


Care Coordination Quickinar Series
2. Care Transition Assessment Overview

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Health Services Advisory Group (HSAG)

February 1, 2022

To Do's by Today (Feb. 1, 2022)

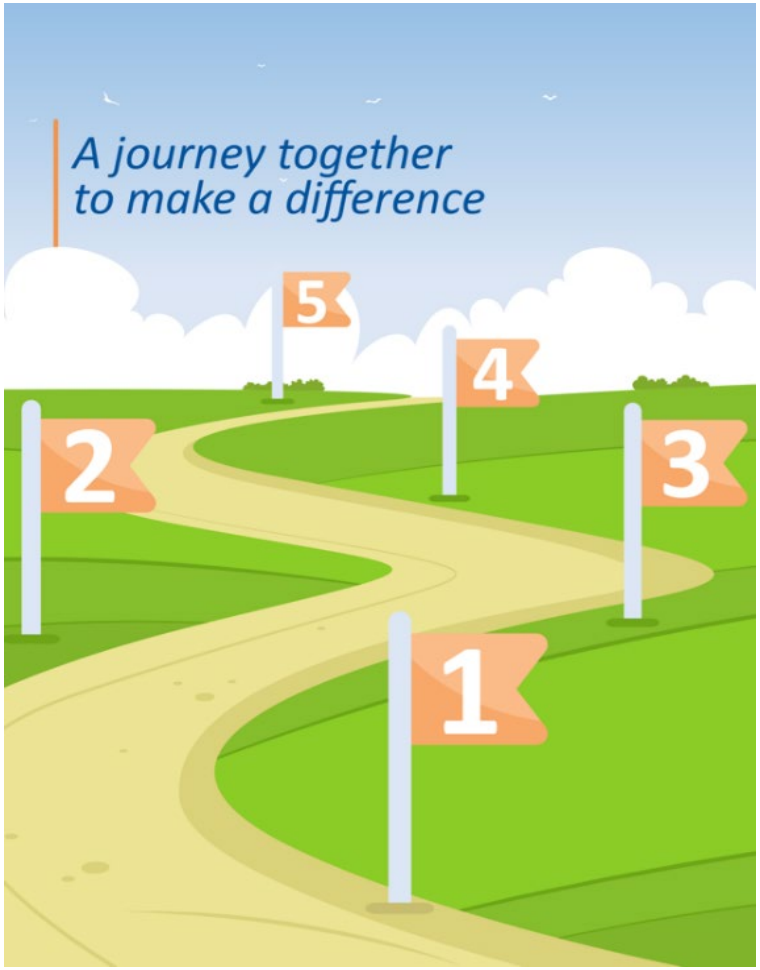
1. Ensure you have QIIP access https://qiip.hsag.com.
2. Visit the care coordination website www.hsag.com/cc-resources.
3. Invite colleagues to register for the entire quickinar series.

OBJECTIVES

- Describe the main categories of the Care Transitions Assessment.
- Discuss experiences, challenges, and lessons learned using the assessment.

2022 Care Coordination Journey

1. **Assessment:** Complete the care transition assessment and root-cause analysis (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.



Care Coordination Question

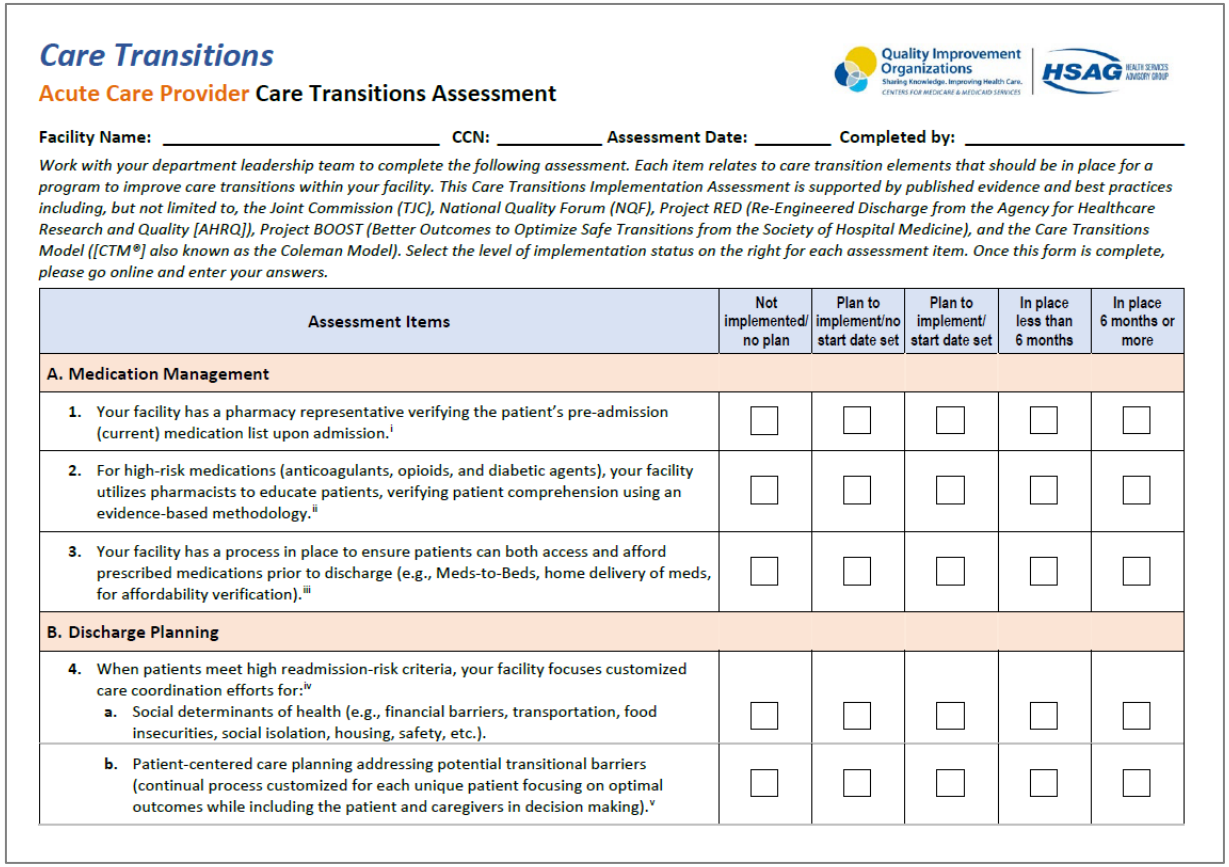
What are some areas your organization needs to work on related to care coordination? (Select all that apply).

- A. Collaborating with community partners
- B. Identifying patients at high risk for readmission
- C. Obtaining an accurate medication history
- D. Tracking and reviewing data on transitional care support
- E. Starting patient education on the day of admission
- F. Other
- G. I don't know

How Do You Know Where to Start?

Care Transitions Assessment

- Assesses the current status of care transition initiatives
- Identifies actionable improvement opportunities
- Measures progress



Care Transitions

Acute Care Provider Care Transitions Assessment

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Facility Name: _____ **CCN:** _____ **Assessment Date:** _____ **Completed by:** _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Medication Management					
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission.[i]	☐	☐	☐	☐	☐
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.[ii]	☐	☐	☐	☐	☐
3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification).[iii]	☐	☐	☐	☐	☐
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses customized care coordination efforts for:[iv] a. Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	☐	☐	☐	☐	☐
b. Patient-centered care planning addressing potential transitional barriers (continual process customized for each unique patient focusing on optimal outcomes while including the patient and caregivers in decision making).[v]	☐	☐	☐	☐	☐

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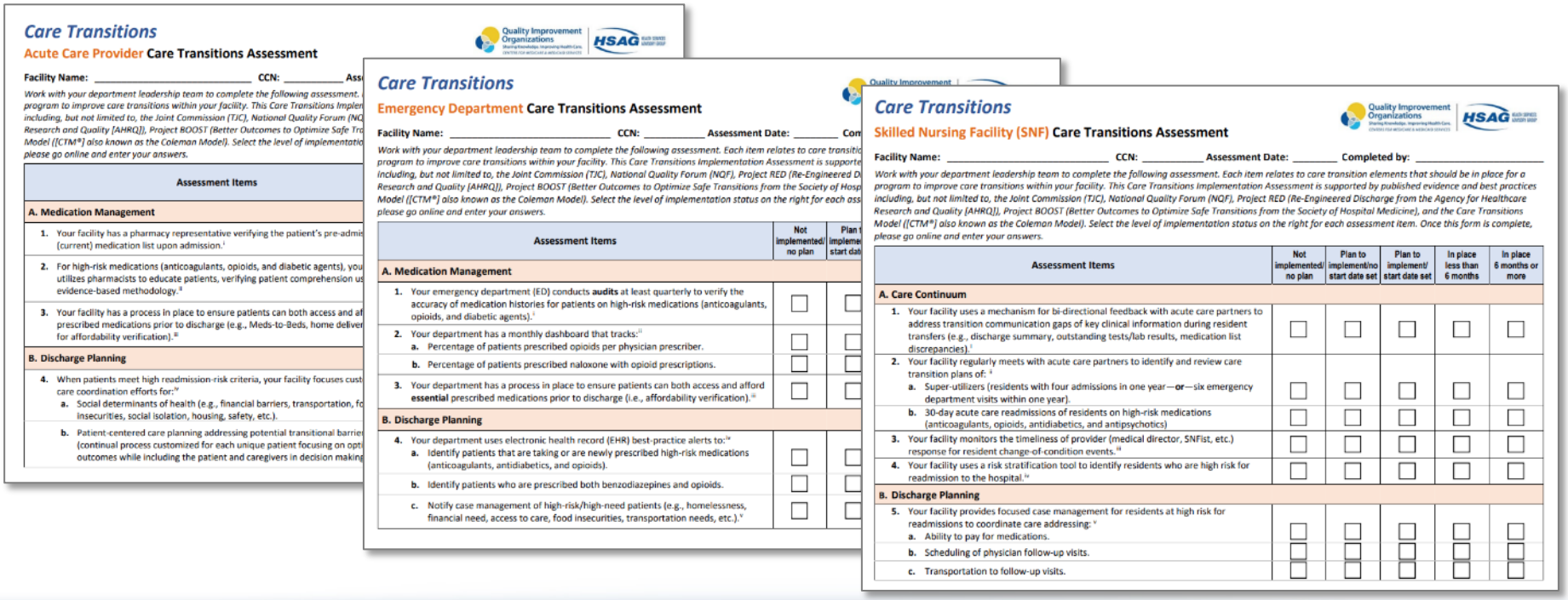
Who Are the Assessments For?

Assessments have been developed to align with each setting's specific needs.

Acute Care → Emergency Department → Skilled Nursing



Care Transitions

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Care Transitions

Emergency Department Care Transitions Assessment

Facility Name: _____ CCN: _____ Assessment Date: _____ Con

Work with your department leadership team to complete the following assessment. Each item relates to care transiti program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supporte including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered D Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hosp Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each ass please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan t implem start dat
A. Medication Management		
1. Your emergency department (ED) conducts **audits** at least quarterly to verify the accuracy of medication histories for patients on high-risk medications (anticoagulants, opioids, and diabetic agents).[i]	☐	☐
2. Your department has a monthly dashboard that tracks:[ii]		
a. Percentage of patients prescribed opioids per physician prescriber.	☐	☐
b. Percentage of patients prescribed naloxone with opioid prescriptions.	☐	☐
3. Your department has a process in place to ensure patients can both access and afford **essential** prescribed medications prior to discharge (i.e., affordability verification).[iii]	☐	☐
B. Discharge Planning		
4. Your department uses electronic health record (EHR) best-practice alerts to:[iv]		
a. Identify patients that are taking or are newly prescribed high-risk medications (anticoagulants, antidiabetics, and opioids).	☐	☐
b. Identify patients who are prescribed both benzodiazepines and opioids.	☐	☐
c. Notify case management of high-risk/high-need patients (e.g., homelessness, financial need, access to care, food insecurities, transportation needs, etc.).[v]	☐	☐

Care Transitions

Skilled Nursing Facility (SNF) Care Transitions Assessment

Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Care Continuum					
1. Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication gaps of key clinical information during resident transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies).[i]	☐	☐	☐	☐	☐
2. Your facility regularly meets with acute care partners to identify and review care transition plans of:[ii]					
a. Super-utilizers (residents with four admissions in one year—**or**—six emergency department visits within one year).	☐	☐	☐	☐	☐
b. 30-day acute care readmissions of residents on high-risk medications (anticoagulants, opioids, antidiabetics, and antipsychotics)	☐	☐	☐	☐	☐
3. Your facility monitors the timeliness of provider (medical director, SNFist, etc.) response for resident change-of-condition events.[iii]	☐	☐	☐	☐	☐
4. Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital.[iv]	☐	☐	☐	☐	☐
B. Discharge Planning					
5. Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing:[v]					
a. Ability to pay for medications.	☐	☐	☐	☐	☐
b. Scheduling of physician follow-up visits.	☐	☐	☐	☐	☐
c. Transportation to follow-up visits.	☐	☐	☐	☐	☐

Assessment Format

Acute Care & Emergency Department

- Medication Management
- Discharge Planning
- Care Continuum
- Facility Infrastructure

Skilled Nursing Facility

- Care Continuum
- Discharge Planning
- Quality Improvement of Care Transitions

Levels of Implementation

Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐

Sample Implementation Question

Category: Discharge Planning

Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing:

a) Ability to pay for medications.

b) Scheduling of physician follow-up visits.

c) Transportation to follow-up visits.

d) Availability of family/friends to assist patient/resident at time of discharge.

Evidence-Based Strategies

Every question on the assessment is supported by scientific evidence found in literature. Rationales and references can be found at the end of each of the assessments.

Rationale: Residents at high risk for readmission require increased care coordination planning to address social determinants of health. Focused coordination efforts for this population reduces the probability for subsequent rehospitalization.

References:

1. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
2. http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
3. https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/quality-improvements-and-interventions

A Hospital Perspective

Rachel Vance, BSN, RN, CPHQ
Quality Services Director
Parkview Community Hospital
Medical Center

Tips for Completing the Assessment

Utilize a multidisciplinary team when completing the assessment.

Keep an open mind and consider everyone's input.

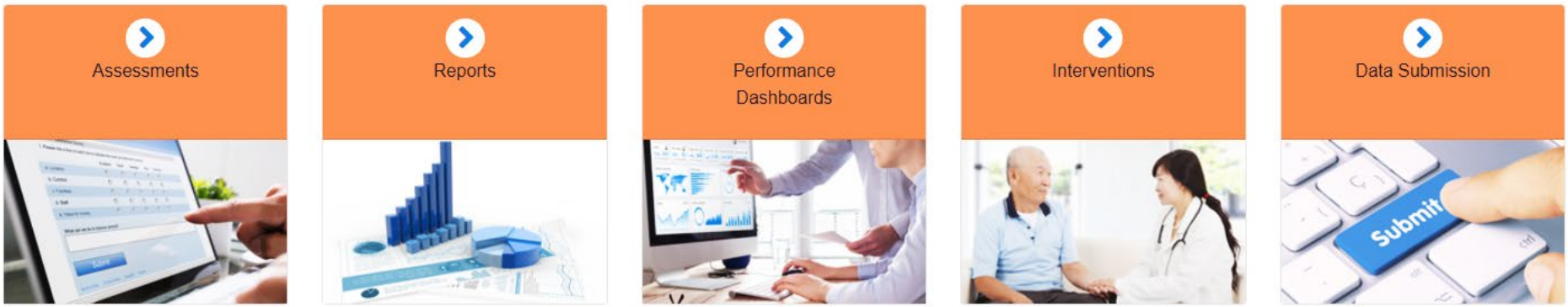
Prioritize opportunities for improvement and focus on systems not individuals.

Start small and primarily focus on one element from the assessment.

Why Document Assessment Results in QIIP

- Provides a historical record—storing previous assessment answers allows you to generate reports for your QI committees.
- HSAG can track and trend community progress and share results.

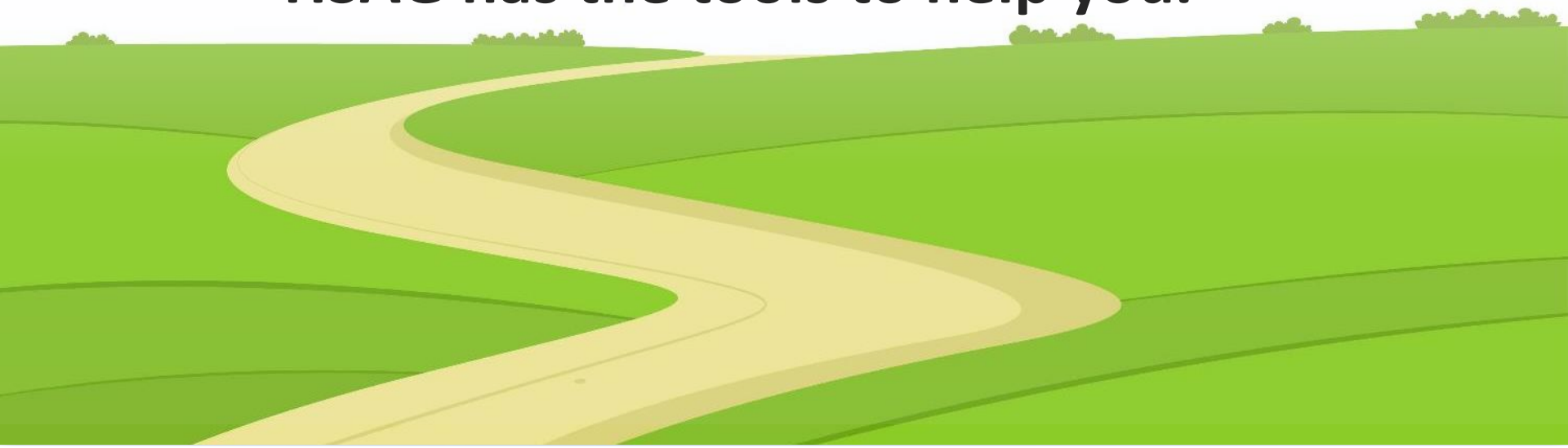
https://qiip.hsag.com



Continuing the Care Coordination Journey

- The assessment is the first tool required to identify and prioritize opportunities for improvement.
- Now the team needs to get a better understanding of the gap and its root causes.

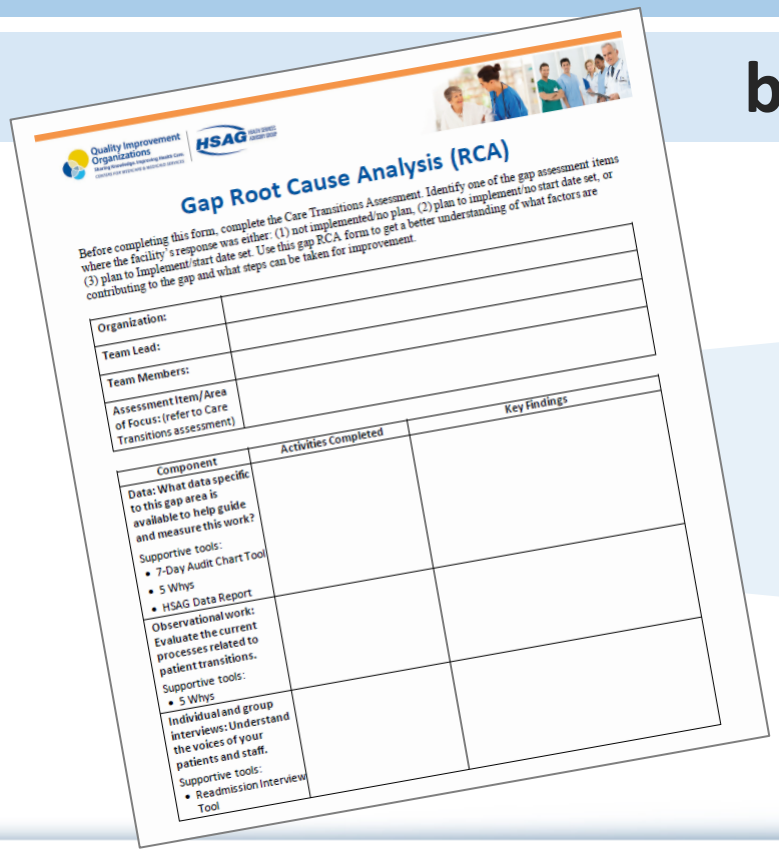
HSAG has the tools to help you.



Our Next Care Coordination Quickinar

Gap Root-Cause Analysis (RCA)

Tuesday, February 15, 2022 | 11 a.m. PT



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Gap Root Cause Analysis (RCA)

Before completing this form, complete the Care Transitions Assessment. Identify one of the gap assessment items where the facility's response was either: (1) not implemented/no plan, (2) plan to implement/no start date set, or (3) plan to Implement/start date set. Use this gap RCA form to get a better understanding of what factors are contributing to the gap and what steps can be taken for improvement.

Organization:	
Team Lead:	
Team Members:	
Assessment Item/Area of Focus: (refer to Care Transitions assessment)	

Component	Activities Completed	Key Findings
Data: What data specific to this gap area is available to help guide and measure this work? Supportive tools: • 7-Day Audit Chart Tool • 5 Whys • HSAG Data Report		
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys		
Individual and group interviews: Understand the voices of your patients and staff. Supportive tools: • Readmission Interview Tool		

bit.ly/cc-quickinars

Guest speaker joining us!
Think Reliability: Your Trusted Authority on Root-Cause Analysis

HSAG Health Services Advisory Group

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

To Do's by the Next Quickinar (Feb. 15, 2022)

1. Form a team and complete the care transitions assessment.
2. Enter assessment results into QIIP https://qiip.hsag.com.
3. Review an assessment reference related to one of your gap areas.

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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