



Friday Focus 4 Health

A diverse and collaborative learning experience
designed to improve patient outcomes



Reducing Avoidable Emergency Department Visits

Fridays | 12:00 - 12:30 pm CT

February 3, 10, 17, 24

One topic. 4 weeks. 30 minutes. YOUR pace.



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We Would Love Your Feedback



Scan the QR code to let us know how we did

OR...

Access the link (via chat) to complete the evaluation



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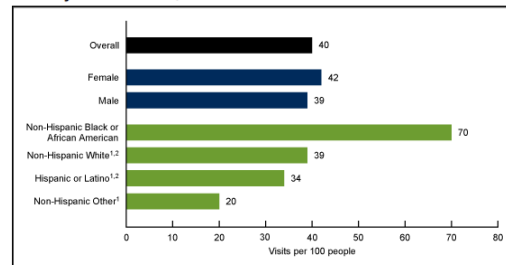
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Reducing Avoidable ED Visits



- Social Determinants of Health (SDOH)
 - ✓ Housing instability/food insecurity
 - ✓ Transportation
- Poor communication
- Poor health literacy
- Poor access

Figure 2. Emergency department visit rate, by sex and race and ethnicity: United States, 2020

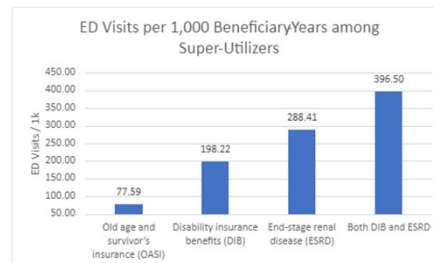
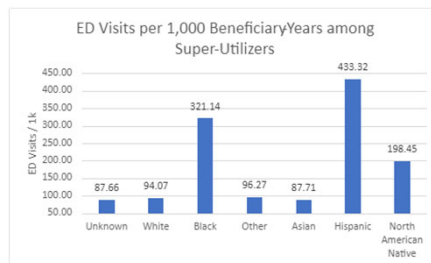


¹Significantly different from non-Hispanic Black or African American.
²Significantly different from non-Hispanic Other.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8272918/>

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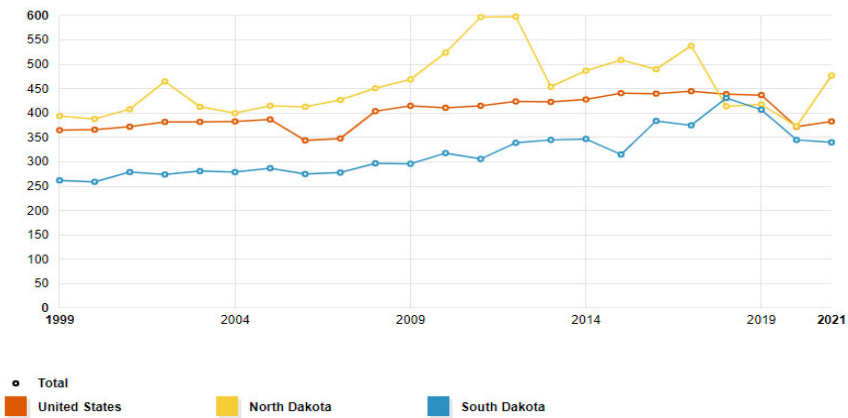
ED Visit per 1,000 Bene Years Among Super-Utilizers in ND & SD



Medicare Claims Fee for Service | Sep 2021 - Aug 2022

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2021 Hospital Emergency Room Visits Per 1000 Population



[KFF State Health Facts](#)

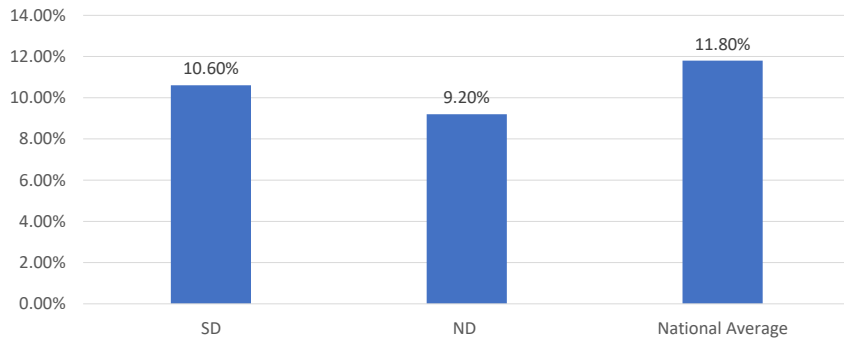
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State ED Nursing Home Data



% of SS Residents who had an Outpatient ED Visit



<https://www.medicare.gov/care-compare/?providerType=NursingHome>
 Dates: 07/01/2021-06/30/2022

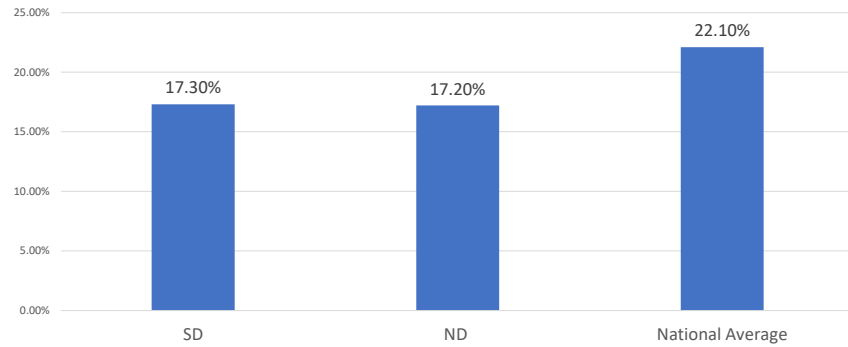
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State ED Nursing Home Data



SS Residents who were re-hospitalized after a NH Admit

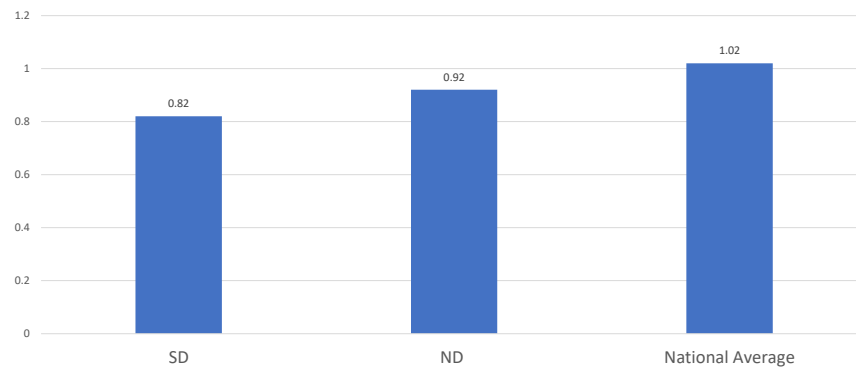


<https://www.medicare.gov/care-compare/?providerType=NursingHome>
Dates: 07/01/2021-06/30/2022

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Percent of Outpatient ED Visits per 1000 LS Resident Days - Nursing Home



<https://www.medicare.gov/care-compare/?providerType=NursingHome>
Dates: 07/01/2021-06/30/2022

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Common Reasons for ED Visits



- Inadequate communication
 - ✓ Between transferring organization
 - ✓ Between staff and primary care provider
 - ✓ Between healthcare staff and pt/resident or family
- Lack of awareness of accepting healthcare organizations such as nursing homes and assisted living
- Early change of condition unrecognized
- Lack of resources
- Inadequate end of life conversations/advance care directives
- Inadequate chronic care management/gaps in care coordination
- Events related to infection (respiratory, GI, urinary tract, skin/wound, sepsis)
- Events related to care (falls, abrasions, trauma, dehydration, pressure injury, inadequate monitoring)
- Medication adverse events

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INTERACT[®] Tools



- [INTERACT[®] Version 4.5 Tools for Skilled Nursing](#)
- [INTERACT[®] Version 2.0 Tools for Assisted Living](#)
- [INTERACT[®] Version 1.0 Tools for Home Health Care](#)



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What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

4Ms Framework

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

For related work, this graphic may be used in its entirety without requesting permission. Graphic files and guidance at www.AgeFriendly.org

<https://www.johnahartford.org/images/uploads/resources/JAHF-MHc-Webinar-AFHS-Case-Studies-final.pdf>

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Leave in Action

- Who is utilizing the Emergency Department?
 - Did you play a role ?
- [Reducing Avoidable Emergency Department Visit & Hospitalization Visit Toolkit](#)
- [GPQIN Quality Improvement Project Guide & Tools](#)
 - Build Your Team
 - Collect/Analyze Data [INTERACT®](#) Hospital Rate Tracking Tool
 - Emergency department transfers
 - Root Cause Analysis Review
 - Define Problem (after data review)

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Polling Question

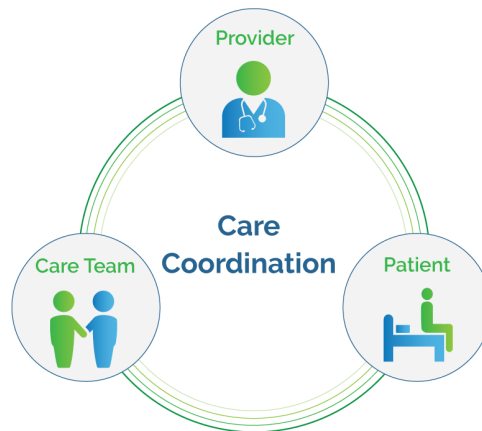


- If you are working on Reducing ED Visits or Hospital Readmission - Where are you in the QI Process?
 - PLAN - Building Your Team
 - PLAN - Collecting/Analyzing Data
 - PLAN - Developing Problem Statement
 - PLAN - Measuring the Impact (SMARTIE Goal)
 - DO - Implementing an Intervention
 - STUDY - Monitoring Progress
 - STUDY - Studying Improvement
 - ACT - Action & Spread
 - Not yet, but hope to soon

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Reduce ED Visits - Super-Utilizers



<https://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/MusicOfCoordinatedCare.aspx>

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Office Hours

Questions & Sharing in a Safe Environment



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Thank You For Joining | Share Your Feedback

Scan the QR code
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complete the evaluation



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