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Community Health Improvement Collaborative (CHIC)
Session 4: Setting-Specific Tools
Step 5: Applying Setting-Specific Tools

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Quality Improvement Advisor

June 5, 2024

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.

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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.

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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.

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Introductions

- Please let us know the following:
  - Name and title
  - Organization
  - State that you are located (Minnesota, Michigan or Wisconsin)
  - What care settings have you worked in?

Agenda and Timeline: Five Sessions, Six Steps

Session One	Session Two	Session Three	Session Four	Session Five
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 4 Tools, Superior Health

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Today's Poll

- Do you have a favorite care transition tool that you use at your organization?
  - Yes
    - If yes, chat the tool name.
  - No

Step 5: Applying 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)

Superior Health

INTERACT

Others

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Setting-Specific Tools: Hospital Care Transitions

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Patient Risk Assessment Tools

Others

PRAPARE - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

- Downloadable SDOH screening questionnaire (25 languages).

BOOST Implementation Guide (Society of Hospital Medicine)

Appendix K: 8P's Tool

- Assess Risk for Adverse Events After discharge.

Appendix L: General Assessment of Preparedness GAP Tool

- Assessing Preparedness for Transitioning Out of the Hospital.

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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).

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Medication Reconciliation Tools

BOOST Implementation Guide (Society of Hospital Medicine)

- Medication discrepancies at discharge are a major barrier to reducing hospital readmissions.
- Many consequences to medication discrepancies.
- BOOST Guide recommends the MARQUIS Toolkit.

Others

MARQUIS Toolkit

(Society of Hospital Medicine)

- Best Possible Medication History (BPMH)
- BPMH Pocket Card

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- **Medications at Transitions and Clinical Handoffs** (MATCH), AHRQ
- Toolkit for Medication Reconciliation

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Patient Education

BOOST Implementation Guide (Society of Hospital Medicine)

- Patient-Centered Written Discharge Instructions
- **Appendix M**: Prepare patients to transition home safely with Patient PASS, a health literate patient-centered educational tool to take home.
- **Appendix A**: Diagram of the teach back technique to help patients understand information about their medical condition.

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- Teach-Back: Intervention
  - Explaining medical information so patients/families understand.
- Teach-Back Strategy: Patient and Family Engagement, AHRQ

The BOOST Toolkit, Society of Hospital Medicine (See pages 57, 138-141, and 110)

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Closing the Referral Loop

BOOST Implementation Guide
(Society of Hospital Medicine)

- Follow-up Telephone Calls
  - Clinical condition since discharge
  - Medications
  - Follow-up plans
- Follow-up Appointments
  - High-risk – 48-72 hrs.
  - Moderate-risk – Seven days
  - Low-risk – as deemed medically necessary
- Interprofessional Rounds

The BOOST Toolkit (Society of Hospital Medicine): See pages 60-65.

ED Transitions

ED CARE PLAN TEMPLATE

Patient Name	
Patient MRN	
DOB / Age / Gender	
Care plan date	Date care plan created: _____ Date(s) modified: _____
Situation [Reason for care plan]	[Provide brief (1 line) summarizing history of repeated presentations and reason for this care plan]
Background [Patterns of utilization and summary of relevant testing]	[Provide 2-3 sentences summarizing history of repeated presentations, including symptomatic complaints. List presentations in past (12) months, list or provide count of number of relevant tests (e.g., abdominal CT scans). Summarize what has been tried in the past.]
Assessment [Drivers of repeated utilization, resource(s) in place]	[Provide interdisciplinary assessment of the drivers of utilization] [Identify the clinical, behavioral, and social services in place, with contact names and numbers]
Recommendations [Directed at ED clinical staff to promote safety, quality, consistency and otherwise advance care]	[Provide recommendations to promote safety, quality, consistency of care] [Provide recommendations to minimize harm – such as avoiding certain medications or repeated tests without clear benefit] [Provide specific name/team/service to call while patient is in ED]
Whom to contact about care plan:	Name: _____ Phone/Email: _____

Designing and Delivering Whole-Person Transitional Care (AHRQ)

Emergency Department Care Plan

- This tool provides an emergency department care plan template and examples of ED care plans.
- Hospitals can use this template, adapt the template, or draw inspiration from the examples to develop their own template to suit their specific needs and preferences.

Designing and Delivering Whole-Person Transitional Care, AHRQ, Tool 13

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Setting-Specific Tools: Skilled Nursing Facilities (SNF)

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Care Transition Planning

BOOST Implementation Guide (Society of Hospital Medicine)

BOOST Implementation Guide

Address issues of problems of poor care plan communication and reduced clinical resources at SNF through partnerships with SNF providers to reduce readmissions.

Two strategies for improving transitions:

- Cross-continuum teams
- Rigorous process improvement

Others

Go to the Hospital or Stay Here: A Decision Guide for Residents, Their Families, Friends and Caregivers

- **Involving Nursing Home Residents and Families in Acute Care Transfer Decisions** (Patient Centered Outcomes Research Institute, HHS.GOV).

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Reducing Acute Care Transfers

INTERACT

- Interventions to **R**educe **A**cute **C**are **T**ransfers (INTERACT)
- **Tool Categories:**
  - Quality Improvement
  - Communication
  - Decision Support
  - Advance Care Planning

INTERACT Quality Improvement Tools

- **Tracking hospitalization rates:**
  - Acute Care Transfer Log – Worksheet
  - Calculating Hospitalization Rates
  - Hospitalization Rate Tracking Tool for 2024
- **Quality improvement reviews – root cause analyses:**
  - Quality Improvement Tool for Review of Acute Care Transfers
  - Quality Improvement Summary – Worksheet

INTERACT Communication Tools

INTERACT

- **For communication within the nursing home:**
  - Stop and Watch Early Warning Tool
  - SBAR Communication Form
  - Medication Reconciliation Worksheet for Post-Hospital Care
- **For communication between the nursing home and hospital:**
  - Engaging Your Hospitals – Tip Sheets
  - SNF/NF Capabilities List
  - SNF/NF – Hospital Transfer Form
  - Acute Care Transfer Checklist
  - Hospital – Post-Acute Transfer Form

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INTERACT Decision Support Tools

- **Change in condition file cards:**
  - Acute Change in Condition File Cards
- **Care paths:**
  - Acute Mental Status Change
  - Change in Behavior: New or Worsening Behavioral Symptoms
  - Dehydration
  - Fever
  - GI Symptoms – nausea, vomiting, diarrhea
  - Shortness of Breath
  - Symptoms of CHF
  - Symptoms of Lower Respiratory Illness
  - Symptoms of UTI
  - Fall

INTERACT Advance Care Planning Tools

INTERACT

- Advance Care Planning Tracking Tool
- Advance Care Planning Communication Guide
- Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
- Comfort Care Order Set
- Deciding About Going to the Hospital
- Education on CPR
- Education on Tube Feeding
- Guidance on Possible Sepsis
- Guidance on Possible Infection

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Resources for Teaching Frontline Staff

- Front Line Forces Main page: Short on-demand learning modules, and other resources, for front line and direct care staff working in long-term care and other health care settings.
- Change in Conditions Front Line Forces Module for front line staff.
- Recognizing Change in Condition for leaders/managers.
- Recognizing Resident Change in Condition poster for SNF.

Decreasing Hospitalizations and ED Use

Designing and Delivering Whole-Person Transitional Care (AHRQ)

- AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits
- Hospital Transfer Self Assessment Worksheet:
  - Section 1: Screening for Hospital Transfer Risk
  - Section 2: Preventable Hospital and ED Visits - Prevention Plan
  - Section 3: Communication Practices
  - Section 4: Investigations/Root Cause Analysis of Potentially Preventable
    - Acute Care Transfers

Setting-Specific Tools: Home Health Agencies

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Reducing Hospitalizations and ED Use

- Call Us First Toolkit* for Home Health Organizations
  - Interventions to help decrease hospital readmissions and ED use.
  - Diagnosis specific (stop-light) action plans.
- Timeliness of Care toolkit*: Helps reduce delays in the start of home health services from hospital discharge.
  - Home Care Intake Scripting Tool - explains benefits of home care.
  - Timeliness of Care Instructional video - how to track home care acceptance rates.
- Home Health Change in Condition Poster

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

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 26, 2024 - Sustainability, Evaluation

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Resources

- Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits, Agency for Health Research and Quality (AHRQ)
- BOOST Implementation Guide, Society of Hospital Medicine
- Call Us First Toolkit for Home Health Organizations, Superior Health
- Change in Conditions Front Line Forces Module, Superior Health
- Designing and Delivering Whole-Person Transitional Care, AHRQ
- Front Line Forces Main page, Superior Health
- Go to the Hospital or Stay Here: Involving Nursing Home Residents and Families in Acute Care Transfer Decisions, Patient Centered Outcomes Research Institute, CMS, Florida Atlantic University
- MARQUIS Toolkit, Society of Hospital Medicine
- MATCH Toolkit, AHRQ

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Resources

- PRAPARE, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations
- Patient Change in Condition Poster for Home Health, Superior Health
- Patient Change in Condition Poster for SNF, Superior Health
- Recognizing Resident Change in Condition, Superior Health
- Recognizing Resident Change in Condition, Superior Health
- Social Drivers of Health (SDOH) Z Code Documentation Guide, Superior Health
- Social Drivers of Health - ICD-10-CM: Z Diagnosis Codes and Documentation, Superior Health
- Teach-Back: Intervention, AHRQ
- Tools and Resources for Hospitals, Long-term Care Facilities and Primary Care Facilities: Hospitals and Health Systems, AHRQ
- Timeliness of Care Toolkit for Home Health Organizations: Home Care Intake Scripting Tool, Timeliness of Care Instructional video, Tracking Tool and example, Instructional PPT Handouts, Superior Health

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:
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