Quality Summit Performance Improvement Project
ED Frequent users Collaboration Project

I.   Back ground and Data Reporting.

The project initially started in January 2015 with ED MD's, ER Manager, Case Managers, Transitional Care Manager and Behavioral Health, to create care plans for six most frequent ER users. Since February 2015 we have been collaborating with CCFD, Sherriff Dept, FISH, Ron Wood "Health and Human Services" , Most and Fast Programs, Jail Forensic psychologist, NVHC and Carson Mental Health meeting once monthly to exchange information.

II.   Indicators

Top six ER patients have been identified and data has been collected from 2014, and January through March 2015 on admissions to ER. The latest data was manually collected from April 2015 to June 2015. See attached graphs. The study will continue through 2015 and beyond if necessary.

III.   Finding / Conclusions

distributed to the ER and the Coalition. Spreadsheets have collected data during the progression of the Coalition. Every participant in the Coalition can contribute data to the spreadsheet for accurate accounting and collective communication. Significant improvements have been made in indentifying all the resources available in the community as well as in the hospital. Attached is a successful patient experience navigating the system.
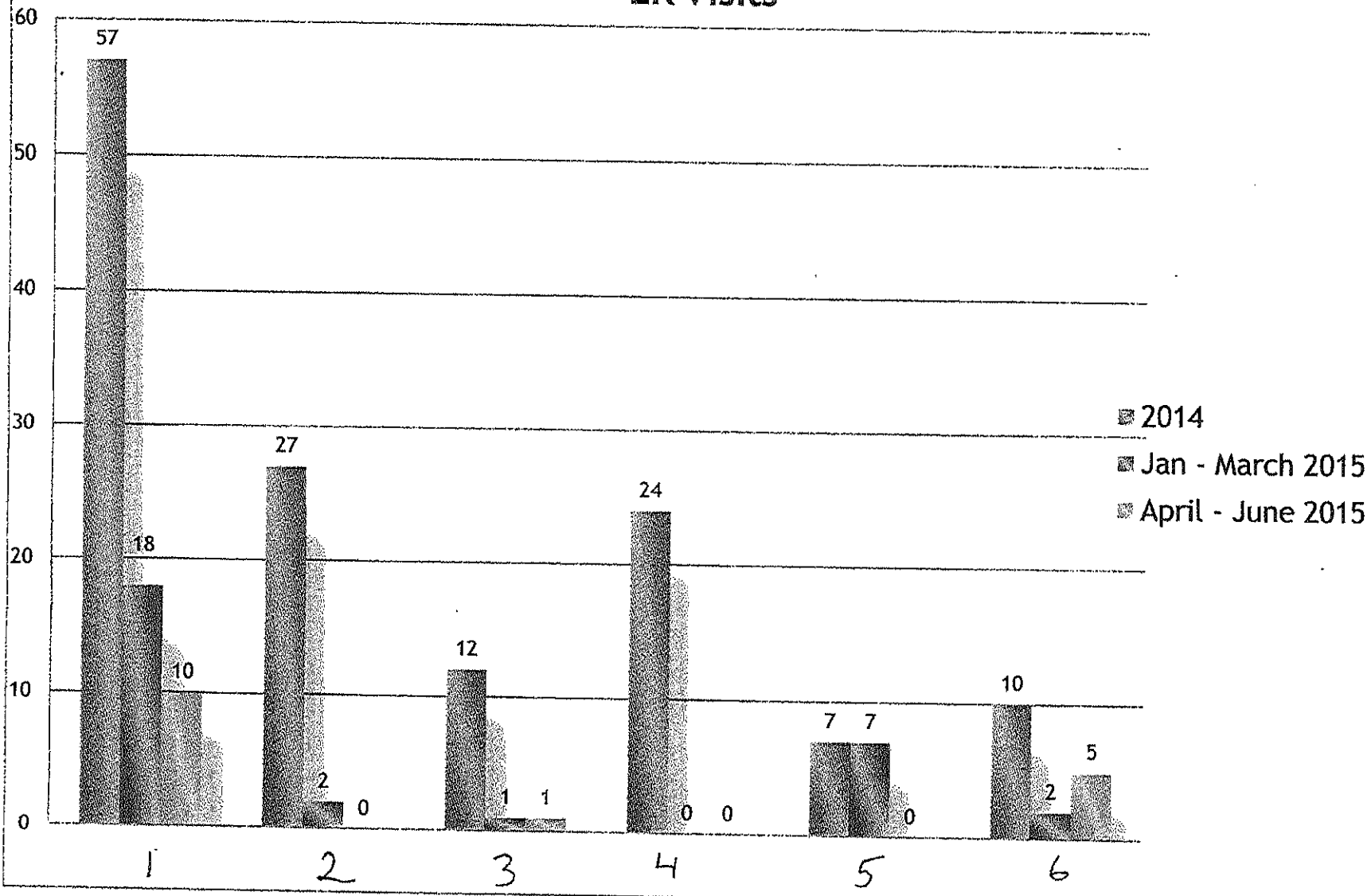
IV.   Recommendations / Actions

This coalition collaboration study will identify obstacles within the health care system and the team will continue to meet to provided the best outcomes for ER frequent users of the community and the hospital

V.   Data Distribution

The Data will be provided to all Directors, Managers, Physicians, Quality Summit and the Board of Directors

ER visits

	1	2	3	4	5	6
2014	57	27	12	24	7	10
Jan - March 2015	18	2	1	0	7	2
April - June 2015	10	0	1	0	0	5

Patient Experience Map for _____ Integrated Case Management

Your Area/Site/Practice

Pt has had no ER visits or admits for 45 days

Pt admitted to ER for the 8th time in 4 months

Case Manager does assessment

Shelter Plus provides permanent housing

Admitted to Med-Onc

Case Discussed in monthly Community Coalition

Case Manager does F/U assessment

TCM coordinates assistance with FISH and Ron Wood

Case discussed in AM rounds

TCM contacts CC H/H resources

Patient:

Social Work referral done re: homelessness

Referral to Transitional Care Manager to F/U

BHS referral re: Etoh

Discharged to motel with oxygen and cab ride

CMA faxing packet for ECF placement

Hospital will pay for 1 month in motel

Accepted at ECF and transported

Case Manager F/U

Pt release from ECF due to non-compliance

Admitted to Med-Onc for SOB

Social work referral

ER Case Manager does assessment

Pt calls 911 and is brought to ER