Emergency Department Care Transitions Collaborative Update

Susan Choi, PhD, CPHQ
Partnership for Patient Care | Annual Leadership Summit
March 18, 2015
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

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Kick-off: Regional Symposium</td>
<td>Jan</td>
<td></td>
</tr>
<tr>
<td>Participant Enrollment</td>
<td>Feb</td>
<td></td>
</tr>
<tr>
<td>Introductory Webinars</td>
<td>Mar</td>
<td>Apr</td>
</tr>
<tr>
<td>Baseline and Ongoing Measurement</td>
<td>Apr</td>
<td></td>
</tr>
<tr>
<td>Workgroup Meetings</td>
<td>May</td>
<td>Oct</td>
</tr>
<tr>
<td>Site Visits</td>
<td></td>
<td>Nov</td>
</tr>
<tr>
<td>Webinars &amp; Networking Opportunities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up Measurement &amp; Dissemination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

Month Rate of 72-hour returns (%)

May-14 2
Jun-14 2
Jul-14 2.5
Aug-14 2.5
Sep-14 2
Oct-14 1.5
Nov-14 2
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@hcifonline.org

Susan Cosgrove
Project Manager
215.575.3746
scosgrove@hcifonline.org