THE HEALTH CARE IMPROVEMENT FOUNDATION
Building Partnerships For Better Health Care

Improving Transitions of Care in Southeastern Pennsylvania
About HCIF

Mission: To lead healthcare improvement initiatives by engaging multi-stakeholder resources to implement solutions that no market participant could achieve individually.

Vision: Through an engaged, collaborative community, the SE PA region benefits from a high-performing healthcare system demonstrating enhanced measures of safety, quality and effectiveness.
HCIF as Convenor

Unique role as regional non-profit organization dedicated to quality and safety

Neutral, expert resource trusted by hospitals and health plans

Leadership stature to engage multiple stakeholders
What is “Transition of Care”?
The movement of patients from one health care practitioner or setting to another as their condition and care needs change

(c) Eric A. Coleman, MD, MPH
Transitions occur at multiple levels

Within Settings
- Primary care > Specialty care
- ICU > Med/surg unit

Between Settings
- Hospital > Sub-acute facility
- Ambulatory clinic > Senior center
- Hospital > Home

Across health states
- Curative care > Hospice
- Personal residence > Assisted living
SE PA Care Transitions: Unique Challenges
Compact geography and density of hospitals & physicians – many choices and tertiary referrals

ER as major access point - 9-1-1- calls go to nearest (not always primary) hospital

Up to 50% of readmitted patients return to a different facility
Southeastern Pennsylvania's 580,000 Inpatient Admissions by Healthsystem FY2011-2012

- UPHS: 16%
- MLHS: 11%
- TJUH: 8%
- JHS combined: 19%
- Abington: 7%
- Einstein: 5%
- ARIA: 4%
- CHE: 10%
- CHOP: 5%
- CHS: 6%
- Crozer-Keystone: 6%
- Doylestown: 2%
- Lukes Quakertown: 1%
- NPHS: 1%
- Prime Healthcare: 2%
- Grand View: 2%
- Holy Redeemer: 2%
- HAP 1%
Collaborative initiative to reduce hospital readmissions
HCIF Collaborative Project Model

1. Convene advisory panel of experts
2. Host a regional conference
3. Baseline survey and data collection
4. Webinar series; learning resources
5. Collaborative workgroup meetings and/or networking calls
6. Post-project data collection and analysis
PREVENTING AVOIDABLE EPISODES

Smoothing the Path for Better Transitions

Care Transitions Workgroup

Medication Management Workgroup

Personal Health Record Workgroup
SEPA-READS
Southeastern Pennsylvania (SEPA)
Regional Enhancements Addressing Disconnects (READS)
in Cardiovascular Health Communication

Preventive Health and Health Services Block Grant
through PA Department of Health

October 2010 – June 2015

Partnership with

Jefferson
What is health literacy?

Health literacy measures your ability to obtain, process, and understand basic health information...

...and then use that information to make informed and appropriate healthcare decisions.

Poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race.

-The American Medical Association
What a patient hears....
Provider Training

3 train-the-trainer, interactive modules:

Module 1: Health literacy overview and effective oral communication, including teach-back, plain language

Module 2: Written material development

Module 3: Website development and additional topics as requested by partners (e.g., informed consent and wayfinding)

250 health care professionals trained
Positive evaluations of trainings
Increased knowledge and intentions to change practices as result of training
Health care consumer training and education on Ask Me 3 using a peer educator model.

Outreach and Training of peer educators at each participating senior-serving organization

Consumer education sessions led by peer educators for members of their communities

77 peer educators trained
350+ peers educated
Positive evaluations of sessions
Health information exchange facilitating transitions of care
THE PLAN

H.I.E.s

whenever it is needed to improve

YouTube
Use Case #1
Direct Messaging: Discharge Information

Hospital sends inpatient and ED discharge information

HealthShare Exchange of Southeastern Pennsylvania supports direct routing and directory requests via the web as well as automated web services

Health Plan IDs PCP/Care Team Routes to Care Manager

Provider (eg, PCPs, specialists, home health) receives info via EHR, email or via health plan portal
Use Case #2: Routing Claims History via Payers

Provider requests eligibility and clinical history from Health Plan

Patient visits Provider (hospital or practice)

Provider receives data via EHR or secure email in support of medication reconciliation and treatment

Eligibility Request triggers plan to request medication history and claims data

Information returned via PDF or CCD which can be consumed by EHR

Health Plan Claims Data
Towards Safe, High Quality Emergency Department Care Transitions in Southeastern PA
Background

- Newest Partnership for Patient Care initiative
- 18-month collaborative
- Aim to improve care transitions both to and from EDs in the region, with focus on transitions between EDs and community settings (e.g., home, skilled nursing facilities)
- Opportunity to develop regional approach to quality in the ED, with impact on safety and efficiency
Project Overview

Participants
Diverse partners across 5-county Southeastern
PA invited to join:
- Hospitals and Health Systems
- Skilled Nursing Facilities, Long Term Care
- Physician's Offices
- Other Community Providers
- Payers

Goals
- Identify and share best practices for transitions of care to and from EDs
- Develop standardized regional approaches and tools to facilitate ED transition processes
- Increase implementation of best practices across collaborative members
- Engage providers and healthcare professionals across the continuum of care, as well as patients and their families, in the transition improvement process

Design and Timeline
Workgroups

- **Purpose**
  - Forum for multi-organizational collaborative innovation and experimentation
  - Each group charged to develop at least one strategy or deliverable with potential for significant regional impact

- **Topics**
  - Improving transitions between ED and SNFs
  - Standardization of ED discharge processes
  - Early, reliable follow up from ED visit
  - Addressing needs of frequent ED users
Transforming our Transitions
Transforming our Transitions