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CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

Home Health Agency (HHA) Workgroup Care Transitions Best Practices

July 24, 2024

HHA Workgroup Goal 2024

- Join us on the fourth Wednesday of the month for Superior Health Quality Alliance's (Superior Health) HHA Workgroup.
  - These meetings provide opportunities to connect with other HHAs across Michigan, Minnesota and Wisconsin to support each other by sharing ideas, current information and best practices.
  - We will use "discover and discuss" strategies to help your agency provide the best care for patients.

Agenda

- Welcome
- Past workgroup goals and discussion topics
- Staffing and Retention
  - Home Health Value-Based Purchasing (HHVBP) Session 1: Overview, Functional Score
  - HHVBP Session 2: Improvement in Dyspnea
  - HHVBP Session 3: Improvement in Management of Oral Medication
- Today's Topic - Best Practices in Care Transitions - Group
- Project updates
  - Call Us First Toolkit and Timeliness of Care
- Next steps and action items

Introductions

Please let us know your:

- Name and title
- Organization
- State that you are located (Minnesota, Michigan or Wisconsin)
- Favorite animal

Today's Topic: Care Transitions Best Practices

- Discover and discuss:
  - What works and doesn't work in the current health care environment.
  - Review the Superior Health Care Transition Team's online "compendium of toolkits" relevant to HHA settings.
    - Care Transitions Resources, Superior Health
- Home Health Within-Stay Potentially Preventable Hospitalization (PPH)
  - Quick reference resource on the Centers for Medicare and Medicaid Services (CMS) PPH measure specifications, strategies to enhance PPH measure outcomes and other helpful resource links.

Transitioning Care from Home Health to Another Care Setting

- Use shared decision-making processes with patient and caregivers.
- Assure complete and timely communication of information to receiving provider.
  - Initiate prompt follow-up calls to next care provider(s).
- Arrange appropriate transportation (i.e. ambulance or other).

Transitioning Care from Home Health to Another Care Setting (Cont.)

- Send all required documentation and data with patient.
  - Reconciled medication list, allergies, problems, demographics, etc.
  - Health related social needs and supports, physician orders for life-sustaining treatment (POLST), etc.
  - Current care plan, treatments and diagnostics.
- Assure coordinated care with past and future provider(s), services and resources
  - Other service providers, vendors, clinicians and specialists.
  - Appointments, therapies and other ancillary services.
  - Community supports

Open Discussion

- What tools or processes do you use for successful care transitions?
  - When it works well, what is included in that care transition?
  - What are the most challenging aspects of care transitions?
- Do you collect data for care transitions?
- What do you need from Superior Health?

Front Line Forces: Recognizing Resident/Patient's Change in Condition

- PPT overview for leaders/managers. (27-minute YouTube video)
  - Presentation PDF with resource links.
  - Online module for front line staff.
- Posters
  - Change in Resident Condition
  - Change in Patient Condition

Over 20 modules for front line staff.

Community Health Improvement Collaborative (CHIC) Sessions, Steps and Resources

Session 1. Step 1: Analyze Data and Identify Target Population	Presentation PDF YouTube Video Session 1 Tools
Session 2. Steps 2 and 3: Establish Community Health Teams and Mobilize Resources	Presentation PDF YouTube Video Session 2 Tools
Session 3. Step 4: Review Care Transition Guides and Choose Setting-Specific Tools	Presentation PDF YouTube Video Session 3 Tools
Session 4. Step 5: Apply Setting-Specific Tools	Presentation PDF YouTube Video Session 4 Tools
Session 5. Step 6: Evaluate and Create a Sustainable Shared Learning Collaborative	Presentation PDF YouTube Video Session 5 Tools

Project Updates

- Call Us First Toolkit - tools to help decrease the number of patients going to the emergency department (ED) without contacting home health first.
- Timeliness of Care Campaign training video - decrease delay in the timeliness between hospital discharge and the start of home health services.
  - Home Care Intake Scripting Tool
  - Home Care Acceptance Tracking Tool

Next Steps

- What would you find valuable in future meetings?
  - For example: sharing best practices, sharing resources, sharing successes and challenges, identifying potential interventions, hot topics in home health care, etc.
- Top areas of interest and how to move forward.

Action Items

- Start or continue the Timeliness of Care Intervention and the Call Us First Toolkit at your HHA.
- EMAIL: hattool@superiorhealthqa.org
  - Send results of Home Care Acceptance Tracker Tool
  - Questions?
  - 1:1 Technical Assistance
- Post any resources you would like to share to the HHA Workgroup: Reducing ED Visits group in Connect.

Thank you for attending today!

- Questions, please contact:
  - Minnesota
    - Janelle Shearer: Jshearer@stratishealth.org
    - Lisa Gall: Lgall@stratishealth.org
  - Wisconsin
    - Carrie Finley: Cfinley@metastar.org
    - Christine Lamm: clamm@metastar.com

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

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