HealthChoices PCMH Learning Network Housekeeping

For introductions and breakout room assignment based on the following topic of interest, please rename yourself to include the following:

Full name, Organization, either 1 or 2

1. Identifying and prioritizing patients for post-discharge follow-up

Topic could include: Getting comprehensive information on transitions of care, stratifying and prioritizing patients, etc.

or

2. Getting people to complete follow-up appointments

Topic could include: coordination with in-patient, right type of scheduling, etc.

In the breakouts, each room will discuss and share main challenges, what has worked vs. what hasn't, and why, for each topic

Post-Hospital Follow Up Sprint Learning Session #1

March 19, 2025

HealthChoices PCMH Learning Network

SUZANNE COHEN, SENIOR DIRECTOR OF POPULATION HEALTH, HEALTH FEDERATION OF PHILADELPHIA

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

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The PCMH Learning Network

Designed to support the PCMHs and MCOs in:

- ✓Achieving the shared aims of the HealthChoices PCMH Program
- ✓Identifying and acting on strategies in response to opportunities for improvement
- ✓Developing an internal capacity to continuously learn, adapt, and improve

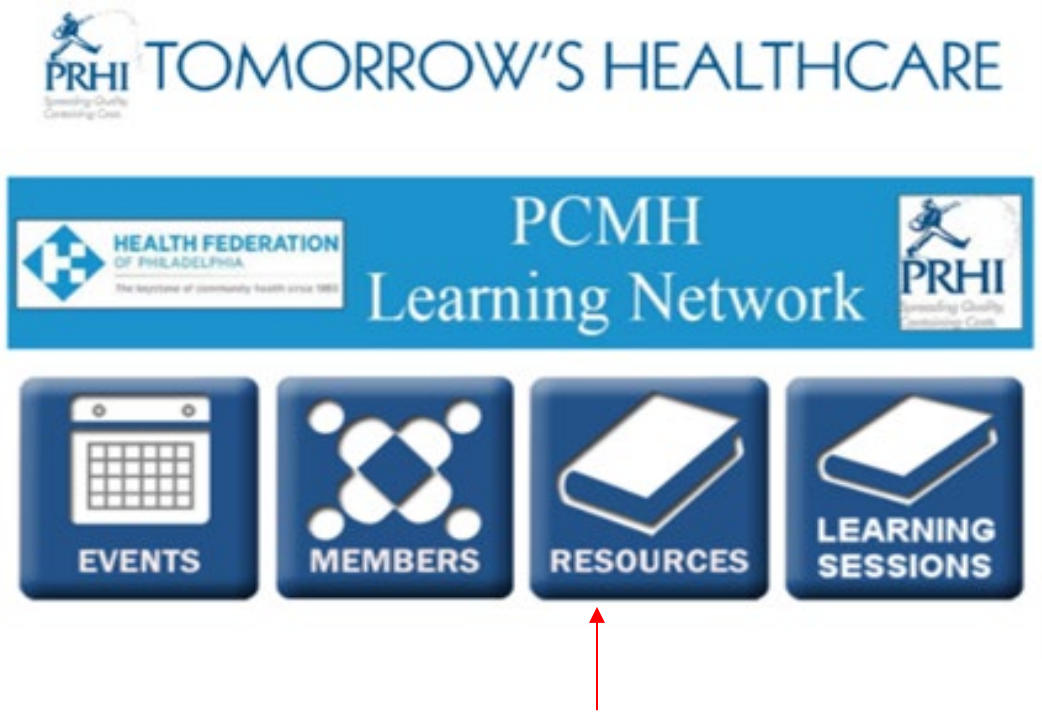
Access today's slides online

GO TO: www.tomorrowshealthcare.org

Your Login: The email address you RSVP'd with
Your Password: Welcome

To get assistance or access for your colleagues:
email Lisa at ***boyd@jhf.org***

PCMH Online Community



Keep track of upcoming sessions in "Events"

Access session materials in "Learning Sessions" Including slides and webinar recording

Look for guides and tools in "Resources"

Learning Objectives for Today

- Establish a shared understanding of the 2025 PCMH Sprint goals and framework for addressing post-hospital follow-up and readmission prevention
- Define the key intervention each PCMH is implementing and next steps for making progress.
- Identify the root cause(s) to address as part of each key intervention.
- Describe strategies for increasing the percent of patients seen within ten days of post-hospital follow-up.

Agenda

10:30-10:50 am	Welcome & Presentation of 2025 Sprint	Suzanne Cohen, Health Federation of Philadelphia
10:50-11:20am	Peer Panel on Key Interventions and Progress to Date	Nicole Hartung, Wayne Memorial Community Health Center Erin McFadden, The Wright Center Rachel Reis, Jefferson Health
11:20-11:40am	Breakouts	
2:20 – 2:30 p.m.	Sprint Timeline, Next Steps & Evaluation	Suzanne Cohen, Health Federation of Philadelphia

Sprint Structure

SUZANNE COHEN, SENIOR DIRECTOR OF POPULATION HEALTH, HEALTH FEDERATION OF PHILADELPHIA

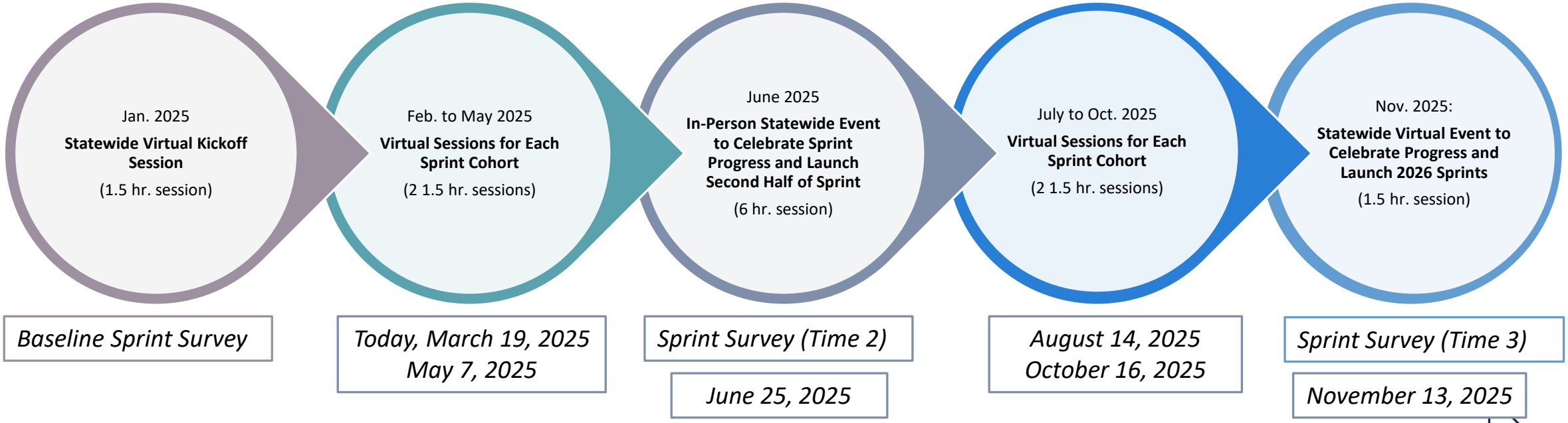
Post-Hospital Follow Up Sprint Participating Practices

- Allegheny Health Network (Physician Partners of Western PA LLC)
- East Liberty Family Health Care Center
- Geisinger 65 Forward
- Greater Philadelphia Health Action
- Jefferson Health
- Jefferson Health - Einstein
- Kid's Plus Pediatrics (PA Pediatric Health Network PPHN)
- Levyn
- Prospect Crozer Health
- River Valley Health and Dental
- Sadler Health Center Corporation
- Spectrum Health Services Inc
- Union Community Care
- UPMC Central PA
- UPMC Community Medicine Inc
- UPMC Susquehanna (multiple practices)
- Wayne Memorial
- WellSpan

Goals and Intent of 2025 PCMH LN Structure

- Promote further engagement from and learning across PCMHs
- Increase awareness and alignment around key PCMH focus areas and best practices (within and across organizations)
- Apply best practices and lessons learned from other statewide learning networks (e.g., PA PQC, etc.)
- Demonstrate measurable impact
- Create a learning structure around these goals with the same number of learning hours for PCMHs (recognizing healthcare workforce shortages)

2025 PCMH Learning Network



Measures: Post-Hospital Follow-up and All-Cause Readmissions

PCMH Program Measure / Requirement

"See at least 75% of patients within 10 days of discharge from inpatient care for an ambulatory sensitive condition"

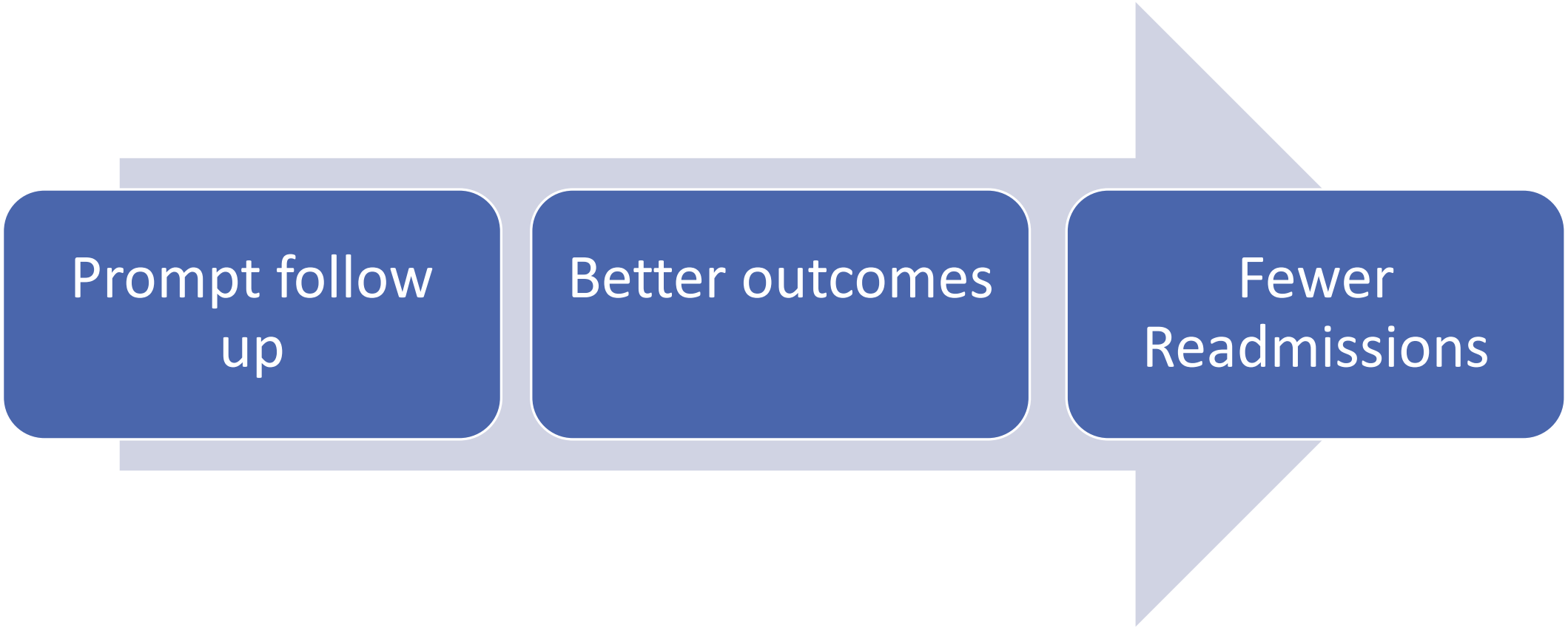
Ambulatory Sensitive Condition List

APR-DRG	Condition
0053	Seizure
0054	Migraine & Other Headaches
0113	Infections Of Upper Respiratory Tract
0137	Major Respiratory Infections & Inflammations
0139	Other Pneumonia
0140	Chronic Obstructive Pulmonary Disease
0141	Asthma
0191	Cardiac Catheterization W Circ Disord Exc Ischemic Heart Disease
0192	Cardiac Catheterization For Ischemic Heart Disease
0194	Heart Failure
0198	Angina Pectoris & Coronary Atherosclerosis
0199	Hypertension
0203	Chest Pain
0245	Inflammatory Bowel Disease
0249	Non-Bacterial Gastroenteritis, Nausea & Vomiting
0251	Abdominal Pain
0304	Dorsal & Lumbar Fusion Proc Except For Curvature Of Back
0310	Intervertebral Disc Excision & Decompression
0383	Cellulitis & Other Bacterial Skin Infections
0420	Diabetes
0422	Hypovolemia & Related Electrolyte Disorders
0463	Kidney & Urinary Tract Infections
0465	Urinary Stones & Acquired Upper Urinary Tract Obstruction
0662	Sickle Cell Anemia Crisis
0722	Fever

Medicare Transitional Care Management (TCM) Requirements

1. Phone call within 2 days of discharge (nurse)
2. Provider visit within 7 or 14 days based on Risk
3. Ongoing Care Coordination
4. Specific coding requirements

The Theory:



HEDIS Measure: Plan All-Cause Readmissions

"For members 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission."

2023 HealthChoices Ratio = 1.01%

Key Interventions and PCMH Survey Responses

Key Interventions

Coordinate with inpatient discharge planners and care teams for follow-up scheduling and shared plan of care (including referrals for other needs, such as behavioral health, occupational therapy, and other specialties)

Develop **a multi-disciplinary team** with roles, such as care coordinators, pharmacists, nurses, social workers, and community health workers (CHWs)

Implement **telehealth programs for follow-ups**, including team members going out to the home to "room" the patient for the provider

Stratify the needs of the patient population, including SDOH and comorbidities to prioritize follow-up and outreach

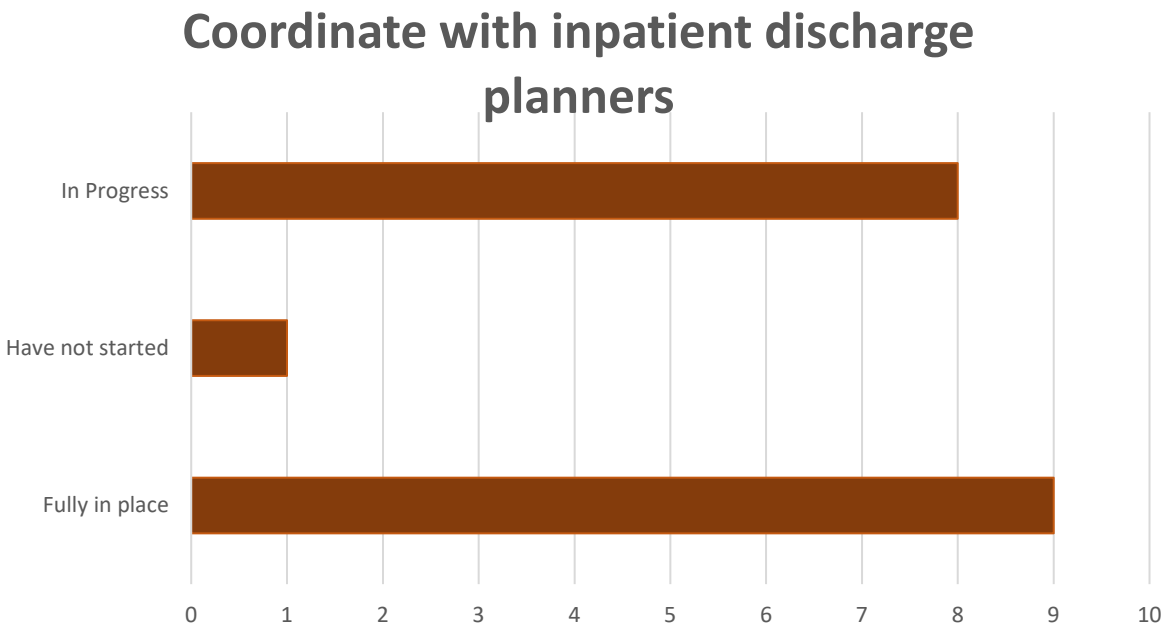
Educate patients and families about the importance of post-discharge follow-up

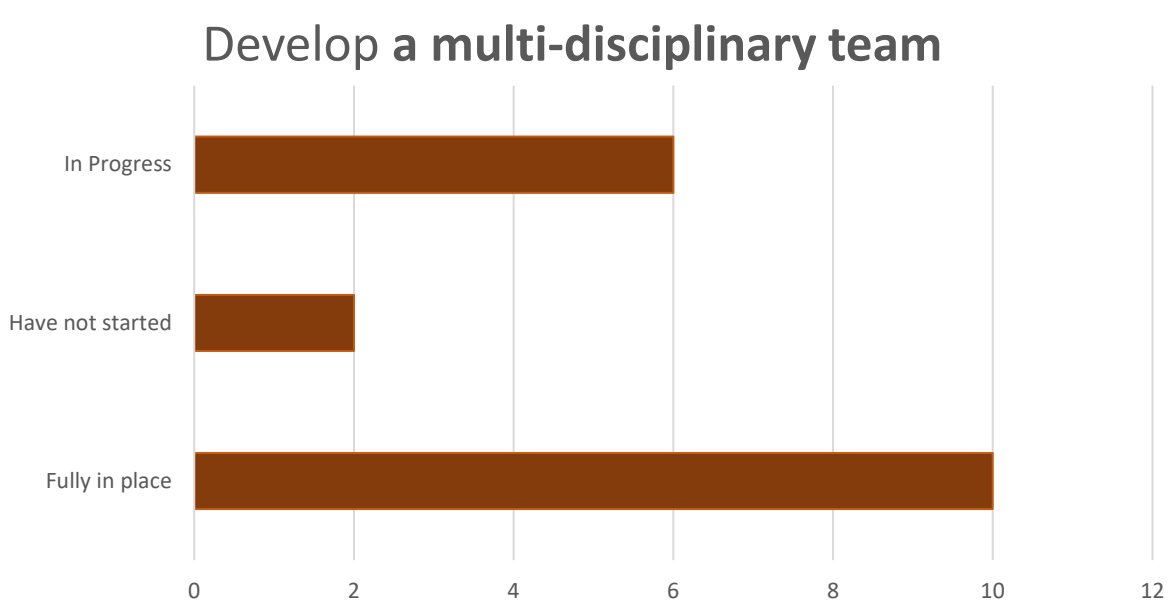
Use systems for **appointment completion reminders** and follow-up

Allow **flexibility** on which team member/provider performs the **post-hospital follow-up visit** (e.g. not requiring that the patient see their own PCP if that provider is already booked)

Implement team roles and workflows for making **follow-up phone calls within 24-72 hours** post-discharge to review and **reconcile medications**, review instructions, and set up follow-up appointment

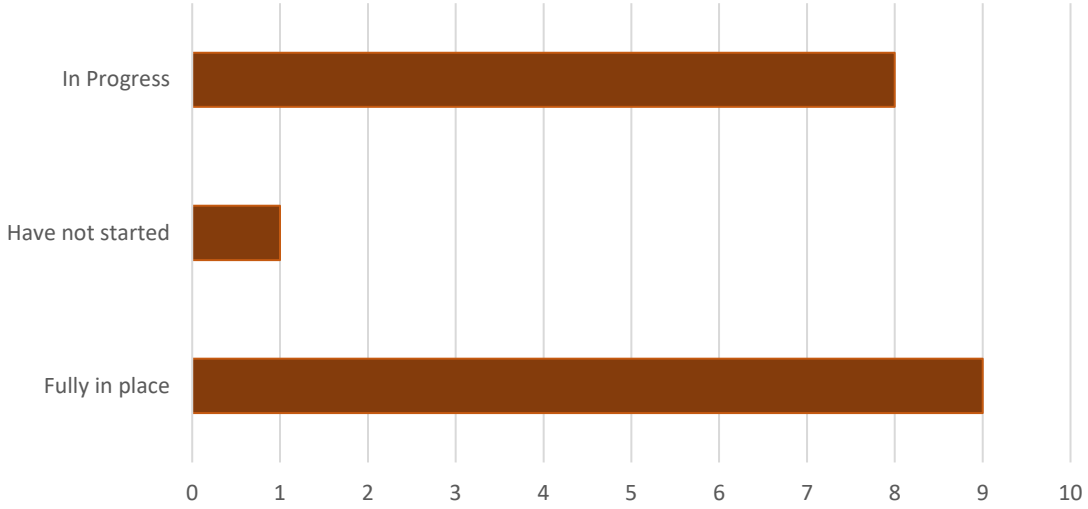
Key Interventions: Practice Responses



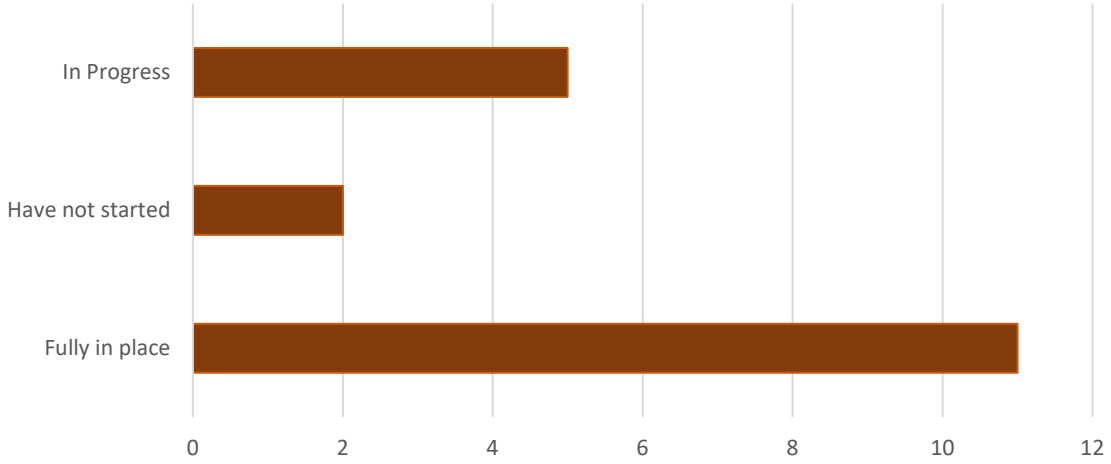


Key Interventions: Practice Responses

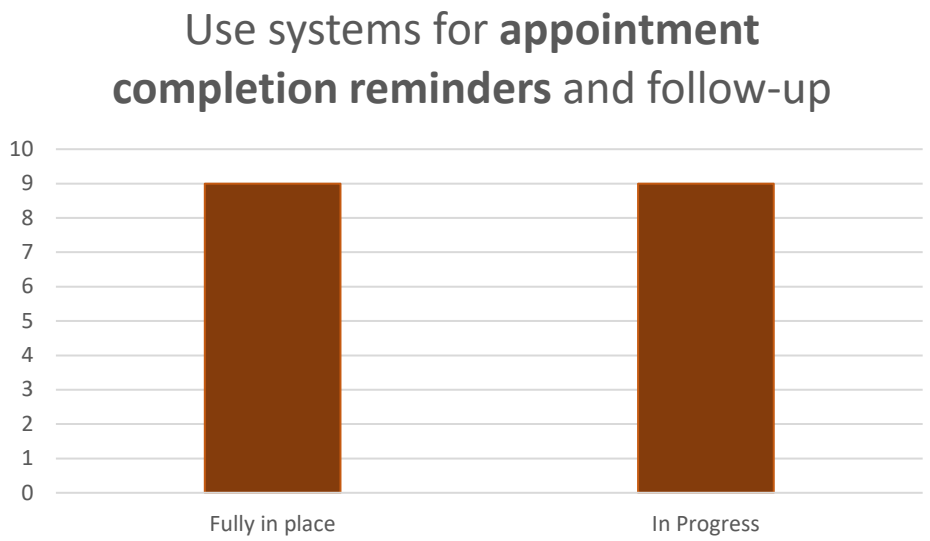
Implement **telehealth programs for follow-ups**

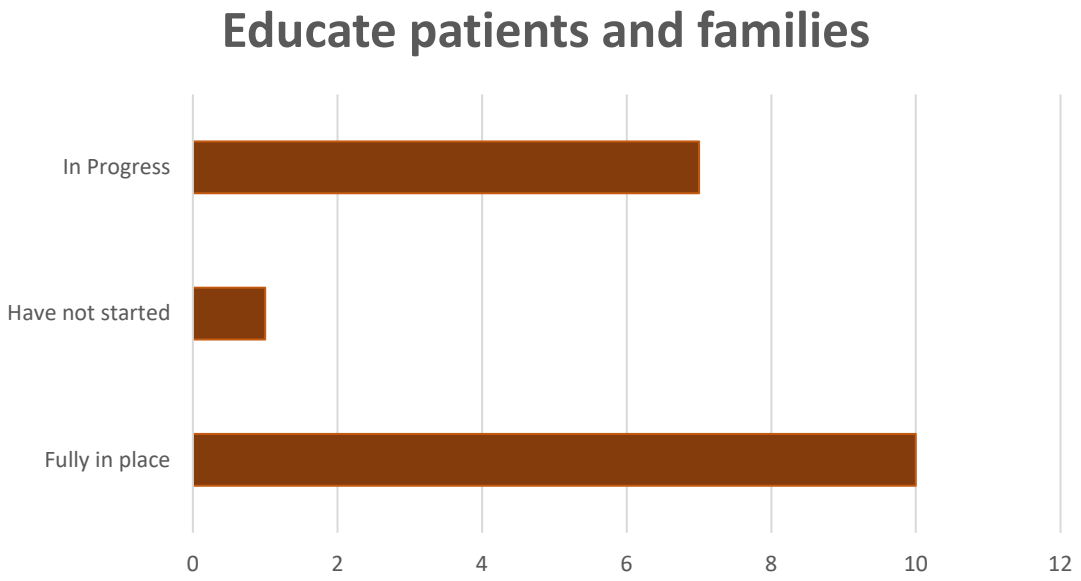


Stratify the needs of the patient population

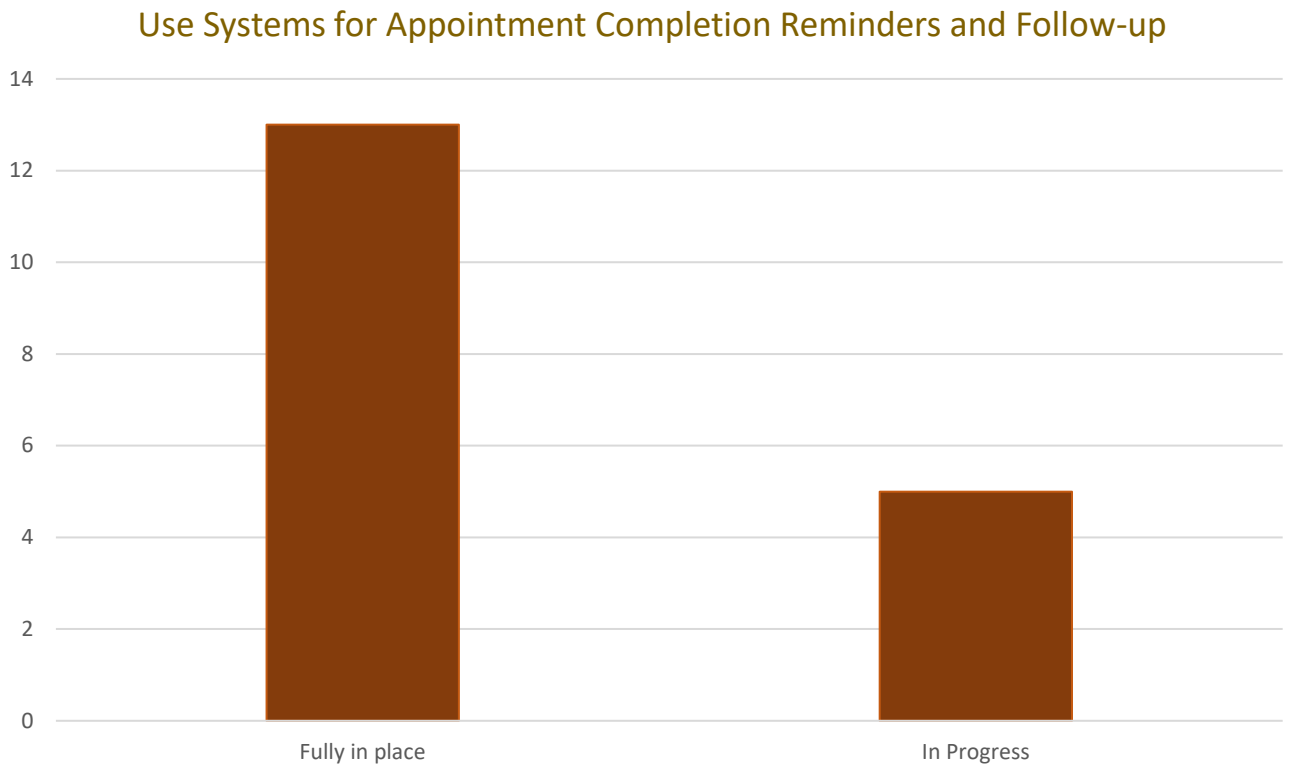


Key Interventions: Practice Responses



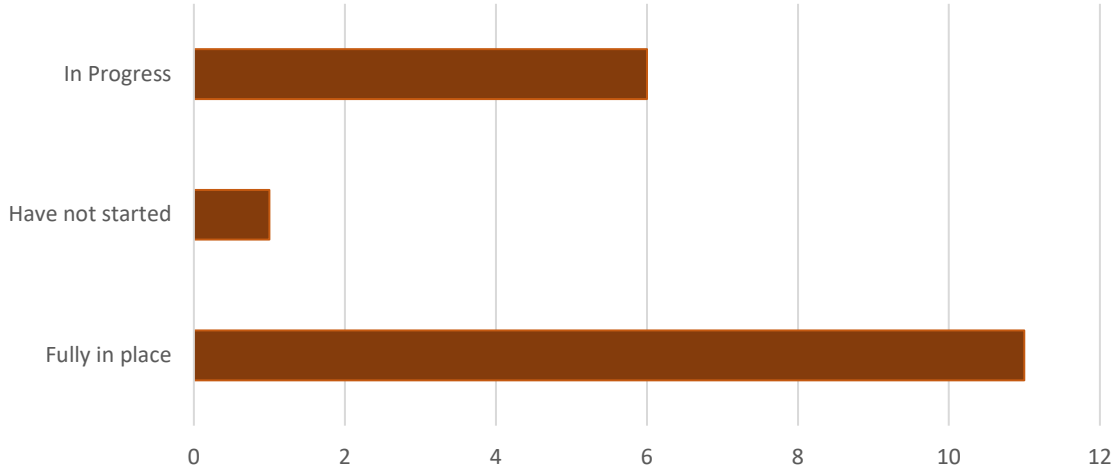


Key Interventions: Practice Responses

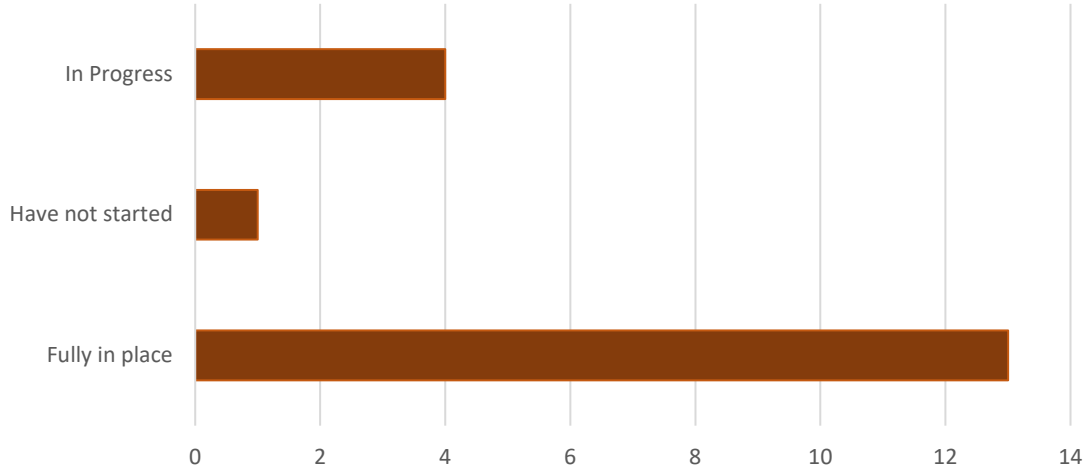


Key Interventions: Practice Responses

Allow **flexibility** on which team member/provider performs the **post-hospital follow-up visit**



Implement team roles and workflows for making **follow-up phone calls within 24-72 hours**



Panel on Key Intervention Progress to Date and Discussion

Nicole Hartung, LSW, Value-based Care Manager, Wayne Memorial Community Health Center

Erin McFadden, MD, Deputy Chief Medical Officer and Medical Director, The Wright Center

Rachel Reis, BSN, RN-CCM, Director Care Coordination, Jefferson Health

Panel on Key Interventions

TOPICS + PANELISTS

Implement telehealth calls for follow-up

Nicole Hartung, LSW, Value-based Care Manager, Wayne Memorial Community Health Center

Coordinate with inpatient discharge planners and care teams for follow-up scheduling and shared plan of care

Erin McFadden, MD, Deputy Chief Medical Officer and Medical Director, The Wright Center

Use systems for appointment completion reminders and follow-ups

Rachel Reis, BSN, RN-CCM, Director Care Coordination, Jefferson Health

QUESTIONS

What is your current approach?

Who is on the team that implements this approach and what are their roles?

What have been the biggest hurdles to overcome to complete the key intervention well?

What did you find helped to get this key intervention fully in place?

Peer to Peer Sharing

Breakout Rooms

Break Out Room Topics

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Takeaways from Breakout Sessions

Homework!

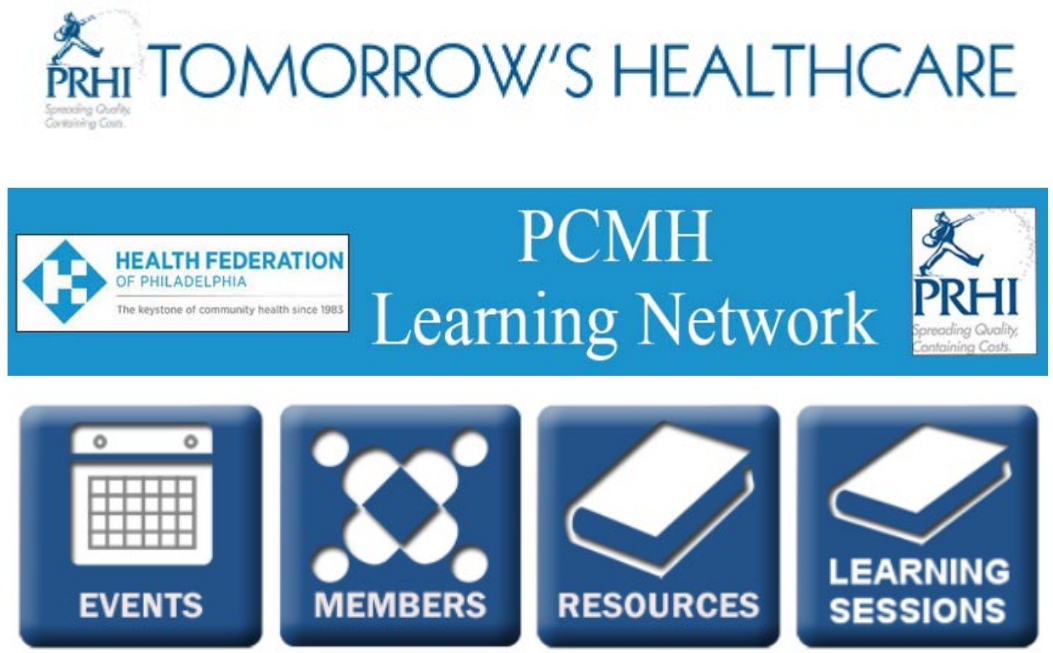
- **What approaches or ideas from today's call can be incorporated into your processes?**
- Action: Select one idea from today and make a commitment to apply it in your work.
- We want to hear about your progress and challenges at the next sprint

Wrap Up & Session Evaluation

PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/VFQ6SQX by**3/26/2025**

1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, please be sure the email you enter on the survey matches the UPMC CCE account email that you create.

2. The UPMC Center for Continuing Education will follow up with you via email after **3/26/2025** with instructions on how to claim your credits.
   - ❑ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

Upcoming Sessions

Next Sprint Virtual Session:
May 7, 2025
10:30 am – 12:00pm
Register here!

In-person Statewide Session:
June 25, 2025
Location: Hilton Harrisburg
1 N. Second St., Harrisburg, PA 17101
Register here!

Thank You!