Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

Community Health Improvement Collaborative (CHIC)
Session 5 – Step 6: Program Evaluation
Create a Sustainable Shared Learning Collaborative

Presented by: Lisa Gall, DNP, FNP-BC, LHIT-HP

Quality Improvement Advisor

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About Superior Health Quality Alliance (Superior Health)

- Superior Health is a regional Quality Innovation Network - Quality Improvement Organization (QIN-QIO) operating under the direction of the Centers for Medicare and Medicaid Services (CMS).
- Superior Health provides free support for health care organizations in Minnesota, Wisconsin and Michigan.

What is CHIC?

- Reducing avoidable emergency department (ED) and hospital readmissions.
  - Establish community networks among two or more organizations within a community to address health and social needs that impact patient outcomes which can lead to avoidable ED use and hospital readmissions.
- Who can join?
  - Any organization that can impact individual and community health through collaboration with another health care service provider or another provider or supplier to address health-related social needs (HRSN) and other factors that impact patients' health and well-being.

Benefits of Participating in CHIC

- Impact organizational quality measures.
- Establish local community networks to improve your patients' outcomes, safety and quality of care.
- Become part of a shared learning collaborative to develop sustainable collaborative solutions.
- Receive free 1:1 technical assistance from Superior Health quality improvement advisors.

Introductions

- Please let us know the following:
  - Name and title
  - Organization
  - State that you are located (Minnesota, Michigan or Wisconsin)
  - Name a personal or professional achievement in past year that you are proud of.

Today's Poll

- Have you started or are you planning to use any of the tools or processes in this series?
  - Analyzing your data, identifying target population.
  - Establishing community health teams (partnerships).
  - Compiling and mobilizing community resources.
  - Using a specific tool or toolkit.
  - Using more than one tool.

Program Overview: Steps 1 - 5

CHIC Step 1: Analyze Data, Identify Target Population

- Agency for Healthcare Research and Quality (AHRQ) Care Transition Tools (Tools 1, 2, 3)
  - Tools for tracking readmission rates, reasons by payer
  - Patient survey, hospital inventory

Designing and Delivering Whole-Person Transitional Care (AHRQ)

Session 1 Tools

CHIC Step 1: Analyze Data, Identify Target Population (Cont.)

- BOOST Implementation Guide & Appendix (Tools B,C,D, I; pgs. 11-38)
  - SMART goals, metrics
  - Organizational assessment and assembly
  - Root cause analysis and data collection
  - Understand the background context at your institution
  - Perform process mapping to understand current care transition
  - process
  - Select and tailor interventions to fix the root causes of any deficiencies
  - Identify community needs, gaps, resources and partners

BOOST Implementation Guide (Society of Hospital Medicine)

Session 1 Tools

CHIC Step 1: Analyze Data, Identify Target Population (Cont.)

- Superior Health Tools
  - Community Needs Assessment
  - Building Successful Coalitions

Superior Health

Session 1 Tools

Track Your Progress: Perform Root Cause Analysis

- Review of CHIC Step 1 (BOOST Section III, pgs. 27-38)
  - Understand the background context at your institution (pg. 27).
  - Understand how your current care transition process functions and where it fails (pg. 28 - 31).
    - Process mapping, details and adding data
  - Establish a quantitative data collection plan (p. 32) .
    - Collect baseline data Readmission Rates Data Tool (AHRQ, Tool 1).
    - Establish a prospective data collection and reporting plan (pg. 34).
  - Understand why there are deficiencies in your current process (pg. 36).

Session 1 Tools

Step 1 Review: Select and Tailor Interventions to Address Root Causes of Deficiencies

Root Cause	Potential Solutions
Patients do not see a doctor soon enough after discharge to identify and help prevent problems.	1. Arrange home health visit for high-risk patients. 2. Schedule doctor's appointment for patient prior to discharge and ensure the patient has transportation to it. 3. Arrange for a nurse or doctor to call the patient at home within 48 hours of discharge.
Patients do not understand the discharge instructions we provide them.	1. Use BOOST's Patient PASS (Patient Preparation to Address Situations Successfully) or DPET (Discharge Patient Education Tool). 2. Revise current EMR form to be more patient centered. 3. Give patient the JAMA or ACP Patient Education Page about their disease. 4. Engage the patient's family/caregiver as a supplemental or alternate target for education.

BOOST Implementation Guide (SHM): Section III
Getting to Work on Improving Transitions of Care., Step 5, pgs. 37- 41

Root Cause	Potential Solutions
Hospital does not assess patients for readmission risk factors.	Apply 8Ps.
Hospital does not assess patients for their preparedness for discharge.	Screen with General Assessment of Preparedness.
Hospital provides patients with discharge instructions that are hard to understand.	Patient PASS DPET
Hospital does not educate patients effectively about their illness, and how to care for themselves after discharge.	Use Teach Back technique with education. Ensure patient's family/caregiver are also involved in the education.
Hospital providers do not coordinate care.	Conduct interprofessional rounds.
Hospital has no mechanism to address patients' questions or concerns that arise after discharge.	Follow-up phone call to patient within 72 hours of discharge. Provide a phone number that patients can call after discharge to reach someone 24 hours/day.
Patients develop complications after discharge that may be preventable by a visit to a healthcare provider.	Schedule a follow-up appointment with patient's primary care provider so that the patient is seen shortly after discharge.
Post-acute care provider does not understand the patient's care plan after hospitalization.	Ensure discharge summary sent to post-acute care provider within at least three days of discharge.

Using an Effort-Impact Matrix

		Effort	
		High	**Low**
Impact	**High**	New Electronic Medical Record form	Use Patient-Centered Instructions (e.g., BOOST's PASS or DPET form) delivered via Teach Back
	Low	Purchase education materials to give to patients	Give patients freely available patient education material (e.g., JAMA Patient Page, ACP Patient Education handouts)

BOOST Implementation Guide (SHM): Section III
Getting to Work on Improving Transitions of Care, pg.. 41

CHIC Step 2: Establish Community Health Team

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- AHRQ Care Transition Tools (Tools 5, 6, 7)
  - Co-design and collaborate
  - Strategic planning
  - Presentations and visual tools for leaders, funders
  - Establish structure
  - Track discharge volume, intervention and outcome data
- BOOST Tools: (Tools F, G, H, J)
  - Establish structure and aims, meetings

BOOST Implementation Guide (SHM)

CHIC Step 3: Mobilize Community Resources

- Co-create a community resource list.
  - AHRQ Care Transition Tools (Tools 4, 5, 6, 7, 11, 12)
    - Community resource templates and guides
    - Strategic planning templates, presentations, data tracking tools
  - BOOST Tools: (Tools F, G, H, J)
    - General aims, community partners and meetings
  - Online resources:
    - 211.org
    - Findhelp.org

Designing and Delivering Whole-Person Transitional Care (AHRQ)

BOOST Implementation Guide (SHM)

Others

Session 2 Tools

CHIC Step 4: Review Appropriate Risk Assessment: Care Transition Guides and Tools

- AHRQ Care Transition Tools (Tools: 8, 9, 10, 13)
  - Overview of all AHRQ tools
  - Links to documents
    - Readmission risk screening tool
    - Discharge checklist
- BOOST Implementation Guide
  - BOOST Appendix

Designing and Delivering Whole-Person Transitional Care (AHRQ)

BOOST Implementation Guide (SHM)

CHIC Step 4: Review Appropriate Risk Assessment: Care Transition Guides and Tools (Cont.)

- Superior Health tools:
  - Call Us First Toolkit – multiple resources
  - Timeliness of Care - scripting
  - Change in Condition, Front Line Forces modules and posters
  - SDOH Guide

Superior Health

CHIC Step 5: Apply Setting-Specific Tools

- Hospital DC planning and care transitions tools:
  - AHRQ (Tools 8, 9, 10): Discharge checklist, planning
  - BOOST: (Tools K, L, M) 8Ps, GAP risk assessment
  - INTERACT Care Transition Tool:
    - Quality improvement, communication
    - Decision support, advance care planning

Designing and Delivering Whole-Person Transitional Care (AHRQ)

BOOST Implementation Guide (SHM)

CHIC Step 5: Apply Setting-Specific Tools (Cont.)

Superior Health

Others

- SDOH Tools: PRAPARE screening tool, SDOH Guide
- Med reconciliation tools: MATCH and MARQUIS
- Patient education: Teach-back strategies and DC tools
- Close the referral loop: Strategies and tools
- Skilled nursing facilities (SNF)/home care/ED tools, preventing ED, rehospitalization

Step 6: Create a Sustainable Shared Learning Collaborative

CHIC Step 6 Program Evaluation: Create a Sustainable Shared Learning Collaborative

- Implement solutions to improve the care transition process.
- Track performance and analyze trends.
- Sustain success of interventions.
- Share data and report back to all involved.
- Spread improvement activities and success.
  - Before implementing a tool, review and modify it for your specific needs and local resources.

Session 5 Tools

Implement Solutions to Improve Care Transition Processes

Implement Solutions to Improve Care Transition Processes

- Planning
  - What is the aim?
    - SMART goal
  - What change and interventions are you implementing?
  - How will you identify the relevant outcome, process and balancing measures?
- PDSA
  - Plan: Identify three to four specific issues you want to look out for during implementation.
  - Do: Execute intervention.
  - Study: Evaluate progress and success of intervention.
  - Act: Revise interventions until obtaining the desired results.

BOOST Implementation Guide (SHM): Section III
Getting to Work on Improving Transitions of Care (pgs. 42 - 46)

Implement Solutions to Improve Care Transition Processes (Cont.)

- Celebrate your successes and share your story.
  - Plan celebrations, record photos, stories and successes.
  - Share with sponsors, participants, staff and community.

BOOST Implementation Guide (SHM): Section III
Getting to Work on Improving Transitions of Care (pgs. 42 - 46)

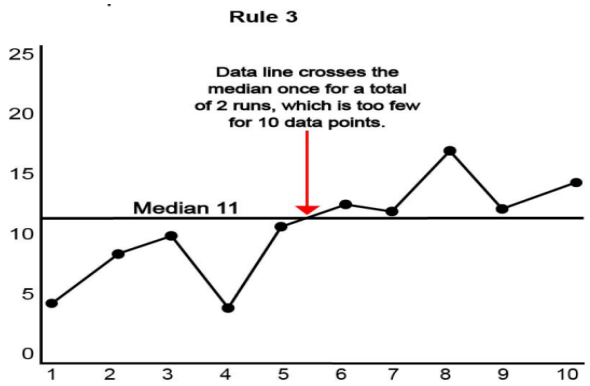
Track Performance and Analyze Trends Using Charts

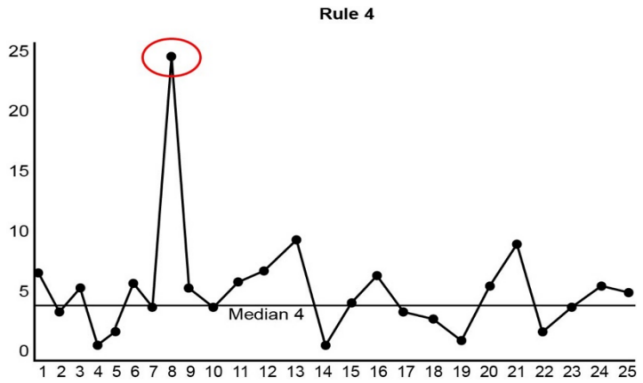
Track Performance and Analyze Trends: Run Charts

- Display data in a graph format as results occur over time.
  - Displays quick, cursory look at performance.
    - Ex: Monthly average length of stay or rehospitalization rates.
  - Identifies variation in data that suggest changes in a process over time.
    - A straight line showing the median.
    - Notations of when the process was modified.

BOOST Implementation Guide (SHM): Section III Getting to Work on Improving Transitions of Care: Steps 6, 7, 8, 9, 10 (pgs. 42 - 50) - Steps 6-7
Run Chart Rules, Institute for Healthcare Improvement (IHI)

Run Chart Rules



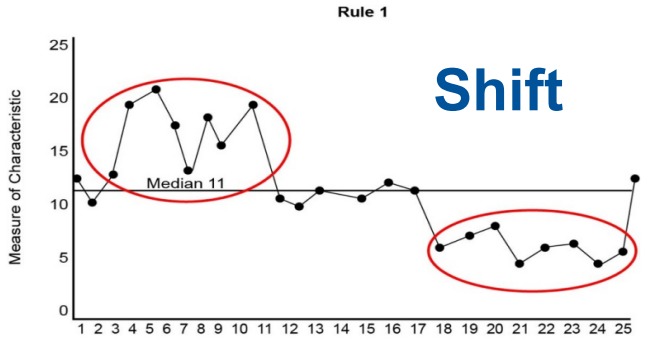


- A run is a series of points in a row on one side of the center line.
- Too few or too many runs signal a nonrandom pattern of change.
- Some points fall right on the median making it difficult to determine which run they are in.
- Data must cross the center line in to identify that a new run has started.

- Obviously different from other points.
- Universal agreement that it is unusual.
- Every data set has a high and low point.
- Not all high and low points are astronomical.

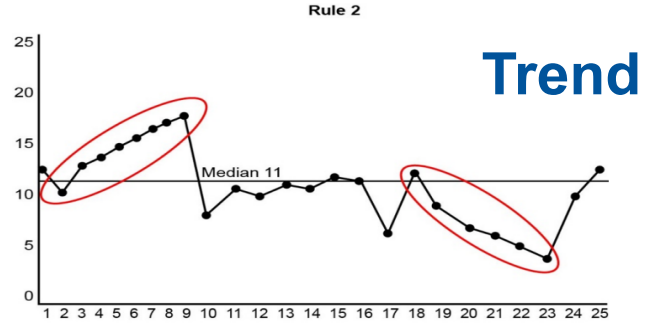
Run Chart Rules, IHI

Run Chart Rules (Cont.)



Shift

- Six or more consecutive points either all above or all below the center line are a shift.
- Points on the center line are not counted towards a shift.
- Points on the center line do not make or break a shift.



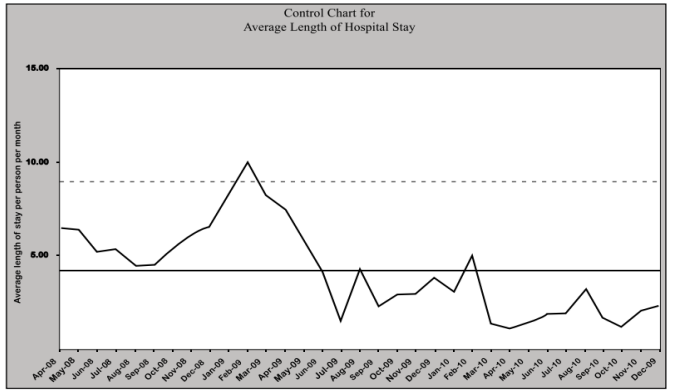
Trend

- Five or more consecutive points all going up are a trend.
- Five or more consecutive points all going down are a trend.
- If two or more points are the same, count only the first point.
- Like values do not make or break a trend.

Run Chart Rules, IHI

Track Performance and Analyze Trends: Control Charts

- Run charts can be modified into control charts placing control limits of the process on the graph.
- Control limits are horizontal lines placed on either side of the mean to indicate the confidence interval.
  - Two standard deviations = 95% confidence interval
  - Three standard deviations = 99% confidence interval
- The area within these lines reflects the expected variation in the performance of the process.
- Data points that fall outside either of these control lines indicate that the process has changed meaningfully.



BOOST Implementation Guide (SHM): Section III Getting to Work on Improving Transitions of Care: Steps 6, 7, 8, 9, 10 (pgs. 42 - 50) - Steps 6-7
Run Chart Rules, IHI

Sustain Success and Share Data

Sustain and Share the Success

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- Sustain your success.
  - Set up a process monitoring plan.
  - Monitor benchmarks.
  - Schedule regular data review sessions.
  - Implement process interventions.
    - Revise interventions and processes.
- Share your data and success.
  - Schedule regular updates with executive sponsors, team, workers, community partners, etc.
  - Outline the main messages (bullet points) you wish to share.
    - AHRQ Care Transitions Tool Overview: tools and templates for data collection, monitoring and presentation slides.

The BOOST Toolkit, SHM

Spread Improvement

Spread the Improvement

- You are ready to spread when:
  - You have evidence of improvement.
  - You have a model for the improvement that others can implement on other units.
  - You have strong support from your senior leadership to spread the intervention.
- Use the care transition process as a model for other areas.
  - Improvement will spread as others learn from your experience.
  - Customize your idea to each unique environment.
  - Establish an aim for spread.

The BOOST Toolkit, SHM

Establish an Aim for Spreading Success in Other Settings, Units or Communities

- Address the “who, what, and where” of spread:
  - Which patient population or area to spread to next?
  - Specific SMART goals expected and time frame to be achieved.
  - Specific improvements to be made in target population.
    - Expect to modify some interventions as the locations/population change.
  - What time frame is most appropriate for the spread?
  - What specific goals or targets for improvement are you attempting to achieve?

The BOOST Toolkit, SHM (pgs. 120-128)
CUSP Toolkit: Spread Presentation Slides, AHRQ

Spread Your Success: Develop an Initial Spread Plan

- Address the "how" of spread: communication, measurement and change management process
  - Include a list of key stakeholders you will need to engage.
    - Appendix E: Record Your Work (BOOST pgs. 120-128)
  - Use organization's approach to spread and rollout.
  - Work with senior executive sponsor(s).
  - Measure performance.
  - Obtain feedback to improve upon plan.
    - IHI White Paper entitled "A Framework for Spread."

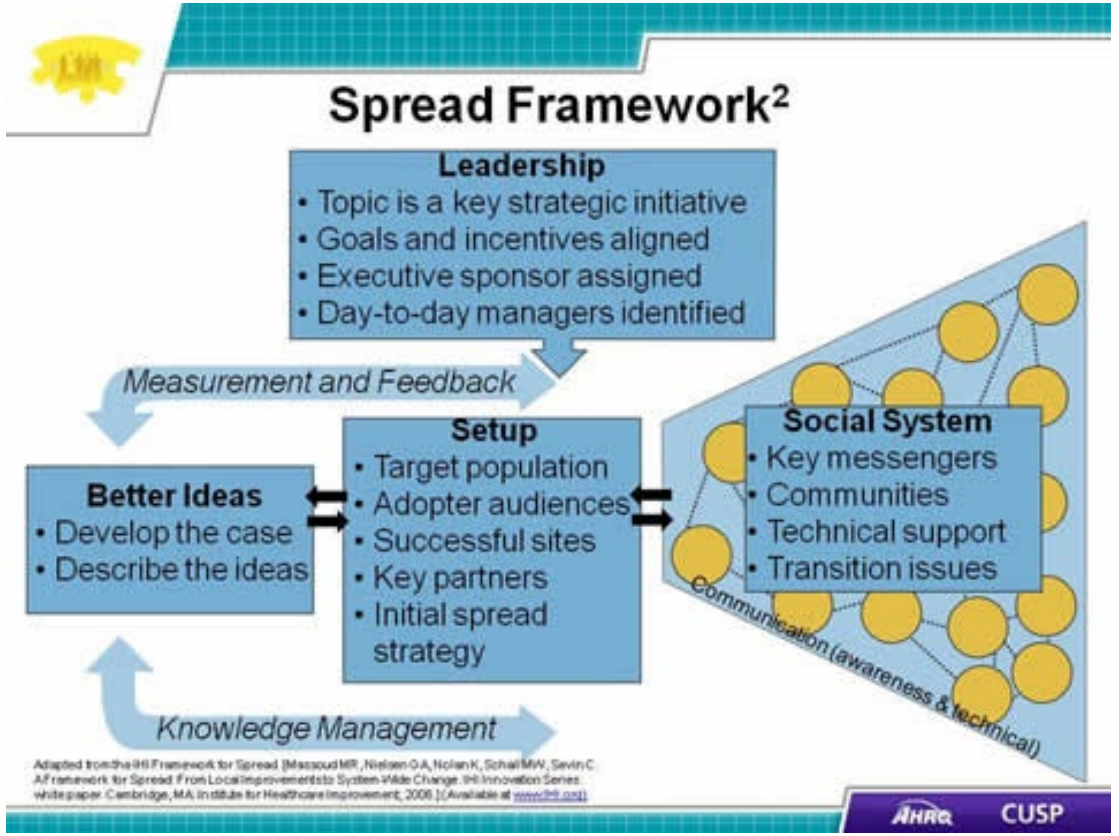
BOOST Implementation Guide (SHM)

Others

The BOOST Toolkit, SHM (pgs. 120-128)
CUSP Toolkit: Spread Presentation Slides, AHRQ

AHRQ CUSP Toolkit

- Adapted from IHI Framework for Spread
  - Video: CUSP: Factors that Affect Spread, YouTube (6:08)



CUSP Toolkit: Spread Presentation Slides, AHRQ

Leverage Shared Resources to Recreate and Implement Community Interventions

- Brainstorm with community partners.
  - Co-recreate
  - Community care transition meetings
  - Team rounds
  - Case studies
- Considerations
  - Project champions at each site
  - HIPAA
  - Technology: capacities and capabilities
  - Efficiency, cost and ROI
  - Plan how to evaluate prevention.

Align Community Aims and Goals to Sustain Community Success

- Sustain a community approach.
  - Celebrate successes together.
  - Leverage shared resources, data and lessons learned.
  - Re-evaluate key partners.
- Share knowledge and spread success.
  - Success
  - Resources
  - Settings
  - Community partners

Discussion

- Where would you rate your organization's readiness to implement a CHIC plan with common goals to impact patient care, safety, utilization or experience?
  - We are working with at least one community organization to develop a CHIC plan
  - We are actively tracking selected interventions with at least one community organization
  - We started or completed a community needs assessment
  - We started or completed an internal organizational readiness assessment
  - We are creating community resource list independently
  - We plan to implement a community collaborative (thinking, planning)

Poll

- Would you like to set up a 1:1 meeting with one of our quality improvement advisors?
  - If yes, please enter your name and email into chat or email/chat one of us

Polling Question

- How useful was this session?
  - Very useful.
  - Somewhat useful.
  - Not at all useful.
  - I will share with a colleague.

Resources

- BOOST Implementation Guide, The Society of Hospital Medicine
- BOOST Appendix The Society of Hospital Medicine
- CUSP Toolkit: Spread Presentation Slides, AHRQ
- Designing and Delivering Whole-Person Transitional Care, AHRQ
- Care Transitions Tool Overview, AHRQ
- ASPIRE Toolbox, AHRQ
- Hospital Guide, AHRQ
- Run Chart Rules, IHI

Continue the Conversation in Superior Health Connect

- Connect is a shared learning environment for Superior Health participants to come together to foster and promote an all-teach-all-learn climate that provides the framework to improve and sustain mutual health care quality improvement initiatives locally, regionally and nationally.
  - https://bit.ly/3BhfHc1

Thank you for attending today!

- Questions, please contact:
  - Michigan
    - Barb Link: Blink@improve.health
  - Minnesota
    - Janelle Shearer: Jshearer@stratishealth.org
    - Lisa Gall: Lgall@stratishealth.org
  - Wisconsin
    - Christine Lamm: clamm@metastar.com

References

- A Framework for Spread: From Local Improvements to System-Wide Change, IHI
- BOOST Implementation Guide, The Society of Hospital Medicine
- CUSP Toolkit: Spread Presentation Slides, AHRQ
- Designing and Delivering Whole-Person Transitional Care, AHRQ
- Run Chart Rules, IHI

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SUPERIOR HEALTH
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