2014 Gage Awards

Reference #	7492310
Status	Complete
Name of hospital or health system	Alameda Health System
Name of project	Emergency Department Navigator
CEO name	Wright Lassiter
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
Submitter name (first and last)	Benita McLarin
Submitter title	Vice President, Ambulatory Health Care Services
Submitter email	bmclarin@alamedahealthsystem.org
Submitter phone	510-895-7374
Project contact person's name (First and Last)	LaTisha Murray
Project contact title	Ambulatory Call Center Director
Project contact email	lmurrary@alamedahealthsystem.org
Project contact phone	510-895-7322
Within which of the two categories does your application best align?	Quality

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	Alameda Health System wanted to improve the patient experience in the Highland Hospital Emergency Department discharge process by creating access and ensuring quality of care. We believed this could be accomplished by ensuring Emergency Department patients received appropriate and timely follow-up back to their Medical Homes. In June 2011 after noticing that many Emergency Department patients were being asked to follow up in the hospital based primary care clinics, seeing these clinics were being overwhelmed with appointments and patients whose Medical Homes were outside of the hospital clinics and that patients often were not experiencing good continuity of care, the Ambulatory Division partnered with the Emergency Department and initiated a relatively inexpensive intervention pilot utilizing a trained appointment clerk who was positioned in the Emergency Department and made responsible for working with Emergency Department providers, staff and patients, making it possible to identify a patient's existing primary care provider, if any, and re-connecting the patient to that provider, whether at Alameda Health System (AHS) or in a community health facility following their Emergency Department visit. Some of the program objectives included: (1) decreased avoidable use of the Emergency Department for chronic conditions that can be successfully managed in Ambulatory settings, (2) increased show rates in primary care follow up appointments at appropriate medical homes, and (3) decreased inpatient hospital readmission rates for patients that receive Navigator assigned appointments. This program enhances inter-department collaboration, continuity of care, makes more efficient use of AHS's limited primary care resources, and contributes to our system reform goals of patient-centered care and access to appropriate levels of care. Data sources for this program included provider surveys, clinic no-show data, the DSRIP Annual Report and the DSRIP Care Transitions Data Report. An informal Plan Do Check Act (PDCA) process was used for the study design. Ambulatory Services staff worked in partnership with the Emergency Department to plan (P) the intervention, identify a lead employee with the best skills to make it successful and start the work (D), track the intervention impacts (C) and maintain and spread the initiative beyond the pilot phase (A). Successful results of this intervention included increased Emergency Department provider satisfaction and confidence that patients are receiving follow up care, increased patient satisfaction with overall services and after-care services, decreased unused clinic appointments and no-shows, improved appropriateness for follow up appointments and more patient involvement in decision making. This initiative has proven that increased department cooperation and collaboration can lead to improved access, quality of care, staff and patient satisfaction and patient outcomes.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	The Plan Do Check Act process improvement method was used informally in this project. The project team consisted of Emergency Department Manager, Emergency Department Medical Director, Emergency Department senior physician, Hospital Clinic Adult Medicine Medical Director, Ambulatory Medical Director, Ambulatory Vice President, Radiology Director, Call Center Director and Emergency Department Navigator met on a regular basis to develop and evaluate the program. The program was initially staffed by only one person, a Specialist Clerk from the Ambulatory Call Center. This position was renamed the Emergency Department Navigator or Patient Access Care Coordinator and was physically positioned in the Emergency Department during regular business hours. She was responsible for working with Emergency Department providers and patients to identify the Medical Home of patients that required follow up after an Emergency Department visit. She was also responsible for identifying Medical Homes, contacting that patient's Medical Home, reviewing past and future appointments (and notifying Emergency Department providers), making the follow up appointment for the patient and sending Emergency Department visit documentation to the clinic when required. After the program was formally approved a second Emergency Department Navigator (Patient Access Care Coordinator) was selected to support the Emergency Department evening shift. The project was successful because it increased communication between Ambulatory Services and the Emergency Department leading to more opportunities for appropriate follow-up patient care at appropriate sites. Some additional successes from the program included: Patients were able to contact the Emergency Department Navigator directly as a personal resource and can get assistance even after their discharge from the Emergency Department. Emergency Department Providers (especially those without an EHR system) know if patients have established provider –which would avoid duplication of referrals and/or slots being used inappropriately. Emergency Department providers are informed about patients who are "frequent flyers" but also were scheduled and missed clinic appointments. No Show rates are decreased through increased communication and relationship between Health System and patient. The Emergency Department Navigator can directly schedule AHS patients into their medical home clinic in the scheduling system and can contact the clinic if special consideration is needed when appointments are not available in a timely fashion. The Emergency Department Navigator also contacts the non-AHS Community Clinics to assist patients to schedule Emergency Department follow up visits at their own medical home. The Emergency Department Navigator helps expedite referrals when the patient presents in the Emergency Department but already has pending referrals for a specialty clinic. This can help to reduce the chance of an admission.

3. Describe the results of the project. What data was used to support improvement results?	Implementation of this program resulted in enhanced inter-department collaboration, improved patient continuity of care, increased Emergency Department provider satisfaction and confidence that patients were receiving follow up care, increased number of patients with specific disease cases receiving follow up care, increased patient satisfaction with overall services and after-care services, decreased unused clinic appointments and no-shows, improved appropriateness for follow up appointments and more patient involvement in decision making. Data from the DSRIP Emergency Department Care Transitions Report and comments from provider surveys were used to support improvement results.
3A. Attachment, if applicable (Only graphically displayed data such as charts will be accepted. Data should include baseline and improvement data)	DSRIPEDCareTransitionSummary_2013.07.08.pdf (56k)
4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	Successful results of this intervention included increased Emergency Department provider satisfaction and confidence that patients are receiving follow up care, increased number of patients with specific disease cases receiving follow up care, increased patient satisfaction with overall services and after-care services, decreased unused clinic appointments and no-shows, improved appropriateness for follow up appointments and more patient involvement in decision making. All improvements were related to the project and can be duplicated by other organizations.

5. Describe how patients, families, and if appropriate, community was included in the work.	The community was involved with this work in that we designed the program to ensure that we involved Medical Homes that were outside of the Alameda Health System family. We made great efforts to identify key contacts within the Community Health Center Network (CHCN) clinics and other facilities so that primary care providers of those clinics could be notified that their patients visited the Emergency Department and so that patients from those sites could be re-directed following an Emergency Department visit. We have recently added a Navigator (Patient Access Care Coordinator) to our new Same Day Clinic service which offers same day access for immediate need issues and acts as a bridge to the primary care clinics and acts as an alternative to the Emergency Department for patients needing immediate care but non-emergency care. In their response to our regular Delivery System Reform Incentive Pool (DSRIP) report The California Department of Health Care Services provided the following comments on the Navigator Program: "The ED Navigator program is an innovative care coordination strategy to enhance patient-centered care and access. Also, commendable is the potential for scaling up this service through other areas of the hospital, such as the inpatient service." Additionally Kaiser Permanente, as part of their work to support the Safety Net, recently awarded Alameda Health System with their Clinical Systems Development Award for our Emergency Department Navigator program and its success collaborating between departments and improving care transitions.
5A. Attachment, if applicable (Applicable attachments include documents created for patients, families, or community members or by them as a result of the project)	EmergencyDepartmentProviderSurveyComments.docx (13k)
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