


Care Coordination Quickinar Series 6: Hot Spotting and Resources

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Health Services Advisory Group (HSAG)

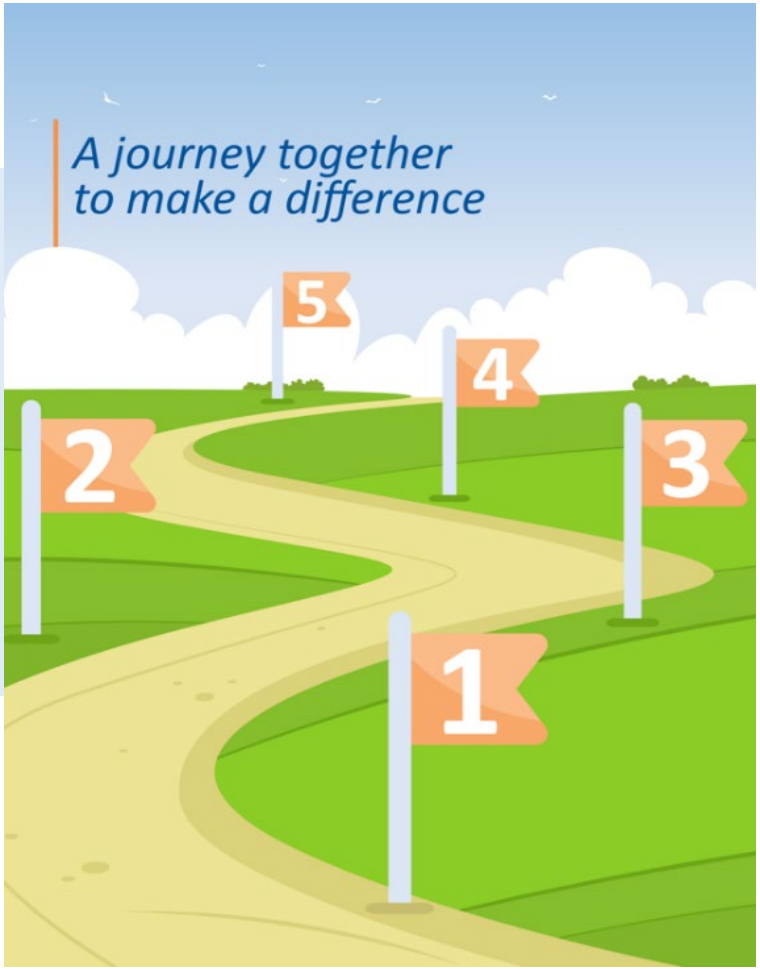
April 5, 2022

OBJECTIVES

- Review data and other tools/mechanisms to identify super utilizers.
- Explain strategies to improve coordination of care and reduce utilization for super utilizers.

2022 Care Coordination Journey

1. **Assessment:** Complete the care transition assessment and RCA to identify your program's strengths and opportunities for improvement.
2. **Strategy Selection:** Evaluate findings, review resources, and select the most appropriate strategy to address your gap.
3. **Implementation:** Develop a strategy tree and implement tactics.
4. **Monitor Results:** This is how you can determine if the strategy is working and make adjustments to your intervention accordingly.
5. **Learn:** Attend HSAG Care Coordination quickinar sessions to learn from subject matter experts.



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Senior Director
Ambulatory Care Management and Home-Based Services
HonorHealth Home Health Administrator
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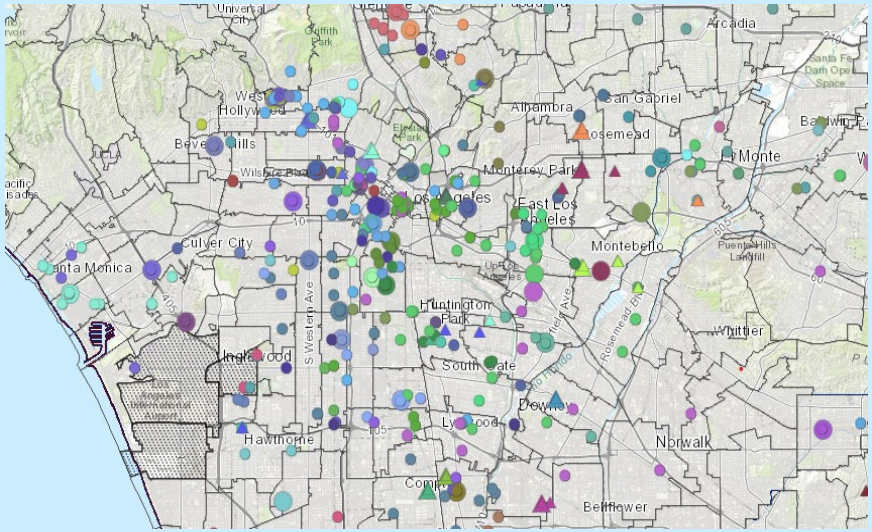
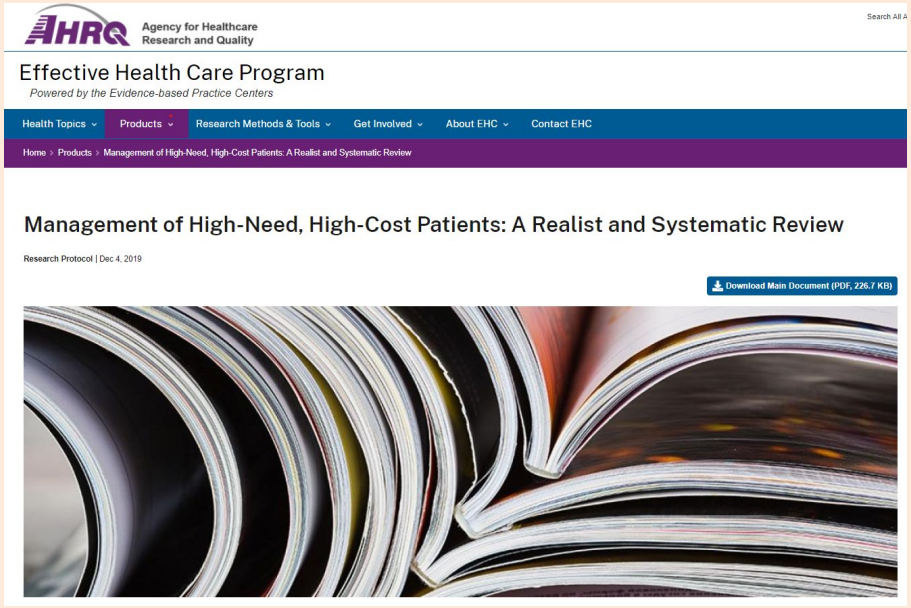
Questions?

Tools and Resources



www.UDSMapper.org

https://effectivehealthcare.ahrq.gov/products/high-utilizers-health-care/protocol



HSAG HEALTH SERVICES ADVISORY GROUP

HSAG Readmission Chart Audit Tool

Care Coordination Toolkit

- 1 Journey to Success
- 2 Gap Analysis
- 3 Tools to Support Gap Analysis
  - About Tools to Support Gap Analysis (PDF)
  - 1. 5 Whys Tool for Root-Cause Analysis (PDF fillable form)
  - 2. 5 Whys Tool for Root-Cause Analysis—Sample (PDF)
  - 3. 7-Day Readmission Checklist and Audit Tool and Instructions (PDF)
  - 4. Readmission Interview with Patients, Family Members and Care Team Members (PDF)
- 4 Goal and Strategy Development
- 5 Teach-Back
- 6 Post-Acute Collaboratives
- 7 Patient Education - Zone Tools

Quality Improvement Organizations | HSAG

Patient Label

7-Day Readmission Chart Audit Tool

Index admission dates_____through_____/Readmission dates_____through_____

1. Is this readmission related to the previous admission? Y or N
2. Is this a hospital penalty related condition?
   a. If yes, circle one: Acute MI / HF / PN / COPD / CABG / Elective TKA/THA*
   b. If no, is readmission reason listed as a comorbid condition on the index admission? Y or N
3. What is the admission source (circle one)? Home / home health agency (HHA) / skilled nursing facility (SNF) / hospice / long-term acute care / inpatient psychiatric / inpatient rehabilitation
4. How many days between discharge and readmission (circle one)? 0–1, 2–4, or 5–7
5. How many times was the patient in the hospital in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
6. How many times was the patient in the ED in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
7. Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
8. Discharged on seven or more medications? Y or N
9. What is the reason for readmission? Check all that apply:
   - ☐ Chronic condition/exacerbation of disease process
   - ☐ Post-operative complication (wound healing, infection, sepsis)
   - ☐ Post-discharge challenges identified (lack of transport, finances, housing, medical care) but not evaluated for or linked to available resources
   - ☐ Patient/family/caregiver did not understand discharge instructions
   - ☐ Patient/family/caregiver did not obtain medications/supplies
   - ☐ Patient/family/caregiver did not agree with higher level of care recommended at previous discharge (refused HHA or SNF)
   - ☐ Discharge services arranged/made were not followed through by service provider. If checked, add service(s) arranged here:_____
   - ☐ Patient left against medical advice (AMA) from previous admission
10. Did patient have a validated primary care physician (PCP) assignment at previous discharge? Y or N
    - ☐ If yes, was a follow-up appointment made with patient's PCP or specialist at previous discharge and documented in discharge instructions? Y or N
    - ☐ Did patient keep scheduled follow up appointment? Y or N
    - ☐ If no, why (circle one)? Felt better, did not show/cancelled, no transportation, financial barrier, readmitted prior to the appointment, date, or other ____
11. Did patient comply with medication orders after discharge? Y or N
    - ☐ If no, why (circle one)? No transportation, financial barriers/lack of resources, did not want to fill, filled but not taking, had something similar at home, or other_____
12. To identify if other patterns or trends exist, indicate:
    a. Discharge unit_____
    b. Hospitalist group_____Discharging physician_____
    c. What day of the week was the patient discharged (circle one)?
    Sun Mon Tues Wed Thurs Fri Sat
13. Was an evaluation of discharge needs documented by case management on the index admission? Y or N
14. Were there emergency room or observation visits between the index admission and readmission? Y or N

Completed by:_____Date:_____Follow-up action: _____

www.hsag.com/cc-toolkit

HSAG Health Services Advisory Group

Continuing the Care Coordination Journey

Next Steps …

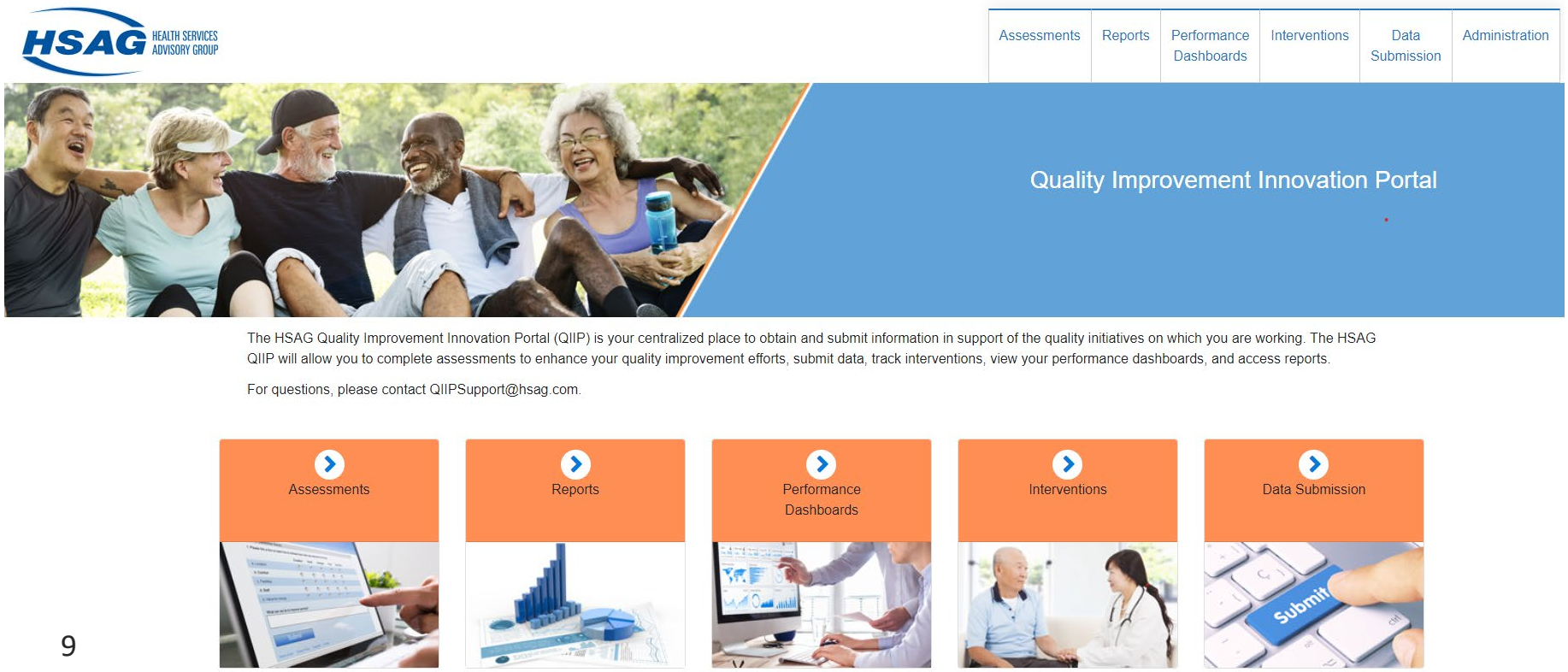
Strategies for Measuring Progress and Monitoring Results

Our Next Care Coordination Quickinar

Measuring Progress: Quality Improvement Innovation Portal (QIIP) Performance Dashboard

Tuesday, April 19, 2022 | 11 a.m. PT

bit.ly/cc-quickinars



Care Coordination Quickinar Series

Care Coordination During a Pandemic
Tuesday, January 18, 2022 | 11:00–11:30 a.m. PT

Care Transitions Assessment Overview
Tuesday, February 1, 2022 | 11:00–11:30 a.m. PT

Gap Root-Cause Analysis (RCA)
Tuesday, February 15, 2022 | 11:00–11:30 a.m. PT

Strategy Tree Development and Implementation
Tuesday, March 1, 2022 | 11:00–11:30 a.m. PT

Readmission Super Utilizers
Tuesday, March 15, 2022 | 11:00–11:30 a.m. PT

Hot Spotting and Resources
Tuesday, April 5, 2022 | 11:00–11:30 a.m. PT

Measuring Progress | QIIP Performance Dashboard
Tuesday, April 19, 2022 | 11:00–11:30 a.m. PT

The Role of Health Equity in Care Coordination
Tuesday, May 3, 2022 | 11:00–11:30 a.m. PT

The Impact of Health Literacy
Tuesday, June 7, 2022 | 11:00–11:30 a.m. PT

Teach-Back: A Strategy to Impact Health Literacy
Tuesday, July 5, 2022 | 11:00–11:30 a.m. PT

Community Collaboration Meetings
Tuesday, August 2, 2022 | 11:00–11:30 a.m. PT

REGISTER NOW! More info at: https://www.hsag.com/cc-quickinars

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing care coordination practices.


Thank you!

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