The Hospital + Healthsystem Association of Pennsylvania

HAP Achievement Awards
Delivering a Healthy Pennsylvania

2023 HAP Achievement Award
Excellence in Care - Medium Division

Penn Highlands Mon Valley

Community Care Network Transitions of Care

The Goal

To improve the care of patients transitioning into the community in a no discharge process that addressed care gaps and social determinants of health (SDOH).

Intervention

The Community Care Network (CCN) started during 2017 with an interdisciplinary team, consisting of nurses, behaviorists, and navigators, uses an assessment on patients admitted to the hospital to identify SDOHs and patients at high risk for readmission. The interdisciplinary team then completes home visits and virtual follow up as needed following care protocols on high-risk patients. The team has a complex care committee that meets each week with the inpatient social services, care management, the CCN medical director and the inpatient behavioral unit to develop solutions and supports for the social determinants of health, prevent errors and remove barriers that's can improved health and reduce preventable readmissions.

Results

Baseline and Outcome measures were evaluated using organizational data.

- Addressing care gaps for patients admitted with post-acute follow up, improving overall health : A1Cs, microalbumin, mammograms and colonoscopies at 43.7% and physician follow up appointments at 78.6% in 2022

- Number of preventable interventions in the community by the CCN (Clinical exacerbation intervened w/physician input, Clinical interventions, Intervention at a facility, Medication discrepancies identified and corrected w/physician input) Result –2017- (198) to 2021 – (318)
- CCN Quality Survey 0-5 scale how satisfied with your CCN Services -Average score of 4.93