IHI ID 01

SAVING 414 BED DAYS IN FY18: DISCHARGE PLANNING FOR PATIENTS WITH NEW TRACHEOSTOMIES

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10.1136/ihiisciabs.1

Background The Progressive Care Unit (PCU) cares for technology dependent children where about 55 patients with newly placed tracheostomy tubes are discharged annually. They are generally discharged to a transitional care center (TCC), where consent and insurance authorization are required, or to home. Home discharges require over 65 hours

Saving 414 bed days in FY18

Discharge planning for patients with new tracheostomies

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DESCRIPTION

The Progressive Care Unit (PCU) cares for technology dependent children where about 55 patients with newly placed tracheostomy tubes are discharged annually. They are generally discharged to a transitional care center (TCC), where consent and insurance authorization are required, or to home. Home discharges require over 65 hours of caregiver training, home equipment inspections, and home nursing. Most families defaulted to the home discharge plan, although several families were unable to complete all discharge requirements by the time their child was medically stable and no longer needed inpatient level of care. This often caused discharge delays.

SMART Aim

Save 100 PCU bed days by
June 30, 2018 through
enhancing discharge
planning.

Keep Kids Out of the Hospital

Increase Effectiveness & Efficiency

Keep Patients Safe

ACTIONS TAKEN

A multidisciplinary team created a Discharge Planning Booklet which was reviewed with new families. The booklet included eligibility criteria to be discharged to home, an eight-week checklist with all home discharge requirements, a map of TCCs in nearby states, and an opportunity to set an appropriate discharge plan.

SUMMARY OF RESULTS

The project resulted in a culture change in the approach to discharge planning for this patient population. The average PCU length of stay decreased from 77.5 days to 62.2 days, saving 15.3 days per patient. This saved 414 PCU bed days for 27 patients. Several process metrics were also impacted:

Process Metrics	Before Project Intervention	After Project Intervention
Avg. days of discharge delay due to incomplete caregiver requirements	44 days (n = 7)	25 days (n = 10)
Avg. duration of caregiver training in the PCU	64 days (n = 12)	38 days (n = 16)
% of Patients with Denials	14.4%	10%

10 Patient Weighted Moving Average PCU Length of Stay

Project Sponsors: Richard Lin, MD, Athena Zuppa, MD, & Jean Anne Cieplinski-Robertson, RN, MSN, NEA-BC
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Abstract IHI ID 01 Figure 1

Abstracts

of caregiver training, home equipment inspections, and home nursing. Most families defaulted to the home discharge plan, although several families were unable to complete all discharge requirements by the time their child was medically stable and no longer needed inpatient level of care. This often caused discharge delays.

Objectives Save 100 PCU bed days by June 30, 2018 through enhancing discharge planning.

Methods A multidisciplinary team created a Discharge Planning Booklet, which was reviewed with new families. The booklet included eligibility criteria to be discharged to home, an eight-week checklist with all home discharge requirements, a map of TCCs in nearby states, and an opportunity to select an appropriate discharge plan.

Results For patients with new tracheostomies, the average PCU length of stay decreased from 77.5 days to 62.2 days, saving 15.3 days per patients. This saved 414 PCU bed days for 27 patients. Several process metrics were also impacted, including decreased training time and decreased days of discharge delay due to incomplete caregiver requirements.

Conclusions The project resulted in a unit culture change in the approach to discharge planning for this patient population. In June 2018, the intervention expanded outside of the PCU to three other units, impacting an additional 20 patients each year.

IHI ID 02 SUSTAINING AN END TO HOMELESSNESS OVER TIME

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10.1136/ihisclabs.2

Background Sustainably ending homelessness requires multi-stakeholder teams to constantly solve for population level outcomes over time. Previously, no measurement framework existed for knowing if a community had reached an end to homelessness, and more importantly, if those gains were continually maintained.

Objectives In 2015, we began to use a sustaining threshold to measure if the communities that had reached functional zero for veteran homelessness had sustained their progress over time by continually developing new solutions to the ever-changing complex problem of homelessness.

Methods Built for Zero communities that have reached functional zero submit seven monthly data points related to the number of actively homeless veterans entering and exiting their systems. We compare this monthly data to the community's original functional zero threshold to measure sustainability over time.

Results To date, eight communities have ended and sustained a measurable end to veteran homelessness. All continue to experience fluctuation in the number of veterans experiencing homelessness, after they reach functional zero. Four communities have sustained consistently, especially those with higher thresholds relative to their system size and capacity. Communities that have sustained for three months or more are more likely to have sustained long term.

Conclusions Sustaining an end to homelessness requires communities to continually track and respond to the dynamics of homelessness across a geographically defined area, even after they have 'ended' homelessness. Given the impact of social determinants on health outcomes, understanding how to maintain an end to homelessness has implications for population-level outcomes across housing and health sectors.

While not sustaining continually, the changes Montgomery County made to impact their system were effective according to run chart rules.

Abstract IHI ID 02 Figure 1 Veterans experiencing homelessness in montgomery country, MD