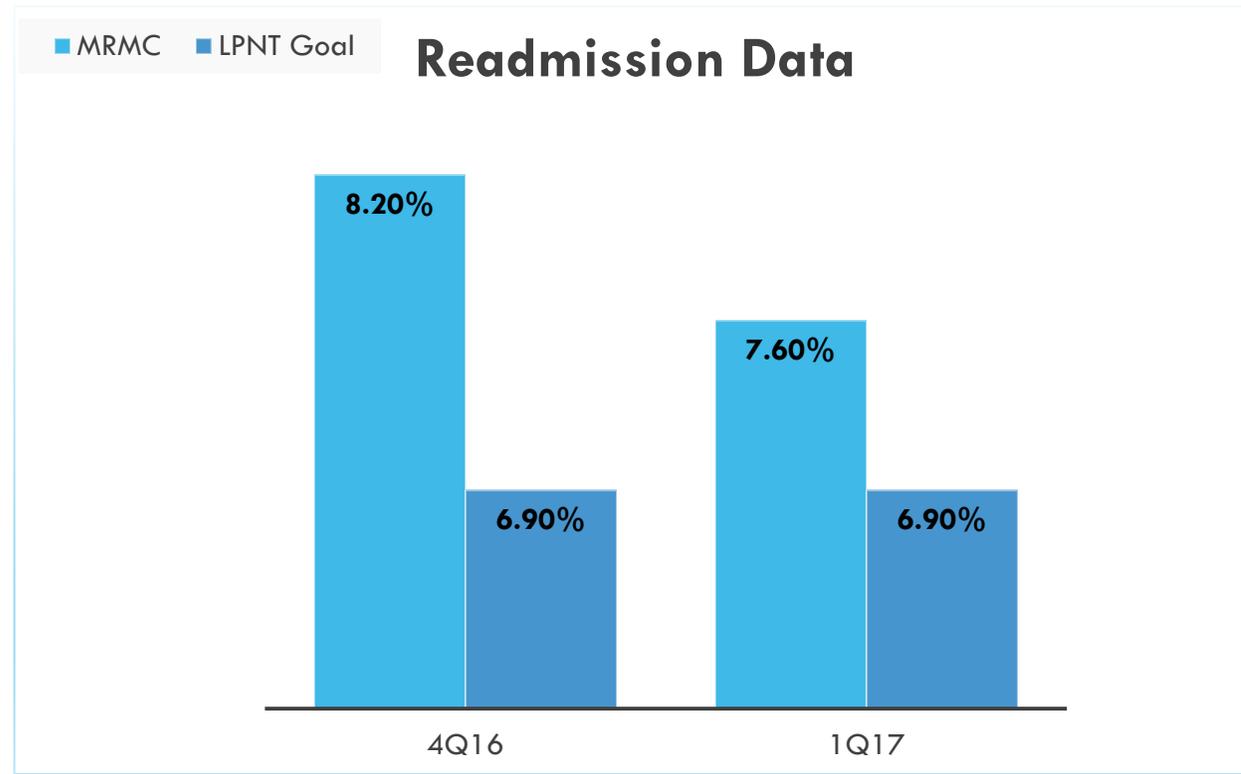
BASELINE DATA

April 2017

Completed a Deep-Dive last 2 Quarters of patients who were readmitted.

- Areas of Opportunity Identified:
 - **Proactive Approach**
 - High Risk Patient Population: COPD/Pneumonia
 - Hospice Appropriate Patients

Baseline Data





WHAT IS ED PAUSE?

One of the tools provided by the Health Research & Educational Trust (HRET) in the 2017 Readmission Change Packet.

It is a strategy with specific actionable items that a hospital can implement based on need or for purposes of improving patient quality of life and care.



ED PAUSE

Primary Driver: Deliver Enhanced Services Based on Need

Secondary Driver: Emergency Department Pause

“Pause and question the need for readmission. If a patient who was recently discharged from the hospital returns to the ED, the patient is often readmitted for “continuity”, or because ED physicians may have been trained that a readmission represents a “failed discharge plan”, and thus the patient should be readmitted to develop a better plan.”

“Alternatives to readmission can sometimes be achieved through use of community resources” (HRET, 2017).

CHANGE IDEA

1. Develop a method for ED staff to know if the patient was hospitalized in the previous 30 days (visual alert on tracker board or EMR).

2. Embed CM or other knowledgeable staff in the ED if possible (alternatively, have CM staff or other knowledgeable staff able to respond rapidly to ED staff).

3. Determine if CM can develop an alternative plan instead of readmission (ie. can pt be discharge and follow-up with PCP the following day)

4. Consider if observation status is an appropriate LOC if the patient can not return home or return to SNF.

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OUR IMPLEMENTATION PROCESS

1. Added the Question to ED Nursing Initial Assessment: Has the patient been hospitalized in the last 30 days

If the answer is yes, the nurse notifies a member of the CM team who responds immediately to ED

Develop a POC utilizing a multidisciplinary approach if needed ie. Discharge home with additional services, follow-up appointment with PCP next day, hospice referral, return to SNF with additional intervention, etc.

If patient unsafe to discharge from ED, can patient be treated and discharged in <23hr and obs appropriate

LESSONS LEARNED-

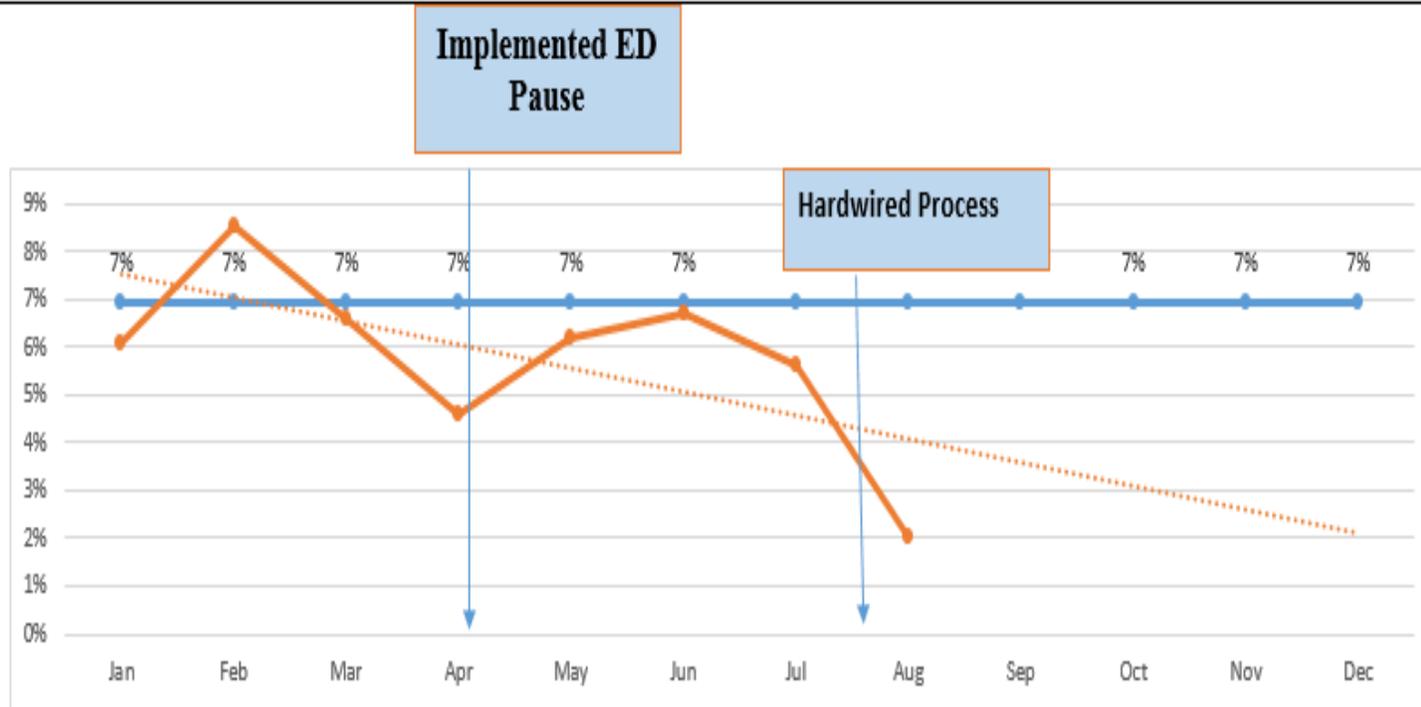
- I. Since most readmits come from the ED, it's a great place to interrupt them and possibly prevent a readmission by redirecting the plan of care.
- II. Readmissions are not a sole Case Management issue. All members of the multidisciplinary team convene to see how the discharge plan didn't meet the patient's needs.
- III. Top three reasons our patient population returned to the ED: 1) non-adherence to medication regimen, 2) chronic patients needing palliative/hospice care, and 3) patients discharged home instead of skilled nursing facility.
- IV. Need for a 24hr Process: Addition of a process when member of CM unavailable.

Educated House Supervisors on how to respond when a member of CM unavailable.

- Created Resources and Guide to assist House Supervisors when called for ED Pause. House Supervisors Educated on ED Process June 2017/Checklist Provided August 2017

CURRENT DATA

Goal: All Payer Readmission Rate of = or <6 %
Baseline: 4Q16 8.2%, 1st Q1 7.1%

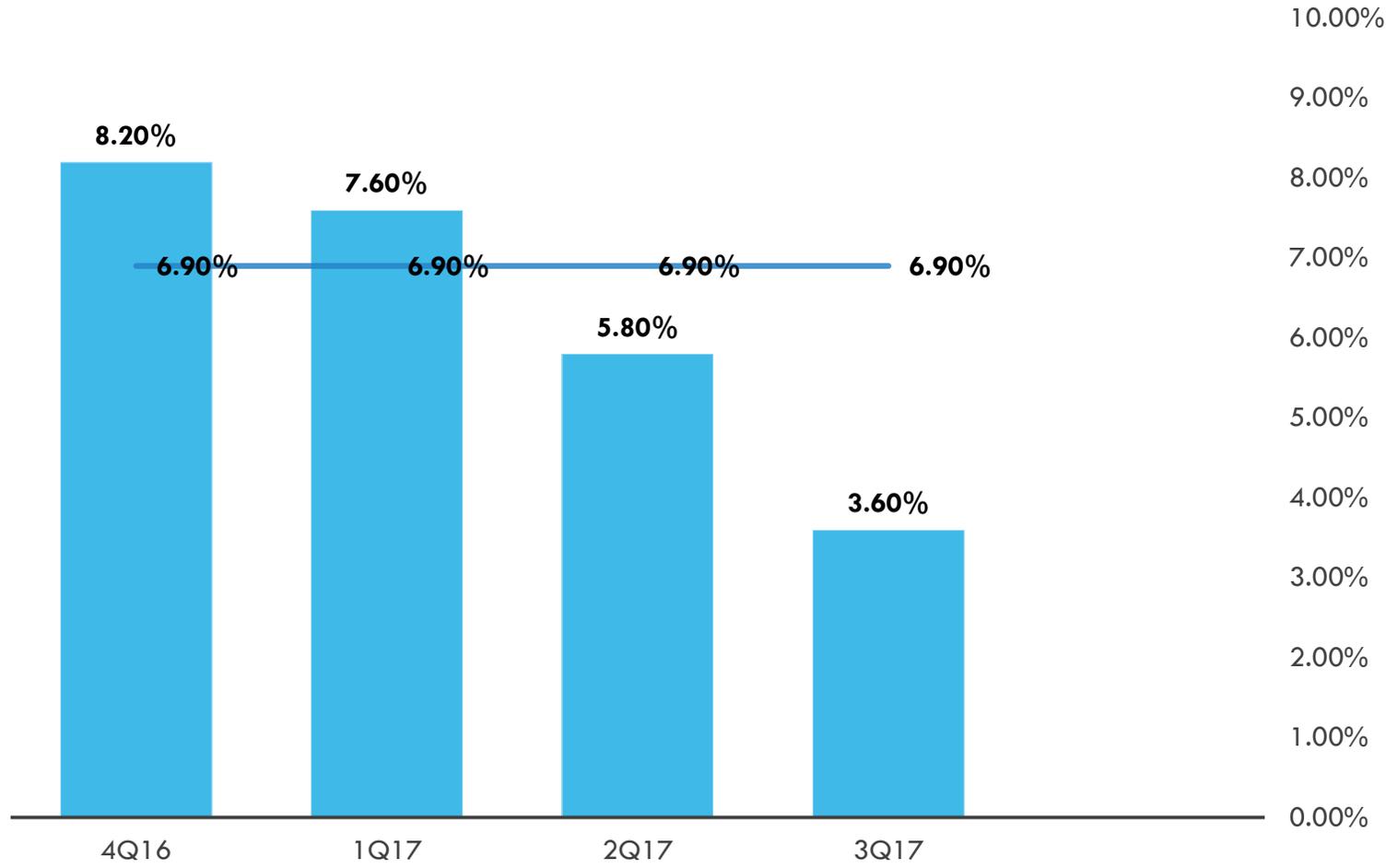


**Current Readmission
Rate 2017**
2Q17: 5.8%
3Q17: 3.6%

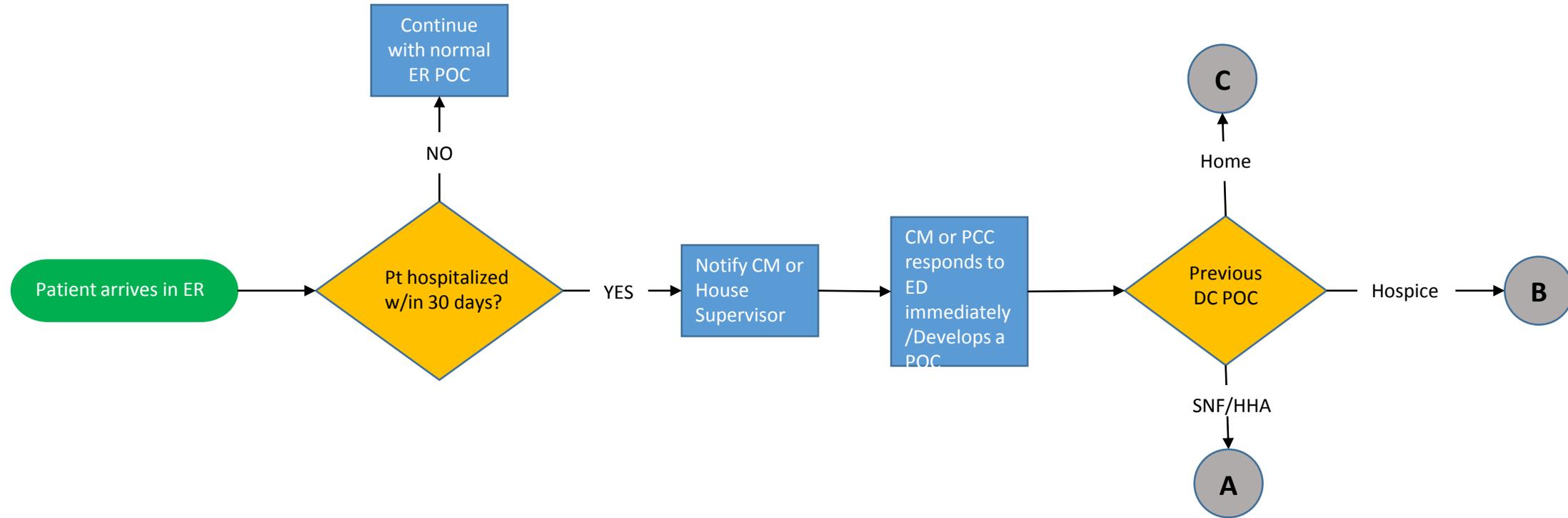
**Total of 21 saved
Readmissions**

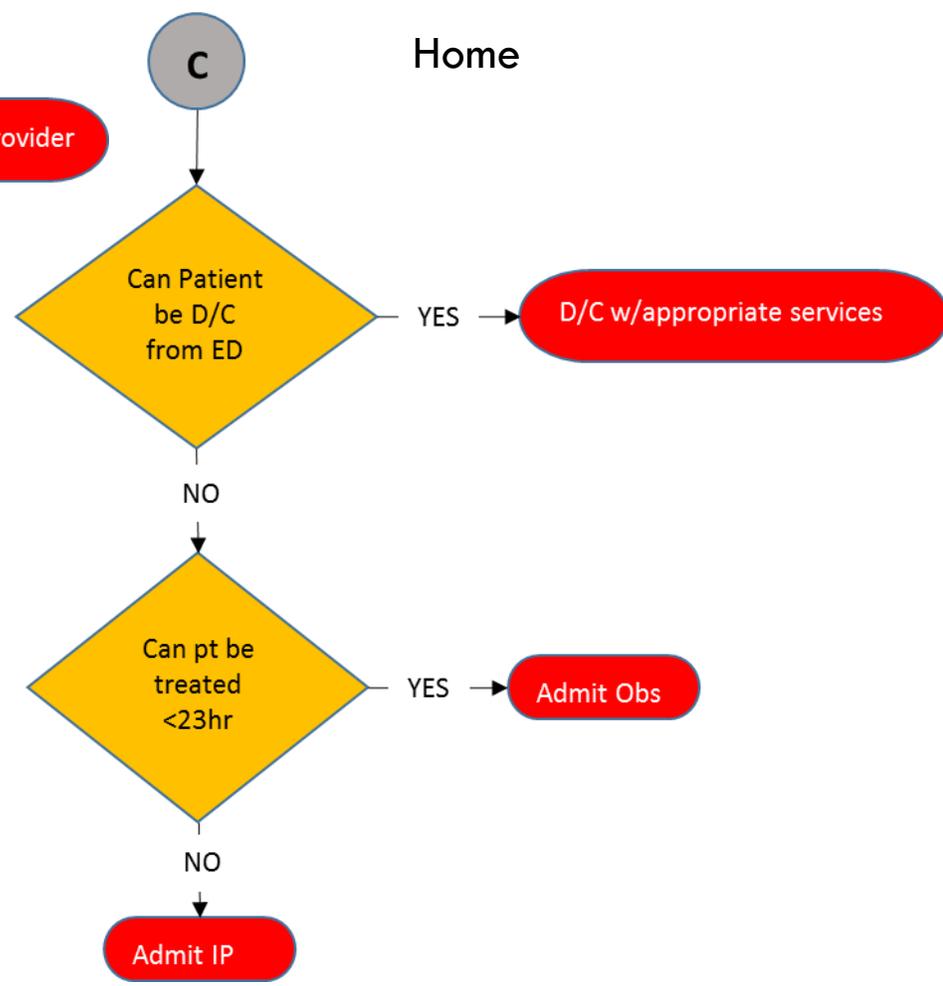
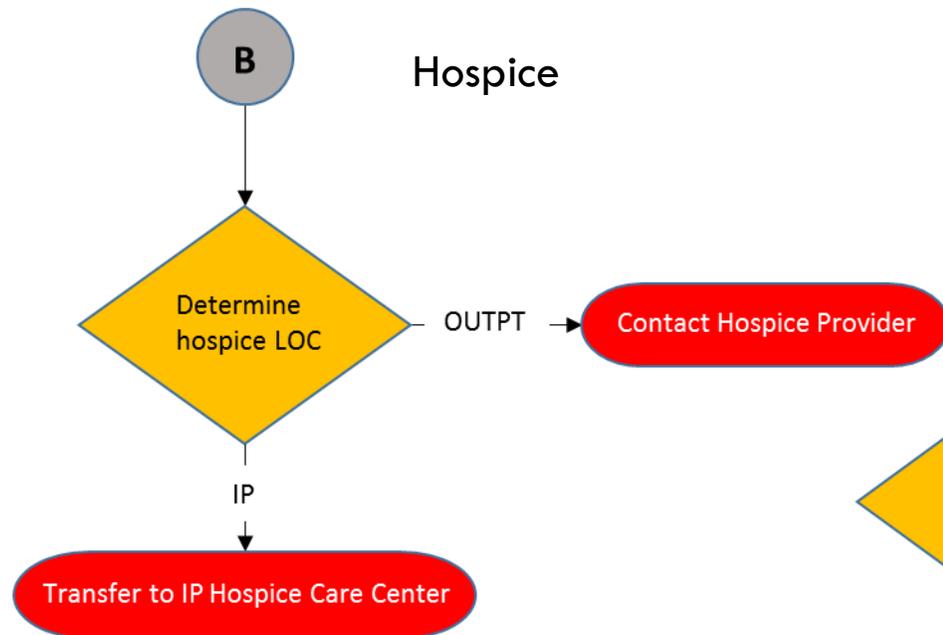
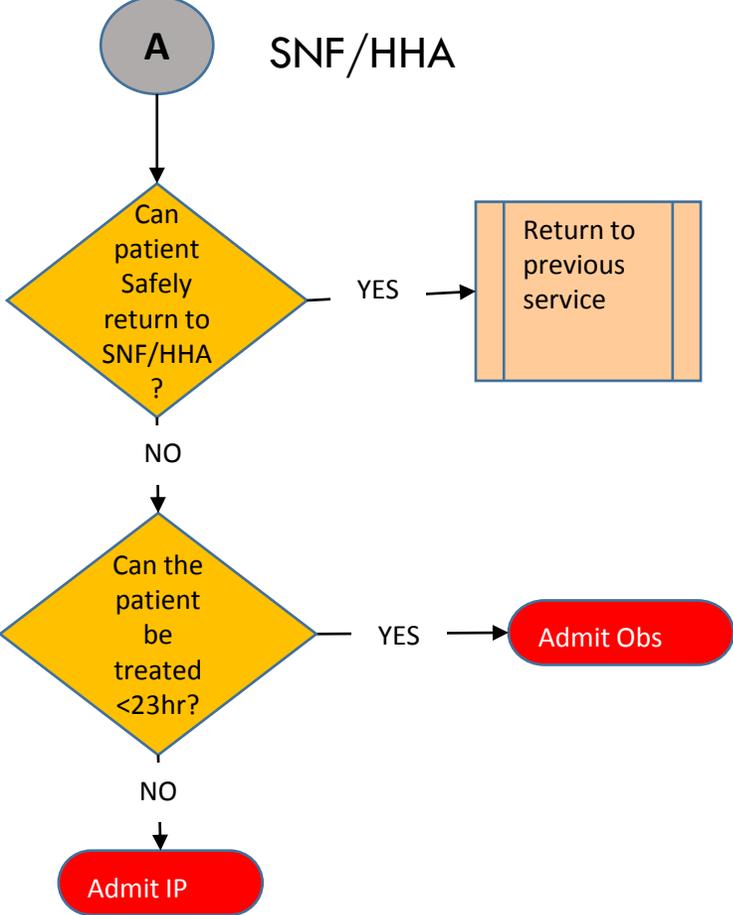
MRMC LPNT Goal

Readmission Data



ED PAUSE PROCESS MAPPING





REFERENCE

Healthcare Research and Educational Trust (2017). 2017 Readmission Change Package. Retrieved <http://www.hret-hiin.org/resources/display/readmissions-change-package>