Impact of Transitional Care Interventions on Reduction of Avoidable Emergency Department Visits by High Utilizers

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Background

TRACED (Transitions of Care in the Emergency Department) program focuses on reducing the number of return visits to the Emergency Department (ED) within 72 hours of previous encounter. The team performs comprehensive assessment of patients’ clinical and psychosocial needs, provides patient education on chronic conditions, coordinates smooth transition into the community by ensuring access to follow up appointments and provides a follow up nursing call within 48 hours of release from the ED.

Project Aim

Patients are selected into the TRACED program by utilizing high risk algorithm embedded into EHR. A comprehensive team approach is assembled to create a clear and concise protocol for patient education and care coordination during and post ED visit with the goal to reduce avoidable ED visits by high utilizers.

Project Design/ Strategy for Change

The TRACED intervention provides patients with an individualized care plan, which focuses on decrease of return to the Emergency Department within 72 hours. Through the interdisciplinary collaboration, the group will risk stratify patients to identify the needs after their ED visit. In order to accomplish that, comprehensive clinical and psychological assessment will be completed by RN Case Manager and Social Work teams to identify gaps in care to be addressed after this visit. Discharge Planning checklist includes interventions such as bedside education on chronic disease management, medication teaching, assistance with scheduling follow-up appointments, ordering transportation, DME or home health services and other community resources. A nurse led transition of care phone call is made for high risk patients to ensure safe transition into the community.

Summary of Results / Primary Outcomes

Between April 2018 and July 2018 there were over 7,500 patients screened. There were 1,071 interventions performed by the team where 505 transitions of care calls were completed. This resulted in 40% reduction of ED returns within 72 hours.

Lessons Learned

This initiative brings culture change around management of high-risk ED utilizers and encourages the team to think critically about patients’ clinical and psychosocial needs. A huddle process with multidisciplinary team provides forum for discussion about outpatient resources and other care coordination options available to the patients with high risk for ED returns and hospital readmissions. This initiative also provides foundation for discussion regarding medical necessity to determine appropriate level of care and whether the admission to inpatient unit is appropriate.