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Community Health Improvement Collaborative (CHIC)
Session 2 – Working with Community Resources
Step 2: Establish community health teams
Step 3: Mobilize community resources

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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 & Medicaid Services (CMS).
- Superior Health provides free support for health care organizations in MN, WI and Michigan.

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What is the Community Health Improvement Collaborative (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 the Community Health Improvement Collaborative (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.

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Introductions

- Please let us know your:
  - Name and title
  - Organization
  - State that you are located (Minnesota, Michigan, Wisconsin)
  - Favorite boardgame or group activity?

Agenda and Timeline: Five sessions, Six steps

Session 1	Session 2	Session 3	Session 4	Session 5
March 6	April 3	May 1	June 5	June 26
Program Introduction Step 1: Analyze data; Identify target population.	Step 2: Establish community health teams. Step 3: Mobilize community resources.	Step 4: Create action plans and toolkits for each organization.	Step 5: Apply setting-specific tools.	Step 6: Create a sustainable shared learning collaborative. Program evaluation
Learn how the CHIC can help your community and organization; Learn how to use data to identify a target population.	Use and build resources to establish community health improvement teams; Co-create and mobilize Community resources and a community resource list.	Choose risk assessment and care transition tools appropriate to your settings, and your targeted population.	Learn how to apply care transition tools and interventions.	Learn to track your progress, analyze trends and leverage shared resources. Discover how to align organizational and community aims and goals to implement a sustained community approach.

CHIC Session Two tools

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Today's Poll

- What resources or services would be beneficial for successful care transitions in your community?
- Choose all that apply:
  - Medical services provided in a patient's home.
  - Support and services for family members.
  - Community resources list.
  - Access to community services or resources.
  - Other – drop your answer in chat.

Step 2: Establish Community Health Teams

- Establish team structure.
- Co-design and collaborate.
- Hold kickoff, set meetings and logistics.
- Establish roles, responsibilities and timelines.

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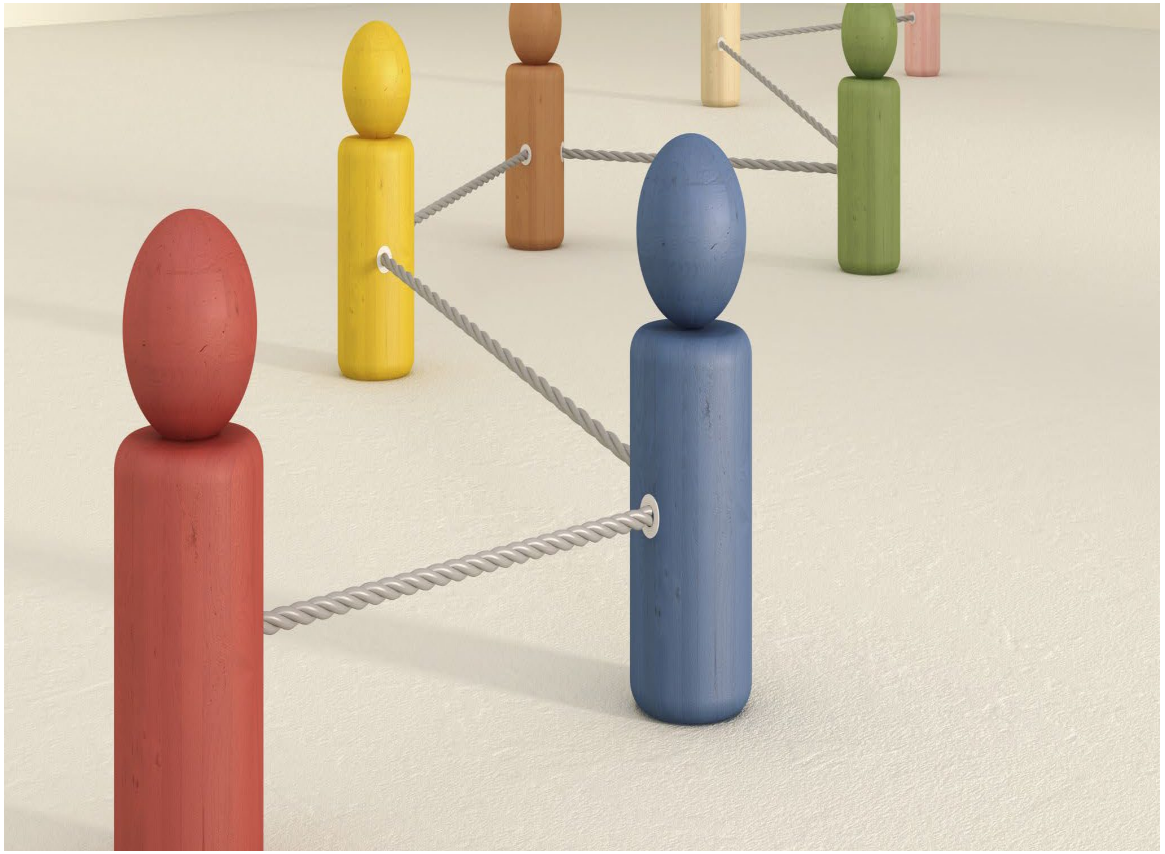
Establishing Team Structure



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Choosing Your Team

- Including the right people on an improvement team is critical to success.
  - Review the aim.
  - Consider the system that relates to that aim.
  - Include members familiar with all the different parts of the process.
  - Each team needs an executive sponsor who takes responsibility for the success of the project.
    - **BOOST Tool G – Page 130-132: Care transition improvement team roster**

Who to Have on The Team

- **Team leader:** Should be respected by the medical and hospital staff and have some topic expertise on care transitions.
- **QI facilitator:** Should be someone with experience in QI.
- **Project manager:** Keeps things moving and organized.
- **Process owners:** The front-line personnel involved in the process.
- **Information technology/Health information services experts:** Help with performance tracking.
  - **Note:** Some rolls may not be needed for your project, or some members may have multiple rolls.
  - **BOOST Tool G – Page 130-132: Care transition improvement team roster**

Team Ground Rules

- All team members and opinions are equal.
- Team members will speak freely and in turn.
- We will listen attentively to others.
- No one may dominate.
- Problems will be discussed, analyzed or attacked (not people).
- All agreements are kept unless renegotiated.
- Once we agree, we will speak with “one voice.”
- Honesty before cohesiveness.
- Consensus versus democracy.
- Members will attend regularly.
- Meetings will start and end on time
  - **BOOST Tool F – Page 129: Tools for running an effective meeting**

Key Front-Line Knowledge Holders to Help Achieve Goals

- Advisory board
- Executive sponsor
- Subgroups
- Ad hoc expertise and support
- Understand key stakeholders and reporting and approval processes.
- Where does your team fit into the organization's quality improvement structure?
  - Clarify the reporting structure and approval process for your interventions.
    - **Boost Tool H – Page 133: Identifying key stakeholders, committees and groups**

Co-Design and Collaborate

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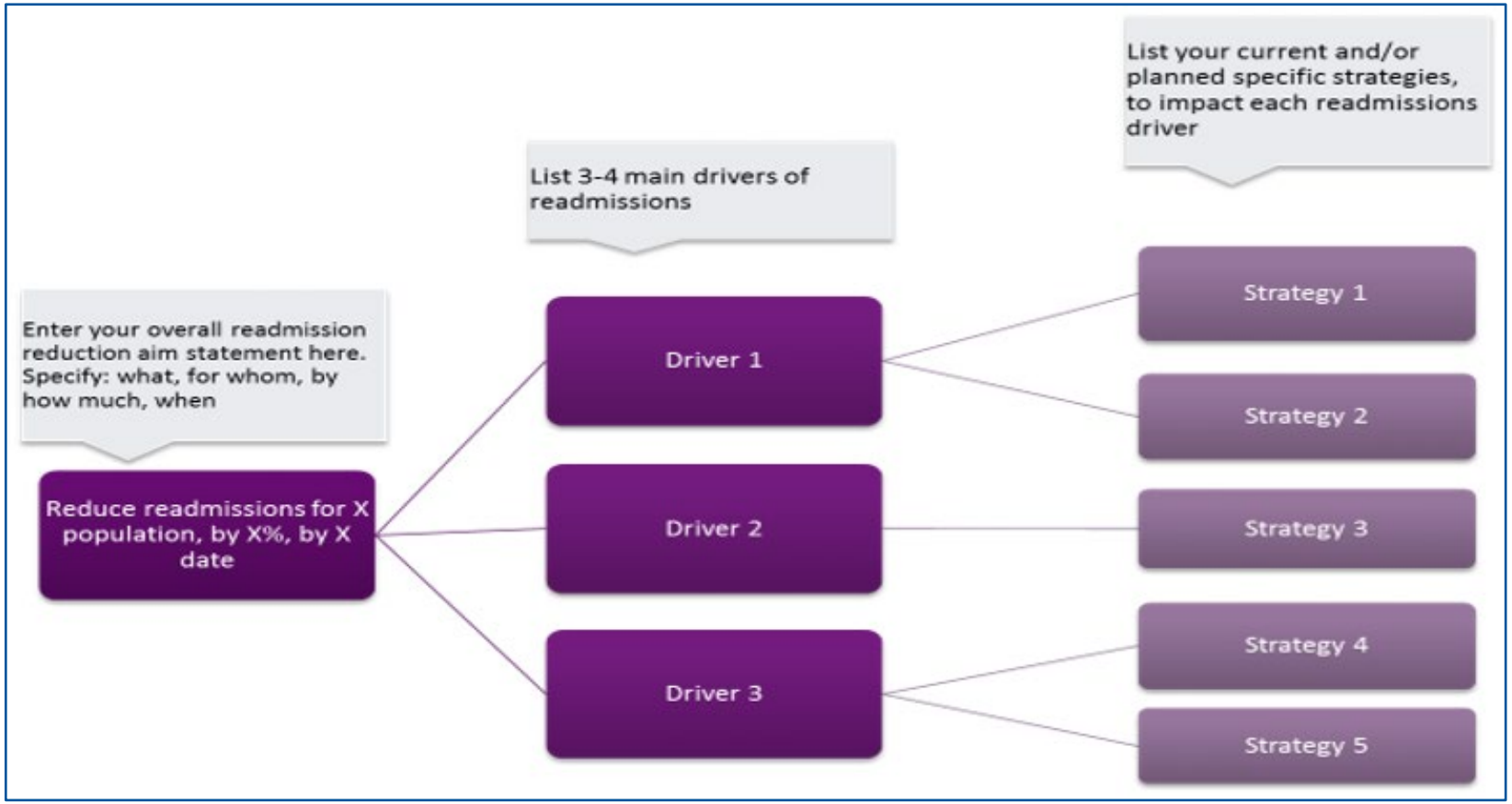
Create a Driver Diagram

- Specify the goal and target population.
- Identify 3-4 primary ways the aim will be achieved.



[AHRQ tool five: Portfolio design]

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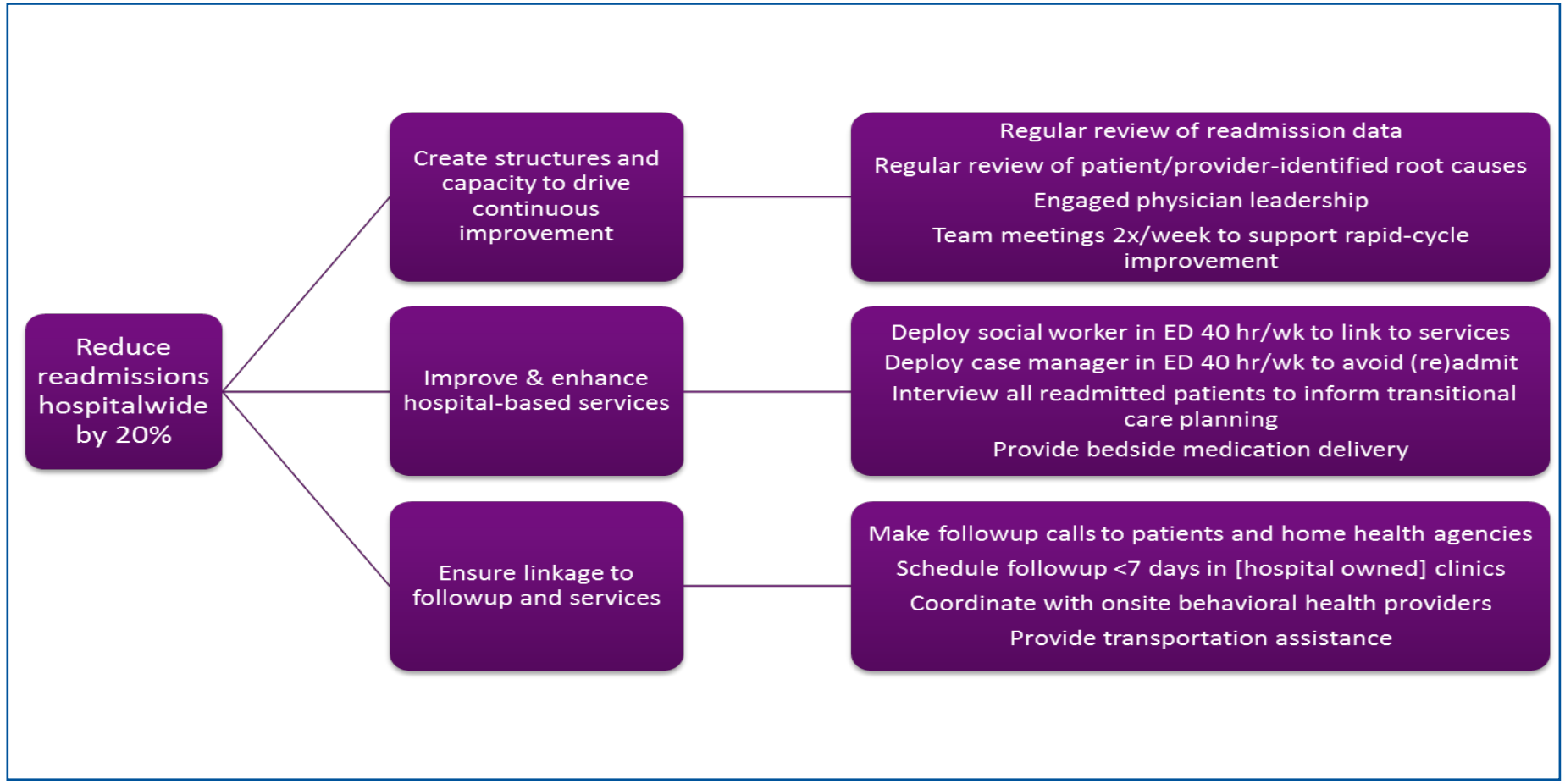
Driver Diagram Example: Chicago Hospital



[AHRQ tool five: Portfolio design]

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Co-Design and Collaborate

- Reach out to a service provider or group of providers who provide similar services, and initiate a transparent, data-informed planning discussion to explore improving linkages to services for patients.
  - Set up a meeting.
  - Prepare data on your hospitals' target population.
    - How many target population discharges per day/week?
    - Describe what factors contribute to readmissions.
  - Prepare questions to learn more about the services they offer and their capabilities.

Hold Kickoff, Set Meetings and Logistics

Positive Kick-off Meeting

- A kick-off meeting brings everyone involved in a project together to transition from the ideation phase to execution.
  - Having all people and teams in the room ensures everyone is either on the same page or can ask questions to get there.
  - You want to use this opportunity to reduce surprises down the line.
  - A good kick-off meeting should get everyone excited.
    - **BOOST Tool F – Page 129: Tools for running an effective meeting**

Team Charter

Elements of a Successful Team Charter	
What are the objectives? (Define the purpose and mission of the team)	**Who is involved?** (Define the team members and stakeholders who are: responsible for the project, accountable for results, need to be consulted during the progression and need to be kept informed along the way)
What are our goals? (Define how the team will know when they are successful. Discuss each person's values and goals; how will they align with the team's values and goals?)	**Who will do what?** (Define the skills and responsibilities of each team member; define who will do what)
What are our milestones? (Define major activities and time frames)	**What are our expectations?** (Discuss team members' workstyles, define all expectations such as ground rules, performance and decision-making processes)
Team member names (Each member signs agreeing to hold themselves and fellow team members accountable)	

AHRQ Project Charter template

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Identifying Key Stakeholders, Committees and Groups

- Identify key stakeholders, committees and special groups that need to be aware of your efforts to improve the discharge care transition, including patient and family members.
  - Utilizing the core components of Person and Family Centered Care of Dignity and Respect, Information Sharing, Participation and Collaboration can help shape who to include on the team.
    - BOOST Guide Appendix H – Page 133

Establish Roles, Responsibilities and Timelines

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Team Roles

- Sponsor
  - Formal leader of performance and process improvement.
- Facilitator
  - Moves team along.
- Leader
- Champion
  - Opinion leader who provides project credibility.
- Technical Expertise
  - Knows subject and understands processes of care.
- Member
  - Shares knowledge and expertise of process or issue.
- Timekeeper
  - Helps the team stay on track
- Scribe
  - Takes minutes.

Step 3: Mobilize Community Resources

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Building a Community Resource Guide

- The purpose of the community resource guide is twofold:
  - Demonstrate that there are community resources.
  - Generate an updated list of those resources for use by hospital discharge planners and those charged with linking patients to services to meet the full range of their posthospital needs.
    - AHRQ TOOL 11: COMMUNITY RESOURCE GUIDE

Building a Community Resource Guide

- Prepare
  - Reach out to a service provider.
  - Prepare data on your hospitals target population.
  - Prepare questions to learn more about the services they offer and their capabilities.
- Ask
  - Make a request – capacity, timeliness, getting started, etc.
- Test
  - Test 10 patients and reflect on outcome.
    - AHRQ TOOL 12: CROSS-CONTINUUM COLLABORATION

Community Inventory Tool

- The Community Inventory tool assists in cataloging community providers and agencies who offer services for post-hospital patient needs to aid in reducing readmissions.
- You might use this inventory as a brief internal team review of the post-acute and community providers.
- Your readmission reduction team can identify a handful of providers or agencies.
  - Community Inventory tool

Building a Community Resource Guide

- Potential Partners for outreach:
  - Area Agencies on Aging
  - 211/United Way
  - State Home Healthcare Association
  - State Hospital Association
    - Ask about local hospitals.
  - State Skilled Nursing Facility Association
  - Councils on Aging
  - County Health Departments
  - State Mental Health Association

Building a Community Resource Guide

- Findhelp.org
- National 211
- 211 Minnesota
- 211 Michigan
- 211 Wisconsin
- Aging and disability resource centers (ADRCs)
- National website that provides information on state Area Agencies on Aging.

Building a Community Resource Guide

- A few other suggestion:
  - Hardcopy guides are in demand by patients so update regularly.
    - Develop criteria on how to vet services.
    - Have point people to keep guide updated.
  - Establishing relationship with local 211 and area agencies on aging information and referral department can be helpful.

Questions?

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Polling Question

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

Upcoming Sessions

- May 1, 2024 - Action Plans, Toolkits
- June 5, 2024 - Setting-Specific Tools
- June 26, 2024 - Sustainability, Evaluation

Resources

- Session 2 Tools, Superior Health
- Go to the Hospital or Stay Here: A Decision Guide for Residents, Their Families, Friends and Caregivers, Department of Health and Human Services
- AHRQ Data tracking tool
  - See tool for additional resources

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.

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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

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References

- AHRQ Practice Facilitation Handbook; Module 14, Creating Quality Improvement Teams and QI Plans
- AHRQ Designing and Delivering Whole-person Care
- Project BOOST Implementation Guide
- AHRQ Project Charter template

Superior Health Opportunity: Free Mobile Vaccination Clinic and Health Fair

- COVID-19 vaccination clinic and health education on topics such as:
  - Self-measured blood pressure
  - Chronic kidney disease
  - Safe opioid use and stigma
  - Dietary – DASH diet / foods that improve continence
  - Cancer screening education
  - Mobility – provide demonstrations for diabetic foot stretches and exercises to improve continence and fall prevention
  - Tobacco cessation
  - Others
- For more information contact immunizations@superiorhealthqa.org and get your Health Fair Request started today!

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