**A logo for a lighthouse award

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**GRANT APPLICATION**

**DEFINITION:**

The Lighthouse Grant category focuses on quality and patient safety risk mitigation activities a member organization would like to complete within the next eighteen months.

**ELIGIBILITY:**

Members of AEIX. “Member” includes any organization (hospital, clinic, long term care, urgent care, behavioral health, outpatient services, etc.) and department (Risk Management, Patient Safety, Quality, High Reliability Team, or an individual unit (for example an ICU, Med-Surg, Peri-natal, Environmental Services, Human Resources/Talent, Education department, etc.) within the member system.

**Please share this application with all clinical and operational departments within your organization** that may be interested in completing a new risk reduction project and who may be interested in applying for an AEIX Risk Management Grant.

* Grants are limited to projects that are forecasted to be completed within the next eighteen (18) months.
* Grants are typically awarded for amounts of $12,000 or less.
  + However, the committee has some limited flexibility in determining the amount of the grant that is awarded.
* Grants must have accompanying information that supports the project’s goals in demonstrating improved patient safety (risk reduction).

**INSTRUCTIONS:**

1. Complete the application in its entirety.

* In the event of missing or incomplete information, *if* the timeline allows, AEIX will send applications back to the member and request completion and/or clarification of the application.
* Blanks and/or incomplete information may result in disqualification if the deadline for application submission has passed.

1. Applications must be submitted to AEIX in **WORD** format.

* Applications must be completed electronically (typed) and be sent in an editable format (do not scan and send the document or send in a non-editable format).

1. Completed applications should be sent via email, as a WORD document attachment,  with a copy to the organization’s risk management leader, to the following email: [aeixawards@premierinc.com](mailto:aeixawards@premierinc.com).
2. Please note, grant monies are not intended to be used for reimbursing hospital staff or the project participants to compensate them financially for their efforts.

**DEADLINE FOR AWARD APPLICATIONS IS FRIDAY JULY 18th, 2025**

**If selected for a GRANT award - GRANT Funds become available January 1, 2026.**

**Lighthouse Award GRANT Application**

***ALL fields/questions within the application must be completed prior to the submission.***

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| **1** | **\*Applicant Name(s):** | Heidi Porter |
| **2** | **\*Title/role:** | Vice President of Quality and Regulatory Affairs |
| **3** | **\*Hospital or Entity Name:** | WVU Medicine Wheeling Hospital |
| **4** | **\*Healthcare System:** | WVU Medicine |
| **5** | **\*Clinical or Operational Area:** | Quality, Patient Safety, Risk and Population Health |
| **6** | **\*Project/GRANT Title:** | Conncted Care: Front Door Initiative |
| **7** | **\*Mailing Address:** | 1Medical Park Wheeling, WV 26003 |
| **8** | **\*Telephone:** | 304-243-8377 |
| **9** | **\*E-mail Address:** | Heidi.porter@wvumedicine.org |

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| --- | --- | --- |
| **10** | **\*Name and address of**  **Hospital/Entity (local) Risk Manager:** | Heidi Porter  1 Medical Park  Wheeling, WV 26003 |
| **11** | **\*Name of and address of SYSTEM Risk Manager if different from above:** | Jerri Kirkland  WVU  Morgantown, WV |
| **12** | **\*Name and address of Hospital/Entity/System CEO** | Douglass Harrison  1 Medical Park  Wheeling, WV 26003 |
| **13** | **\*Name and address of Hospital/Entity/System CFO** | Albert Wright  WVU  Morgantown, WV |

1. **The project being proposed involves the following clinical areas** *(Check all that apply)***:**

Ambulatory Care

Emergency Services

Hospital/System-wide Focus

Obstetrics/Perinatal

Radiology/Imaging Services

Surgical/Peri-Operative

Other *(Please specify)*Click or tap here to enter text.

1. **Briefly describe the project and its importance to the organization:** *(one paragraph maximum)*

*In today’s complex healthcare landscape, ensuring that patients receive safe, seamless, and supported care doesn’t begin at hospital admission or end at discharge—it requires a connected care model that follows patients across the continuum. The Connected Care Center serves as the hospital’s anchor for population health, care coordination, and transitional support. It proactively identifies patients at risk for poor outcomes and surrounds them with services tailored to their medical, social, and emotional needs. By centralizing navigation, follow-up, and care planning, the center:*

* *Reduces avoidable readmissions*
* *Improves chronic disease management*
* *Supports social determinants of health (SDOH) interventions*
* *Ensures continuity across settings – from inpatient to outpatient to home. The Front Door Initiative enhances the patient journey by ensuring that every admission is met with coordinated, compassionate, and comprehensive support. From the moment a patient is identified for potential admission, the initiative:*
* *Engages Connected Care Navigators to plan for safe discharge before hospitalization begins*
* *Uses True North Navigators to round during inpatient stays, identifying gaps and barriers early*
* *Deploys 48-hour post-discharge calls to verify medication access, follow-up compliance, and symptom management*
* *Keeps patients and caregivers connected through the 24/7 Connected Care Line*

*Connected Care:*

* *Closes critical care gaps that often lead to readmissions, ED use, and patient frustration*
* *Personalizes the care experience, fostering trust and satisfaction*
* *Improves patient safety by ensuring understanding of medications, instructions, and follow-up*
* *Supports value-based care goals by improving outcomes and reducing unnecessary utilization*
* *Empowers staff to proactively address needs before they escalate*

1. **Explain how the proposed project described in Question #15 will improve patient safety or reduce the** *potential for liability: (one paragraph maximum)*

*The Connected Care Center and Front Door Initiative meaningfully improves patient safety and reduces organizational liability by proactively addressing the root causes of adverse events, readmissions, and communication breakdowns—especially during high-risk transitions.* ***How This Project Improves Patient Safety: Proactive Risk Identification*** *Patients at high risk for readmission, poor outcomes, or harm are identified early through predictive analytics and screening. Preventive interventions (e.g., care planning, medication review, social support) are initiated before a safety issue arises. Improved Handoff Communication: The initiative bridges gaps between inpatient teams, outpatient providers, and home-based care through coordinated touchpoints. Reduces the risk of communication errors, which are a leading cause of sentinel events. Medication Safety: Prior to discharge, Connected Care Navigators ensure patients understand their medications, resolve any access barriers, and verify there are no duplications, interactions, or omissions. Reduces risk of adverse drug events (ADEs) post-discharge. Safe Discharge Planning: Patients leave the hospital with follow-up appointments, home care support, and contact with the Connected Care Line for emerging concerns. Prevents unsafe discharges, unnecessary ED revisits, and complications due to lack of follow-through. Post-Discharge Surveillance: The 48-hour Connected Care call acts as a safety net, catching warning signs of deterioration or confusion before they result in harm. The Connected Care Center Proactively addresess gaps in care by screening for SDOH and missing preventative screening. How It Reduces Organizational Liability: Documented Due Diligence: The Connected Care workflow establishes clear, traceable steps showing the hospital took action to ensure continuity of care. Helps defend against allegations of negligence or abandonment in discharge or follow-up care. Reduced Readmissions and ED Revisits: Preventing avoidable readmissions not only improves performance metrics—it demonstrates responsible, coordinated care and protects against regulatory penalties and payer disputes. Improved Patient Comprehension: Education and navigation reduce risk of lawsuits related to misunderstood instructions, medication mix-ups, or lack of informed consent. Enhanced Documentation & Compliance: The care coordination process supports compliance with CMS Conditions of Participation, Joint Commission standards, and value-based care documentation—lowering risk of accreditation findings or financial penalties. Decreased Risk of Missed Diagnoses or Follow-Up: The initiative ensures patients don’t “fall through the cracks” when moving between care settings, reducing diagnostic and continuity-related liability.*

1. **List the metric(s) that will be used to measure and to sustain success?** *(one paragraph maximum)*

*Here are key metrics that can be used to measure the success of the Connected Care Center and Front Door Initiative, organized by clinical outcomes, patient safety, operational performance, and patient experience. These align with value-based care, CMS measures, Joint Commission standards, and risk reduction goals.*

***Clinical Outcomes***

1. *30-Day All-Cause Readmission Rate  
   Primary outcome to measure effectiveness of care transitions and discharge support.*
2. *Emergency Department Revisits within 7 and 30 Days  
   Tracks preventable acute care utilization after discharge.*
3. *Medication Reconciliation Completion Rate at Discharge  
   Measures adherence to safe medication transition practices.*
4. *Primary Care or Specialist Follow-Up Rate within 7–14 Days  
   Assesses effectiveness of coordination between inpatient and outpatient care.*

***Patient Safety Metrics***

1. *Adverse Drug Events (ADEs) Post-Discharge  
   Identifies harm due to medication errors or miscommunication.*
2. *Handoff Communication Failures or Safety Events Related to Transition  
   Can be tracked through internal safety reporting (e.g., patient safety event reports).*
3. *Post-Discharge Fall or Infection Rates  
   Evaluates impact of discharge planning on home safety and patient condition.*

***Operational Performance***

1. *48-Hour Post-Discharge Call Completion Rate  
   Measures execution of key safety follow-up workflow.*
2. *Number of High-Risk Patients Navigated Pre-Admission or During Stay  
   Shows reach and scalability of the initiative.*
3. *Utilization of the Connected Care Line (Call Volume & Resolution Rate)  
   Demonstrates patient engagement and early issue identification.*

***Patient Experience and Engagement***

1. *Patient Satisfaction with Discharge Process  
   (Often captured via HCAHPS: “Communication about discharge,” “Care transition composite”)*
2. *Patient-Reported Understanding of Medications and Care Plan  
   (Collected during follow-up calls or post-discharge surveys.)*
3. *Care Navigator Effectiveness Score (if surveyed)  
   Measures perception of support and trust in Connected Care staff.*

***Dashboard Categories:***

* *Outcome Metrics → Readmissions, ED visits*
* *Process Metrics → Navigator touchpoints, post-discharge call rates*
* *Safety Metrics → ADEs, event reports*
* *Experience Metrics → Survey scores, patient feedback*
* *Population Health: Ambulatory Quality*
* *SDOH: Screening and + screening assistance*

1. **Please describe the anticipated tangible results of the proposed project that can be quantified and shared *as Best Practices* with other members of AEIX:** *(one paragraph maximum)*

*Anticipated Tangible Results of the Connected Care Center & Front Door Initiative*

*The Connected Care Center and Front Door Initiative is designed to proactively support patients through high-risk transitions of care. Its goal is to reduce preventable harm, improve outcomes, and optimize the patient experience. The following are the anticipated quantifiable results, which will be measured, monitored, and shared as best practices:*

*Reduction in 30-Day Readmission Rate*

* *Target: ≥20% reduction in all-cause 30-day readmissions among enrolled patients*
* *Why It Matters: Readmission is a key indicator of quality and continuity of care. Avoiding preventable readmissions reduces patient risk and financial penalties from CMS and payers.*

*Reduction in Emergency Department Revisits within 30 Days*

* *Target: ≥15% decrease in ED revisits after discharge*
* *Why It Matters: ED utilization is often a sign of unmet needs. Reducing ED revisits demonstrates improved discharge planning, symptom control, and access to follow-up care.*

*Improvement in 48-Hour Post-Discharge Call Completion Rate and billed TCM visit*

* *Target: ≥90% of eligible patients receive a documented follow-up call within 48 hours*
* *75% Billed TCM visit*
* *Why It Matters: Timely follow-up is critical for detecting early signs of deterioration, resolving medication issues, and reinforcing discharge instructions.*

*Reduction in Post-Discharge Medication Errors or Adverse Drug Events (ADEs)*

* *Target: ≥25% reduction in documented medication-related safety events in Connected Care patients*
* *Why It Matters: Medication issues are a top contributor to readmissions and post-discharge harm. This initiative emphasizes reconciliation and patient understanding.*

*Improvement in Follow-Up Appointment Compliance*

* *Target: ≥85% of high-risk patients have a follow-up appointment scheduled and completed within 7–14 days of discharge*
* *Why It Matters: Timely follow-up is associated with improved chronic disease management, lower readmission rates, and enhanced coordination of care.*

*Increased Navigator Touchpoints*

* *Target: ≥2 proactive patient touchpoints (pre-admission and pre-discharge) for ≥80% of patients in the program*
* *Why It Matters: Early and repeated engagement builds trust, ensures patient understanding, and reduces care fragmentation.*

*Improvement in Patient Satisfaction with Transitions of Care*

* *Target: ≥10-point increase in HCAHPS “Care Transitions” composite score*
* *Why It Matters: Improved patient experience reflects communication, confidence, and trust in the care process.*

*These tangible results will be shared through:*

* *Internal dashboards and scorecards*
* *Annual quality and community benefit reports*
* *Submissions to Vizient, Joint Commission, and state hospital association award programs*
* *Presentations at quality, safety, and population health conferences*
* *Development of a replicable toolkit for other health systems*

1. **Provide the amount you are requesting from AEIX for your GRANT:**

**$12,000**

AEIX grants may not exceed $12,000.

1. **Is this practice an original concept created by the project team, or is it based on successful practices that have been evaluated from literature or other healthcare providers which are being implemented for the first time?**

*The Connected Care Center and Front Door Initiative is grounded in several nationally recognized best practices that focus on safe transitions of care, population health, and patient-centered coordination. It synthesizes proven frameworks from leading healthcare organizations, quality bodies, and evidence-based literature.*

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1. **How does the grant align with AEIX’s mission of “To partner with forward-thinking healthcare leaders to safeguard assets, enhance patient safety, and inspire innovation” and vision of “***Through our collective experience and unique expertise, we will provide the leading pathway for managing risk and improving safety in healthcare***.”?**

*The Connected Care Center and Front Door Initiative is directly aligned with the mission of AEIX, which is to provide members with superior professional liability protection while advancing patient safety, reducing claims, and improving overall risk performance in healthcare delivery.*

*How This Initiative Supports the AEIX Mission:*

*Reduces Risk of Professional Liability Through Safer Transitions*

* *Transitions of care are known high-risk periods for adverse events, miscommunication, and missed follow-up — all of which can lead to claims.*
* *This initiative proactively mitigates liability by:*
  + *Ensuring thorough discharge planning*
  + *Performing medication reconciliation*
  + *Providing timely follow-up through the Connected Care Line*
  + *Documenting all patient communications and care coordination activities*
* *Result: Fewer preventable adverse events → Lower malpractice exposure*

*Improves Early Detection and Response to Safety Risks*

* *The 48-hour post-discharge calls and Navigator rounding help identify early signs of:*
  + *Worsening conditions*
  + *Non-compliance*
  + *Medication issues*

*This prevents escalation and supports timely intervention, avoiding adverse outcomes that might otherwise result in litigation. Example: Catching a medication error before harm occurs = mitigation of potential claim*

*Reduces Frequency and Severity of Claims*

* *AEIX emphasizes reducing claim frequency and severity.*
* *By reducing readmissions, medication-related errors, and communication breakdowns, this initiative helps lower both the number of incidents and their impact, aligning with AEIX’s loss control objectives.*

*Supports a Culture of Safety and High Reliability*

* *AEIX advocates for proactive risk management and system-level safety improvements.*
* *The Connected Care model embeds HRO principles:*
  + *Preoccupation with failure*
  + *Reluctance to simplify discharge risks*
  + *Commitment to resilience in transition planning*

*System-level safeguards = reduced human error and defensible practices*

*Generates Shareable Data to Inform Risk Strategies*

* *Tangible, trackable outcomes from this initiative (e.g., ADE rates, post-discharge event capture, navigator interventions) contribute to:*
  + *Claims prevention strategies*
  + *AEIX educational programming*
  + *Member benchmarking and risk assessment reports*

*Supports AEIX’s mission to provide data-driven risk education and resources.*

1. **Additional information to support the quality of your grant proposal:**

Click or tap here to enter text.

***You may attach any supporting documentation such as graphs, tables, posters, PowerPoint to the application.***

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**Indicate the “Primary Clinical Sponsor”** *(Responsible for monitoring the progress of the initiative which is the basis of the grant, and for submitting receipts and other documentation supporting the use of grant funds, including a one to two-page summary of the grant’s outcome.)*

**Name:**Heidi Porter

**Title:Director Vice President of Quality and Regulatory Affairs**

**Contact Email:heidi.porter@wvumedicine.org**

**Contact Phone Number:304-243-8377**

**Indicate an “Alternate Clinical Sponsor**” *(Responsible for supporting the responsibilities of the Primary Clinical Sponsor, and assuming those responsibilities if the Primary Clinical Sponsor is unable to fulfill the requirements of the project.)*

**Name:**Tami Magruder

**Title:Director of Quality**

**Contact Email:tami.magruder@wvumedicine.org**

**Contact Phone Number:304-243-5342**

Grant monies are not to be used for compensating (paying salaries, overtime, or time spent conducting the grant work) the organization’s staff for their efforts related to the grant.

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**The following questions (I. A through D, and II) must be completed by the applicant and submitted with grant application.**

1. **Using the following criteria, in your opinion, how would you evaluate your application on a scale of 1-3, with three being the highest:**
   1. **Potential to improve safety and reduce liability:**

Practice appears to have had *little* effect on improving safety and reducing liability. (1)

Practice appears to have had *some* effect on improving safety and reduced liability, but metrics are

not distinctly defined and/or it is unclear that measurable effect can be sustained. (2)

Practice appears to have had a *strong* effect on improving safety and reducing liability with clear

defined metrics and sustainability. (3)

* 1. **Potential to share best practice among AEIX members:**

*Little* potential for sharing with or translation of best practices to other organizations (e.g.,

implementation requires major budgetary commitment; the topic is highly specialized and/or metrics are not clearly defined). (1)

*Some* potential for sharing or translation of best practices to other organizations; however, the

implementation process may pose challenges *due to f*actors such as significant budgetary

commitments or the specialized nature of the topic.

* While certain practice settings, such as behavioral health, may find the application relevant, the overall applicability may be limited. Additionally, the metrics for evaluation are not clearly defined.

*Strong* potential for sharing with and translation of best practices to other member organizations. (3)

* 1. **Potential to impact severity of risk exposure:**

Appears to have potential for addressing an issue which may be important from other perspectives,

such as patient satisfaction or reporting of data, but it is *unlikely to impact severity of risk in the clinical*

*or safety area*. (1)

Appears to have potential for addressing an issue which may not result in catastrophic loss, but which

is nevertheless significant regarding patient safety or clinical outcomes (e.g., preventing burns from

hot liquids on dietary trays). (2)

Appears to have potential for addressing an issue which clearly affects severe malpractice exposure

caused by significant risk events (e.g., birth injury). (3)

* 1. **Innovation level of the Project:**

Project/practice is new to this organization but is based primarily on best practices firmly established

in the industry. (1)

Project/practice was developed primarily by applicants with some assistance from outside entities,

and/or it contains well-established best practices but includes additional innovative features which

may benefit other organizations. (2)

Project/practice was created primarily (or solely) by applicants and could add to established literature

or industry best practices. (3)

**II. ATTESTATION:**

**Yes, I (the applicant), attest to the notification of my organization’s Risk Management Leadership of this application and its content.**

1. **Completed applications should be sent via email, as a WORD document attachment, with a copy to the organization’s risk management leader, to the following email:** [**aeixawards@premierinc.com**](mailto:aeixawards@premierinc.com)**.**

**DEADLINE FOR AWARD APPLICATIONS IS FRIDAY JULY 18th, 2025**

**TIMELINE**

* **5/12/2025** - Application period opens
* **7/18/2025** - Application period closes
* **8/19/2025** - Awards & Grants Subcommittee meeting (review applications and vote on winners)
* **9/16/2025** - Subcommittee recommendations to IAC the slate of winners for approval
* **11/11/2025 – SAC/Board Meeting – final approval of winners**

*Notification of winners/non-winners via U.S. Mail occurs following the SAC meeting.*

**If selected for a GRANT award - GRANT Funds become available January 1, 2026.**

*It is recommended that applications are submitted well in advance of the deadline as in the event of missing or incomplete information, if the timeline allows, AEIX will send applications back to the member and request completion and/or clarification of the application.*

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