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

SUPERIOR HEALTH Quality Alliance

Community Health Improvement Collaborative (CHIC)

Session 4 Tools: Apply Setting-Specific Tools

June 5, 2024

Superior Health Quality Alliance (Superior Health) created a list of tools that can be used to complete the steps introduced in each of the five CHIC sessions.

Reference this table for each session's materials.

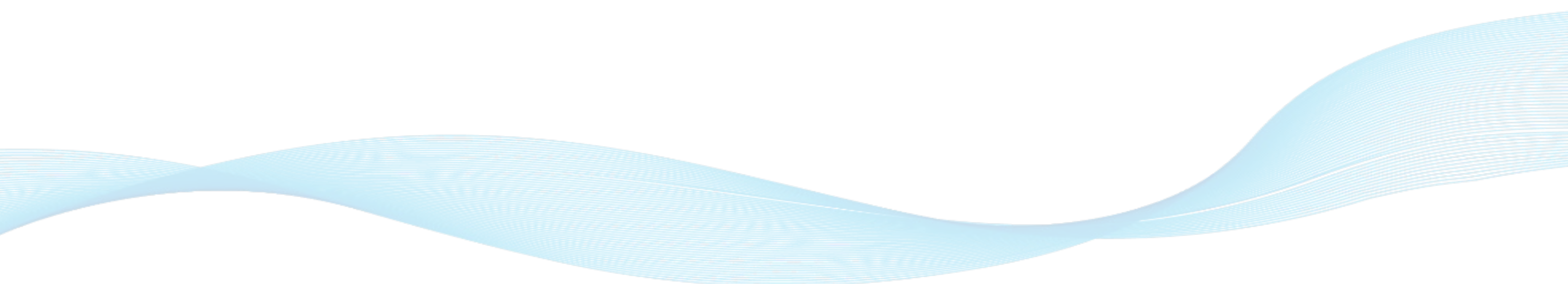
Session Date	PowerPoint Slides	Recording	Tools List
March 6, 2024	Presentation PDF	YouTube Video	PDF Document
April 3, 2024	Presentation PDF	YouTube Video	PDF Document
May 1, 2024	Presentation PDF	YouTube Video	PDF Document
June 5, 2024	Presentation PDF	Coming soon	See Tables Below
June 26, 2024			

Applying Setting-Specific Tools

Step 5: Apply Setting Specific Tools		
Hospital Care Transitions		
Patient Risk Assessment Tools:	**BOOST Implementation Guide** (SHM): **Section IV: The BOOST® Toolkit – Appendix Tools K, L, M Pg 53-56** **PRAPARE** (NACHC & AAPCHO) National Association of Community Health Centers & Association of Asian Pacific Community Health Organizations **Social Drivers of Health (SDOH) Z Code Documentation Guide** (Superior Health)	**Assessing Patient Risk for Adverse Events After Discharge using The 8Ps** (p 53-55) • Appendix K: 8P's Tool (p 136) **Assessing the Patient's Preparedness for Transitioning Out of the Hospital** (p 56) • Appendix L: General Assessment of Preparedness (GAP Tool, p 137) **Universal Patient Discharge Checklist: Includes 8Ps, GAP and Universal d/c checklist** - 3 tools in one document **PRAPARE:** Downloadable SDOH screening questionnaire. Available in over 25 Languages. **SDOH (Z Code) Documentation Guide** - Highlights z codes that capture SDOH for systemic data collection

		• Social Drivers of Health - ICD-10-CM: Z Diagnosis Codes and Documentation *YouTube video
Medication reconciliation Tools	BOOST Implementation Guide (SHM) **Section IV: The BOOST® Toolkit pgs. 69-70** MARQUIS Toolkit **(SHM)** MATCH Toolkit **(AHRQ)**	**Medication Reconciliation** (pgs. 69-70) **Medication Reconciliation MARQUIS Toolkit: Safer Medication Management for Better Transition of Care** • Best Possible Medication History (BPMH) • marquis-bpmh-tri-fold--pocket-card **Medications at Transitions and Clinical Handoffs (MATCH) Toolkit** for Medication Reconciliation
Patient Education	BOOST Implementation Guide (SHM) **Section IV: The BOOST® Toolkit – pgs. 57-59** **Appendix Tools A (p 110), M (p 138)** **Teach-Back: Intervention (AHRQ)**	**Patient-Centered Written Discharge Instructions** (p 57) • **Appendix M: Patient PASS:** A Transition Record and Discharge Patient Education Tool (p 138) **Teach Back** (p 58-59) • **Appendix A: Teach Back Process (p 110)** **Teach-Back: Intervention**
Closing the referral loop	BOOST Implementation Guide (SHM) **Section IV: The BOOST® Toolkit (pgs. 60-65)** **Appendix Tools M**	**Follow-up Telephone Calls pgs. 60-61** **Follow-up Appointments pgs. 62 -63** **Interprofessional Rounds pgs. 64 -65**
Emergency Department Tools	**Designing and Delivering Whole-Person Transitional Care (AHRQ, Tool 13)**	**Tool 13: ED Care Plan Examples** (Word File, 71.25 KB) 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.
Skilled Nursing Facilities Care Transitions		
SNF – General Care Transition Tools	BOOST Implementation Guide (SHM) **Post-Acute Care Transitions (pgs. 66 -67)**	**Post-Acute Care Transitions pgs. 66 -67** **Tool 8: Conditions of Participation** **(**Word File, 65.3 KB**)**

	Designing and Delivering Whole-Person Transitional Care **(AHRQ, Tools 8, 9, 10)**	**Tool 9: Whole-Person Transitional Care Planning** (Word File, 73 KB) **Tool 10: Discharge Process Checklist** (Word File, 76.75 KB)
SNF Decision Guide	**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)	**Go to the Hospital or Stay Here: A Decision Guide for Residents, Their Families, Friends, and Caregivers**. Includes: • Educational resources • Trifold version, online version, audiobooks • Best practices for clinicians and staff to use with SNF residents and their families.
INTERACT Tool	**I**nterventions to **R**educe **A**cute **C**are **T**ransfers, (Florida Atlantic University)	**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** • Quality Improvement Tool for Review of Acute Care Transfers • Quality Improvement Summary – Worksheet **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 **INTERACT Decision Support Tools** • 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** • 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
SNF AHRQ	**AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits** **(AHRQ)**	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

Home Care Tools	**Call Us First Toolkit (Superior Health)**	**Call Us First Toolkit for Home Health Organizations*** Interventions to help decrease hospital readmissions and ED use. Features diagnosis-specific (stoplight) action plans to help patients manage their health conditions (page 9), and many other tools.
	Timeliness of Care Intake Scripting Toolkit (Superior Health)	**Timeliness of Care Home Care Intake Scripting Toolkit** Helps reduce delays in the start of home health services. • Home Care Intake Scripting Tool: Helps staff explain the benefits of home health care. • Timeliness of Care Instructional video: Learn how to track home care acceptance rates using a Tracking Tool, with an example, and Instructional PPT Handouts.
	Change in Conditions Webinar (Superior Health)	**Recognizing Resident Change in Condition** YouTube recording 3:31 min (for leaders & managers) • Recognizing Resident Change in Condition PDF File w/links (for leaders & managers) • Change in Conditions Front Line Forces Module web course (for Front Line Staff)
	Change in Conditions Poster for HHA (Superior Health)	**Patient Change in Condition Poster** post and share with staff.
	Front Line Forces (Superior Health)	**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.
AHRQ Toolkit Guide	**Designing and Delivering Whole-Person Transitional Care (AHRQ)**	**Hospital Guide to Reducing Readmissions** (PDF File, 1.35 MB) Overview of all AHRQ tools with links to documents and estimated time to complete.

Join the private CHIC group in Connect.

If you would like any assistance, or one-on-one support, we're here to help. Please contact us.

Michigan

- Barb Link: Blink@improve.health

Minnesota

- Janelle Shearer: Jshearer@stratishealth.org
- Lisa Gall: Lgall@stratishealth.org

Wisconsin

- Christine Lamm: clamm@metastar.com

References:

1. Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits, Agency for Health Research and Quality (AHRQ)
2. BOOST Implementation Guide, Society of Hospital Medicine
3. Call Us First Toolkit for Home Health Organizations, Superior Health
4. Change in Conditions Front Line Forces Module, Superior Health
5. Designing and Delivering Whole-Person Transitional Care, AHRQ
6. Front Line Forces Main page, Superior Health
7. 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
8. MARQUIS Toolkit, Society of Hospital Medicine
9. MATCH Toolkit, AHRQ
10. PRAPARE, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations
11. Patient Change in Condition Poster for Home Health, Superior Health
12. Patient Change in Condition Poster for SNF, Superior Health
13. Recognizing Resident Change in Condition, Superior Health
14. Recognizing Resident Change in Condition, Superior Health
15. Social Drivers of Health (SDOH) Z Code Documentation Guide, Superior Health
16. Social Drivers of Health - ICD-10-CM: Z Diagnosis Codes and Documentation, Superior Health
17. Teach-Back: Intervention, AHRQ
18. Tools and Resources for Hospitals, Long-term Care Facilities and Primary Care Facilities: Hospitals and Health Systems, AHRQ
19. 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

This material was prepared by the Superior Health Quality Alliance, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-MI/MN/WI-CC-24-171 053024