Emergency Transition Advances Collaborative
Towards Safe, High Quality Emergency Department Care Transitions in Southeastern PA

Susan Cosgrove, MPA
Project Manager
Health Care Improvement Foundation
March 19, 2014

Participants
- Providers
- Hospitals and Health Systems
- Skilled Nursing Facilities, Long Term Care
- Physicians, PA/NS
- Other Community Providers
- Patients
- Currently 20 participating organizations

Workgroups
- Regional Program Office
- Transition: Inpatient to Outpatient
- Transition: ED to Home
- Transition: Inpatient to Inpatient or Outpatient
- Transition: Home to Inpatient/Outpatient

Measurement
- Hospital for End Stage Renal Disease
- ED Discharge
- Skilled Nursing Facility Outcomes
- Transition in Inpatient/Outpatient
- Transition in ED to Home
- Transition in Home to Inpatient/Outpatient

Next Steps
- Measurement will support:
  - Planning/strategic initiatives
  - Reduce the intensity of ED use
  - Share group care model
  - Protect the patient and their family

Background
- The Emergency Transition Collaborative (ETC) is a multi-disciplinary collaborative of care providers and stakeholders, including hospitals, long-term care facilities, and community providers, to improve care transitions for patients transitioning from the ED to inpatient and out-of-hospital settings.

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THANK YOU!
Background

• Newest Partnership for Patient Care initiative
• 18-month collaborative kicked off in January
• 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**

**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

**Timeline**

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<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Kick-off Regional Symposium</td>
<td>Jan</td>
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<tr>
<td>Participant Development</td>
<td>May</td>
<td>Apr</td>
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<tr>
<td>Baseline Data Collection</td>
<td>Sep</td>
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<tr>
<td>Workload &amp; Resource Optimization</td>
<td>Apr</td>
<td>Jun</td>
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<td>Age-Specific Transition Care</td>
<td>May</td>
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<td>Strategy Development &amp; Implementation</td>
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<td>Follow-up Evaluation &amp; Implementation</td>
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**Expert Advisory Panel**

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<tr>
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<tr>
<td>Arria Health</td>
<td>Gary Welch, DO</td>
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<td>Penn Medicine Chester County Hospital</td>
<td>Betty Eremman, Edd, MSN, RN, CEN</td>
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<td>Crozer-Keystone Health System</td>
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<td>Topic-Specific Workgroups Convened</td>
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Regional Symposium

• January 21, 2014 at The College of Physicians of Philadelphia
• Keynote: Jesse Pines, MD, MBA, MSCE, George Washington University
• Topics discussed included best practices in follow up, improving ED-SNF transitions, and models for addressing frequent ED use
• Over 100 attendees from hospitals, skilled nursing facilities, payers, and other organizations across Southeastern PA
Participants

- Diverse partners across 5-county Southeastern PA invited to participate:
  - Hospitals and Health Systems
  - Skilled Nursing Facilities, Long Term Care
  - Physician's Offices
  - Other Community Providers
  - Payers
- Currently, 20 participating organizations
Participants

Bryn Mawr Hospital
Penn Medicine Chester County Hospital
Doylestown Hospital
Einstein-Montgomery
Einstein-Philadelphia
Foulkeways at Gwynedd
Genesis Healthcare
Hahneman University Hospital
HCR Manor Care
Holy Redeemer
Keystone First
Lankenau Medical Center
Magee Rehabilitation
Mercy Health System
Methodist Hospital
Paoli Hospital
Pennsylvania Hospital
St. Christopher's Hospital
Temple University Hospital
Thomas Jefferson University Hospital
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
Measurement

- Hospital/facility transition of care process survey
- ED staffing model assessment
- Quantitative data
  - Rates of return to ED
  - Readmission rates
- Retrospective chart reviews
- Patient/family interviews
Next Steps

- Measurement webinar: Thursday, March 20
- Baseline data collection: March and April
- Workgroups convened: May
- Webinar series begins: Summer
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- Skilled Nursing Facilities
- Long Term Care
- Physicians
- Other Community Providers
- Others
- Currently, 26 participating organizations

Workgroups
- Regional
  - Hospital and health system transitions of care
    - EQ-5D health status assessment
    - Disease-specific data
    - Readmission data
    - Risk adjustment
    - Reimbursement
    - Population health
    - Evidence-based interventions

Region

Measurement

Next Steps
- Measurement
  - Hospital and health system transitions of care
  - EQ-5D health status assessment
  - Disease-specific data
  - Readmission data
  - Risk adjustment
  - Reimbursement
  - Population health
  - Evidence-based interventions

Background
- Emergency Department Patient Care Initiative
- Research collaboration with local hospitals
- Senior care transitions initiatives in use and progress in the region with focus on transitions between ED and community settings and home, skilled nursing, and other settings
- Opportunity to develop regional approach to quality in the ED with support from state and federal agencies

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