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Community Health Improvement Collaborative (CHIC)
Session 3 – Care Transition Guides and Setting-Specific Tools
Step 4: Introduction to Care Transition Guides
Step 5: Introduction to Setting-Specific Tools

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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 Minnesota, Wisconsin and Michigan

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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)
- Favorite springtime activity

Agenda and timeline: 5 sessions, 6 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: Introduction to Care Transition Guides. Step 5: Introduction To Setting-Specific Tools.	Step 5: Applying Setting-Specific Tools.	Step 6: Create a Sustainable Shared Learning Collaborative Program Evaluation.
Learn how 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.	Risk Assessment and care transition tools appropriate to your setting and target 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 3 Tools

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Today’s Poll

- Do you have a screening tool to identify patients' risk for readmissions?
  - Yes
    - If yes, chat about whether you find the tool helpful or not.
  - No

Step 4: Introduction to Care Transition Guides

- Evidence-based guides that offer in-depth information on factors driving readmissions and strategies to reduce them.

Designing and Delivering Whole-Person Transitional Care (AHRQ)

BOOST Implementation Guide (Society of Hospital Medicine)

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Transitional Care Planning

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- Schedule staff educational sessions and distribute a handout as a guide to help improve transitional care.
  - Handout lists transitional care practices as outlined by the guidance and proposed changes to the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COPs)
- Use a screening tool to identify patient readmission risks and take steps to address needs prior to discharge.
  - Collect nonclinical ("social" needs) such as housing, transportation and social support; address identified needs prior to discharge.
- Provide staff guidance to reduce readmissions.
  - Develop a checklist for patient discharge process elements to include.
- Form an ED care plan template to create institutional consistency across numerous providers.

Designing and Delivering Whole-Person Transitional Care, AHRQ (See tools 8, 9 10, 13)

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Transitional Care Planning

BOOST Implementation Guide (Society of Hospital Medicine)

- Section IV of the BOOST implementation guide offers a foundation upon which to build your ideal transitional care plan.
- Elements include:
  - Assessing Patient Risk for Adverse Events After Discharge — The 8Ps
  - Assessing the Patient's Preparedness for Transitioning Out of the Hospital
  - Patient-Centered Written Discharge Instructions
  - Teach Back
  - Follow-up Telephone Calls
  - Follow-up Appointments
  - Interprofessional Rounds
  - Post-Acute Care Transitions
  - Medication Reconciliation

The BOOST Toolkit, Society of Hospital Medicine (See pages 51-71)

Step 5: Introduction to Setting-Specific Tools

When implementing a tool, review and modify it for your specific needs and local resources – some tool elements may require a bit of modification.

Designing and Delivering Whole-Person Transitional Care (AHRQ)

BOOST Implementation Guide (Society of Hospital Medicine)

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Setting-Specific Tools

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- **Tool 8**: Transitional care practices handout is meant to assist in promoting CMS COPs to help staff better understand how their work relates to CMS guidance.
- **Tool 9**: Readmission screening tool offers a checklist of patient challenges possible interventions to offer.
- **Tool 10**: Patient discharge process checklist promotes adherence to processes and practices outlined as guidance by CMS.
- **Tool 13**: ED care plan template is adaptable and includes high-risk and complex care examples.

Designing and Delivering Whole-Person Transitional Care, AHRQ (See tools 8, 9 10, 13)

Setting-Specific Tools

BOOST Implementation Guide (Society of Hospital Medicine)

- **Appendix A**: Diagram of the teach back technique to help patients understand information about their medical condition.
  - Teach-Back Strategy: Patient and Family Engagement, AHRQ
- **Appendix K**: Using the 8Ps to assess patient risk for adverse events after discharge.
  - 8Ps: Problems with medications, psychosocial, principal diagnosis, physical limitations, patient support, prior hospitalization, palliative care.
  - Guide to Patient and Family Engagement in Hospital Quality and Safety, AHRQ
- **Appendix L**: Assess patient preparedness for transition out of the hospital with the GAP tool.
- **Appendix M**: Prepare patients to transition home safely with Patient PASS, a health literate patient-centered educational tool to take home.

The BOOST Toolkit, Society of Hospital Medicine (See pages 110 and 136 - 138)

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Setting-Specific Tools

Superior Health

- Call Us First Toolkit* for Home Health Organizations
  - Interventions to help decrease hospital readmissions and ED use.
- Timeliness of Care toolkit*: Helps reduce delays in the start of home health services from hospital discharge.
  - Timeliness of Care Instructional video for the HIS and HAT Tools.
  - Home Care Intake Scripting Tool - HIS Tool (PDF)
  - Home Care Acceptance Tracking Tool - HAT Tool (Excel): begin using the day after intake staff watches the instructional video.
  - HAT Tool example - HIS Tool (Excel): to practice and play with prior to implementation.
- Social Drivers of Health (SDOH) Z Code Documentation Guide
  - Highlights z codes that can be used to capture Social Drivers of Health, allowing for systemic data collection within medical or electronic health records (EHR).
  - Social Drivers of Health - ICD-10-CM: Z Diagnosis Codes and Documentation, Superior Health

* Toolkits created by SHQA in collaboration with HHAs in MN, MI and WI.

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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

- June 5, 2024 - Setting-Specific Tools
- June 26, 2024 - Sustainability, Evaluation

Resources

- Project BOOST Implementation Guide, The Society of Hospital Medicine
- Designing and Delivering Whole-Person Transitional Care, AHRQ
  - ASPIRE Toolbox, AHRQ
  - Hospital Guide, AHRQ
- Call Us First Toolkit for Home Health Organizations, Superior Health
- Timeliness of Care Toolkit for Home Health Care, Superior Health
  - Instructional video
  - Home Care Intake Scripting Tool
  - Home Care Acceptance Tracking Tool
- Social Drivers of Health (SDOH) Z Code Documentation Guide, Superior Health
- Guide to Patient and Family Engagement in Hospital Quality and Safety, AHRQ

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.

Thank you for attending today!

- Questions, please contact:
  - Michigan
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  - Minnesota
    - Janelle Shearer: Jshearer@stratishealth.org
    - Lisa Gall: Lgall@stratishealth.org
  - Wisconsin
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References

- Project BOOST Implementation Guide, The Society of Hospital Medicine
- Designing and Delivering Whole-Person Transitional Care, AHRQ
- Call Us First Toolkit for Home Health Organizations, Superior Health
- Timeliness of Care Toolkit for Home Health Care, Superior Health
- Social Drivers of Health (SDOH) Z Code Documentation Guide, Superior Health
- Guide to Patient and Family Engagement in Hospital Quality and Safety, AHRQ

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