



THE HEALTH CARE IMPROVEMENT FOUNDATION
Building Partnerships For Better Health Care



Emergency Department Care Transitions Collaborative Update

Susan Choi, PhD, CPHQ

Partnership for Patient Care | Annual Leadership Summit

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Emergency Transition Advances (ETA)

- ▶ 18-month Partnership for Patient Care initiative launched in January 2014
- ▶ Aim to improve care transitions both to and from emergency departments (EDs) in the region, with a 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 potential impact on safety and efficiency

ETA Participants

- ▶ Abramson Center for Jewish Life
- ▶ Bryn Mawr Hospital
- ▶ Chester County Hospital-Penn Medicine
- ▶ Doylestown Hospital
- ▶ Einstein Medical Center-Montgomery
- ▶ Einstein Medical Center-Philadelphia
- ▶ Foulkeways at Gwynedd
- ▶ Freedom Village Brandywine
- ▶ Genesis Healthcare
- ▶ Hahnemann University Hospital
- ▶ HCR Manor Care
- ▶ Health Partners Plans
- ▶ Holy Redeemer Hospital
- ▶ Jeanes Hospital
- ▶ Keystone First
- ▶ Lankenau Medical Center
- ▶ Magee Rehabilitation Hospital
- ▶ Mercy Health System
 - ▶ Mercy Fitzgerald Hospital
 - ▶ Mercy Philadelphia Hospital
 - ▶ Mercy Suburban Hospital
 - ▶ Nazareth Hospital
- ▶ Methodist Hospital
- ▶ Paoli Hospital
- ▶ Pennsylvania Hospital
- ▶ St. Christopher's Hospital for Children
- ▶ Temple University Hospital
- ▶ Thomas Jefferson University Hospital

Timeline

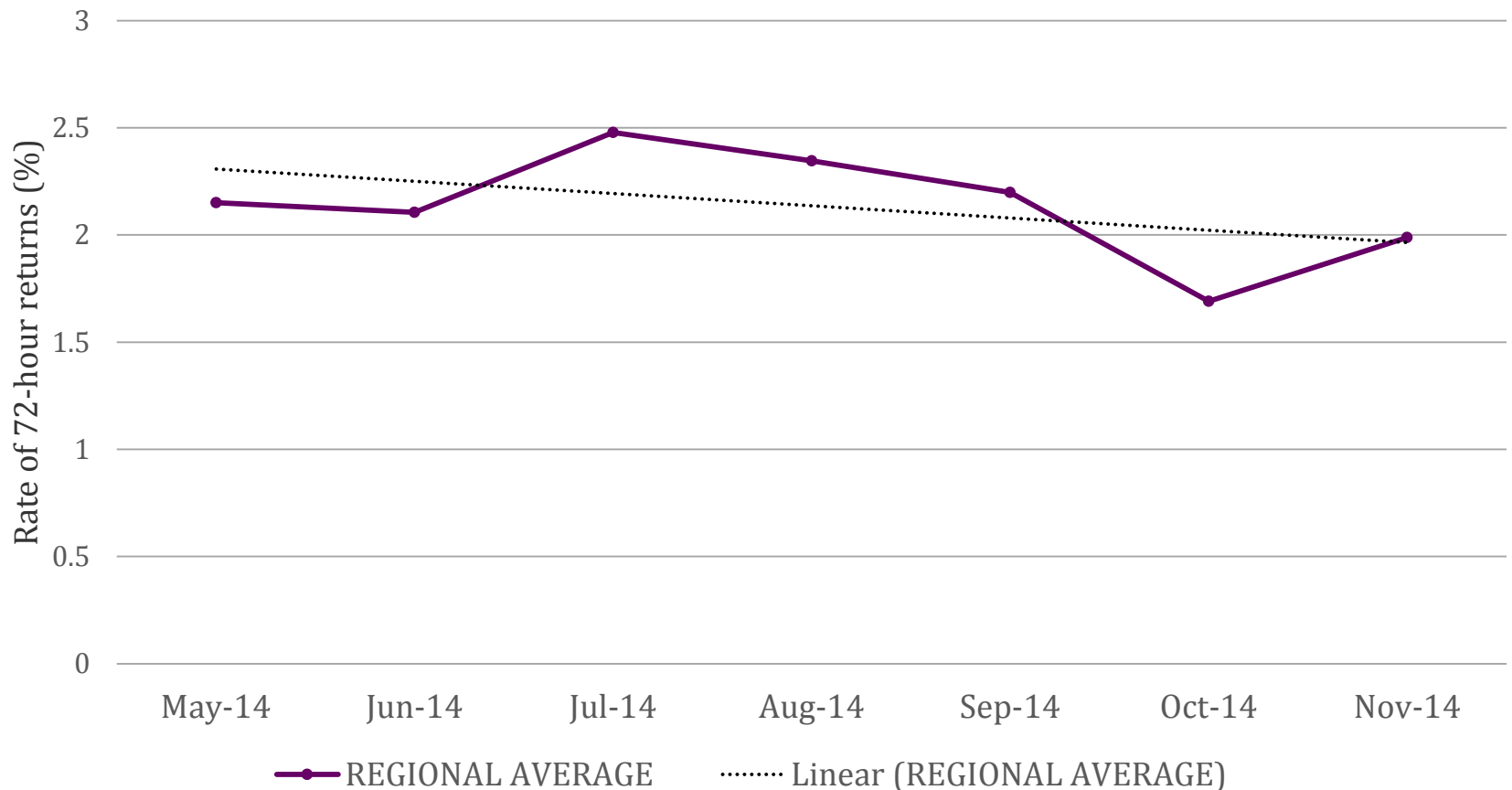
Activity	2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Kick-off: Regional Symposium	Jan							
Participant Enrollment	Feb							
Introductory Webinars	Mar	Apr						
Baseline and Ongoing Measurement		Apr				Jun		
Workgroup Meetings		May		Oct				
Site Visits				Nov		Apr		
Webinars & Networking Opportunities					Mar	Jun		
Follow-up Measurement & Dissemination							Jul	Dec

ED Transitions of Care Survey

- ▶ **Practices with majority fully or partially implemented**
 - ▶ Consistent performing of medication reconciliation
 - ▶ Providing printed discharge instructions with follow-up appointment summary and ED contact number
 - ▶ Nurse-to-nurse communication with other facilities
- ▶ **Practices not implemented, areas for further exploration**
 - ▶ Frequent ED use risk assessment and deployment of interventions
 - ▶ Support for follow-up, including scheduling, before patient leaves ED
 - ▶ Use of teachback at discharge
 - ▶ Palliative care/end-of-life needs assessment

Data Update: 72-hour Returns

Rate of unscheduled returns to the ED for the same or similar condition within 72 hours of discharge from the initial ED visit



Workgroup Areas of Focus



Improving transitions between EDs & skilled nursing facilities (SNFs)

- Develop tools to improve communication between EDs & SNFs
- Promote opportunities for EDs & SNFs to connect and learn about each other's capabilities



Improving ED discharge & follow-up processes

- Seek ways to more effectively educate and set patient expectations at discharge, given time constraints
- Explore methods of ED visit follow-up and consider how to deploy more effectively



Addressing needs of frequent ED users

- Identify multiple sub-types of frequent users and those to be targeted for interventions (consider utilization and potential for impact)
- Explore potential interventions for specific populations

Site Visits

- ▶ Gain better understanding of common issues and specific challenges faced by participants
- ▶ Connect specific participants based on shared interests
- ▶ Tailor programming and resources to better meet specific needs



Next Steps

- ▶ Facilitate further connections between specific participants (e.g., pairing of EDs and SNFs)
- ▶ Facilitate identification of populations targeted for interventions (e.g., prioritizing populations for callback, frequent ED users)
- ▶ Webinars
 - ▶ Improving discharge communication
 - ▶ Presentations from EDs that have developed successful programs to address frequent ED use



Questions?

Susan Choi

Senior Director, Quality
Partnerships & Initiatives

215.575.3742

schoi@hcfonline.org

Susan Cosgrove

Project Manager

215.575.3746

scosgrove@hcfonline.org

