HealthChoices PCMH Learning Network
Post-Hospital Follow-up and Readmission Prevention Sprint
Wednesday, March 19 at 10:30 a.m. – 12:00 p.m. via Zoom

Register: Wednesday, March 19th at 10:30 a.m.-12 p.m. via Zoom

Learning Objectives:

- 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 respective key intervention.
- Describe strategies for implementing key interventions for increasing the percent of patients seen within ten days of post-hospital follow-up.

Agenda:

10:30 a.m. to 10:50 a.m. – **Welcome** & **Presentation of the overall plan for the 2025 sprint, including goals, the description of the measure, and the quality improvement framework**

- Share context for the measure
- Describe HEDIS measures and HealthChoices PCMH Program requirements around Post-Hospital Follow-up and Readmission
    - **Post-hospital follow-up** in the HealthChoices PCMH Program requires a provider to see 75% of patients within ten days of discharge from the hospital with an ambulatory sensitive condition. This includes a follow-up visit with a specialist provider.
    - **Plan All Cause Readmissions - Count of Expected/Observed Ratio** assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicare (18 and older) health plan members.
- **Q&A**

10:50 a.m. to 11:20 a.m. – **Panel on key intervention progress to date and discussion**

- Nicole Hartung, LSW, Value-based Care Manager, Wayne Memorial Community Health Center
    - *Implement telehealth calls for follow-up*
- Erin McFadden, MD, Deputy Chief Medical Officer and Medical Director, The Wright Center
    - *Coordinate with inpatient discharge planners and care teams for follow-up scheduling and shared plan of care*
- Rachel Reis, BSN, RN-CCM, Director Care Coordination, Jefferson Health
    - *Use systems for appointment completion reminders and follow-ups*

11:20 a.m. to 11:40 a.m. **Breakouts**

- Identifying and prioritizing patients for post-discharge follow-up
- Getting people to complete follow-up appointments

11:40 a.m. to 11:50 a.m. – **Takeaways**

11:50 a.m. to 12:00 p.m. – **Sprint Timeline, Next Steps & Evaluation**