


Care Coordination Quickinar Series: A Deeper Dive Into Readmission Data

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Health Services Advisory Group (HSAG)

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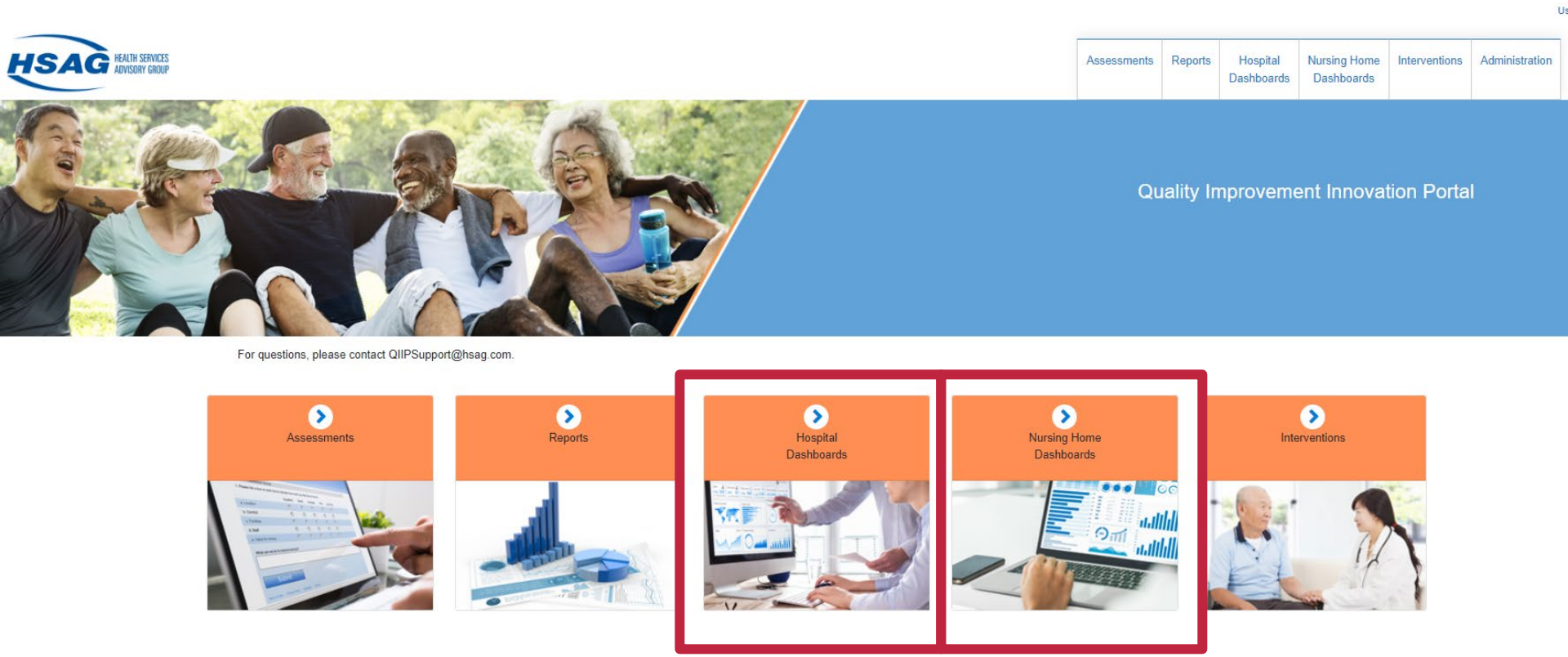
OBJECTIVES

- Discover how to access the performance dashboard in the HSAG Quality Improvement Innovation Portal (QIIP) data application.
- Examine the features and data elements available on the QIIP dashboard.
- Review how to use the dashboard to guide and measure your readmissions progress.
- Identify readmissions data as the basis for implementing a quality improvement project/area of focus.

Tracking Readmissions Data in the QIIP

- Assists in identifying where readmissions are occurring and where to focus efforts.
- Measures progress over time.
- Uses the data to tell a story.

QIIP Readmissions Portal Home Page



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QIIP Hospital Readmissions Dashboard

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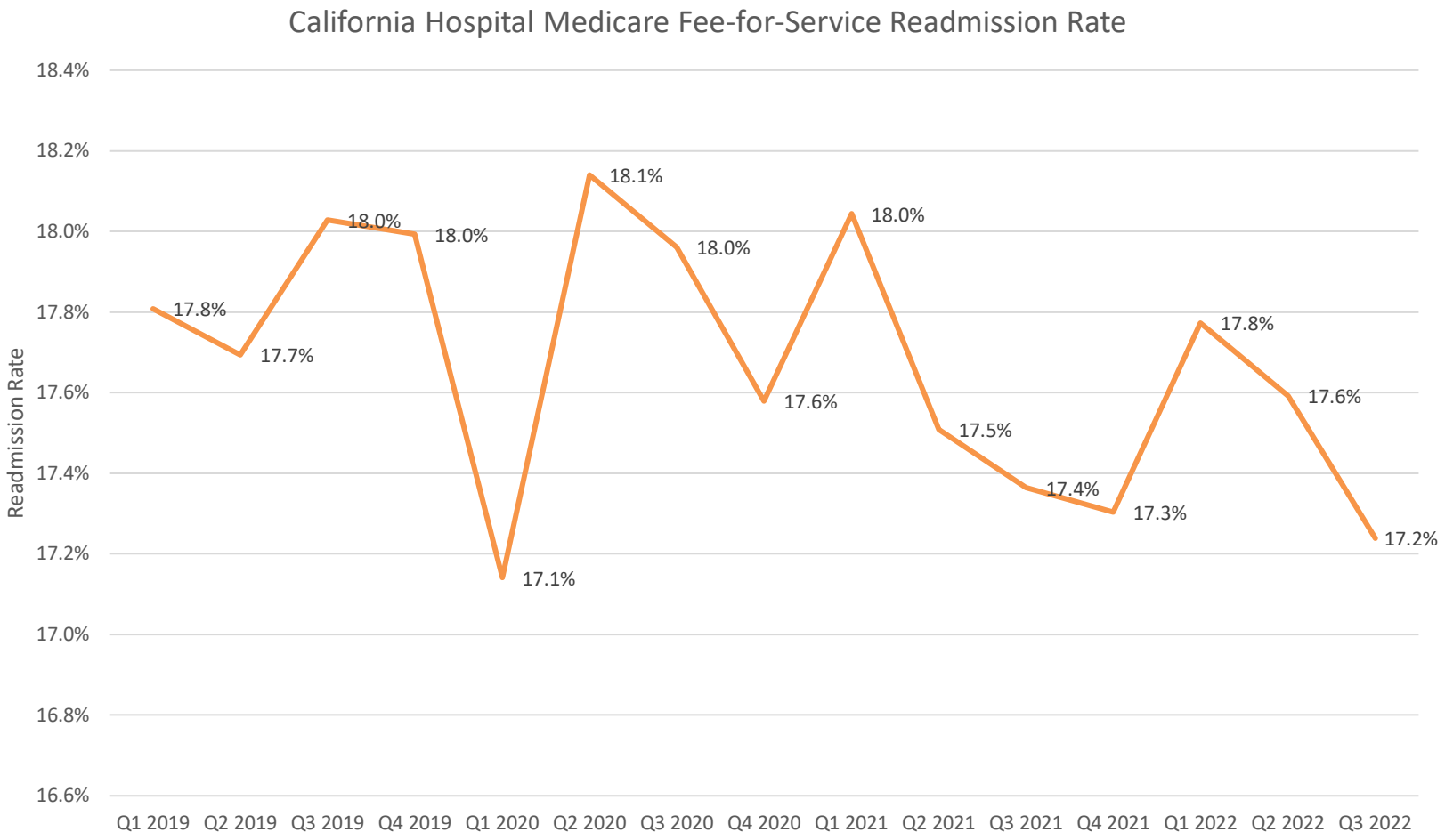
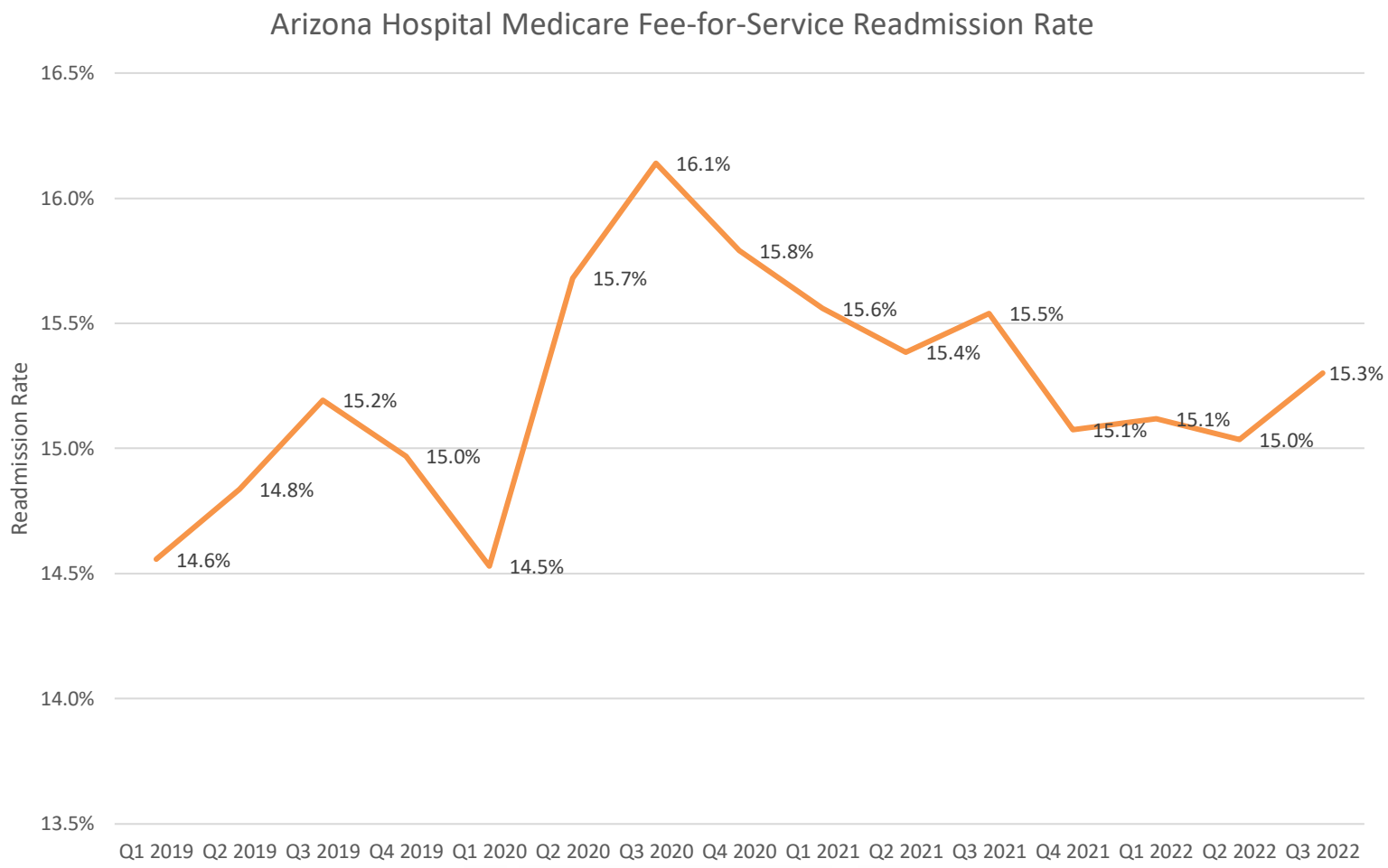
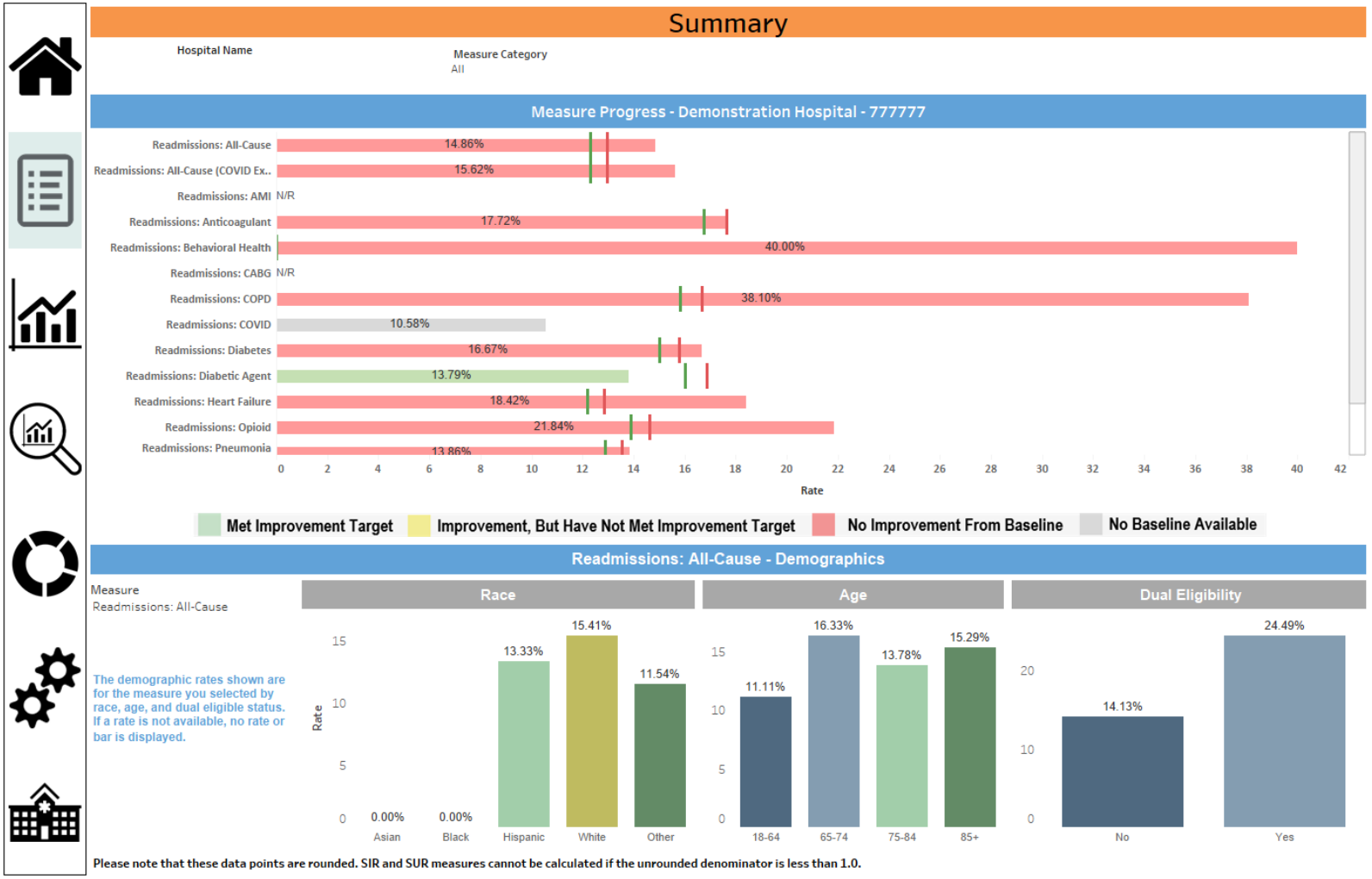
California Hospital Medicare Fee-for-Service (FFS) Readmission Rate by Quarter (Jan. 2019–Sept. 2022)



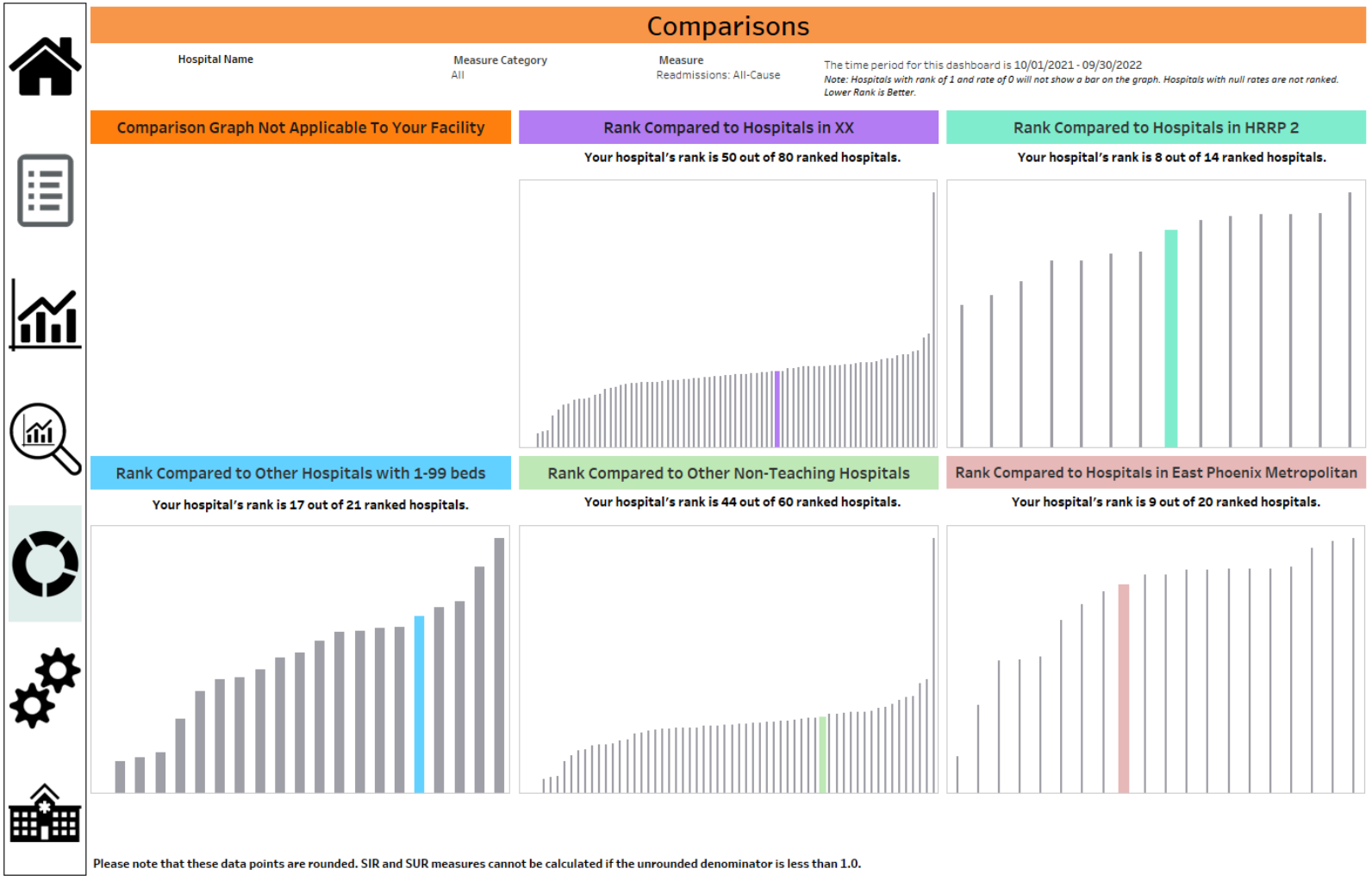
Arizona Hospital Medicare FFS Readmission Rate by Quarter (Jan. 2019–Sept. 2022)



Readmissions Summary Data



Readmissions Comparison Data



Readmissions Discharge Distribution

Readmission Discharge Distribution

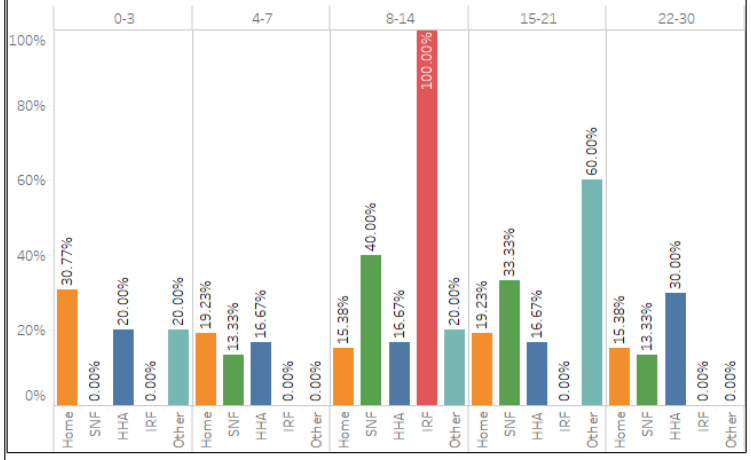
Hospital Name

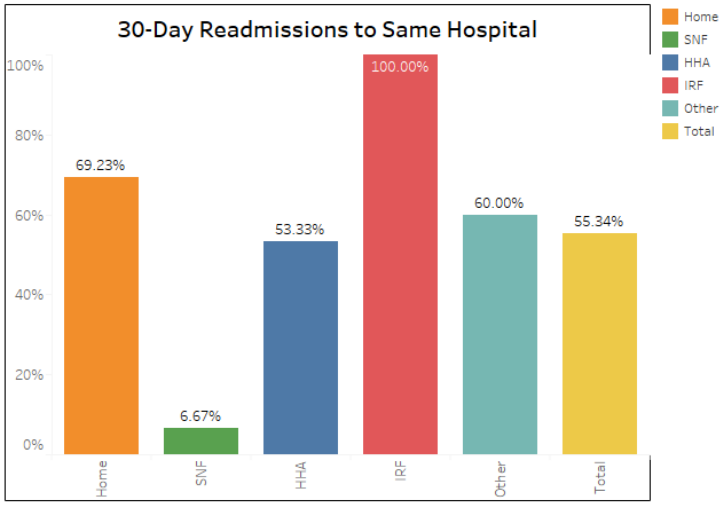
Measure
Readmissions: All-Cause

The time period for this dashboard is 10/01/2021 - 09/30/2022
If a rate is not available, an N/R (no rate) is displayed.

Setting Discharged To *	30-Day Readmit Rate	Discharges	Readmits Within 30 Days	30-Day Readmits to Same Hospital		30-Day Readmits to Different Hospital		Days to Readmission									
								0-3 Days		4-7 Days		8-14 Days		15-21 Days		22-30 Days	
				N	%	N	%	N	%	N	%	N	%	N	%	N	%
Home	12.50%	416	52	36	69.23%	16	30.77%	16	30.77%	10	19.23%	8	15.38%	10	19.23%	8	15.38%
SNF	13.64%	110	15	1	6.67%	14	93.33%	0	0.00%	2	13.33%	6	40.00%	5	33.33%	2	13.33%
HHA	25.42%	118	30	16	53.33%	14	46.67%	6	20.00%	5	16.67%	5	16.67%	5	16.67%	9	30.00%
IRF	7.14%	14	1	1	100.00%	0	0.00%	0	0.00%	0	0.00%	1	100.00%	0	0.00%	0	0.00%
Other	14.29%	35	5	3	60.00%	2	40.00%	1	20.00%	0	0.00%	1	20.00%	3	60.00%	0	0.00%
Total	14.86%	693	103	57	55.34%	46	44.66%	23	22.33%	17	16.50%	21	20.39%	23	22.33%	19	18.45%

*SNF=Skilled Nursing Facility, HHA=Home Health Agency, and IRF=Inpatient Rehabilitation Facility.





QIIP Nursing Home Readmissions Dashboard

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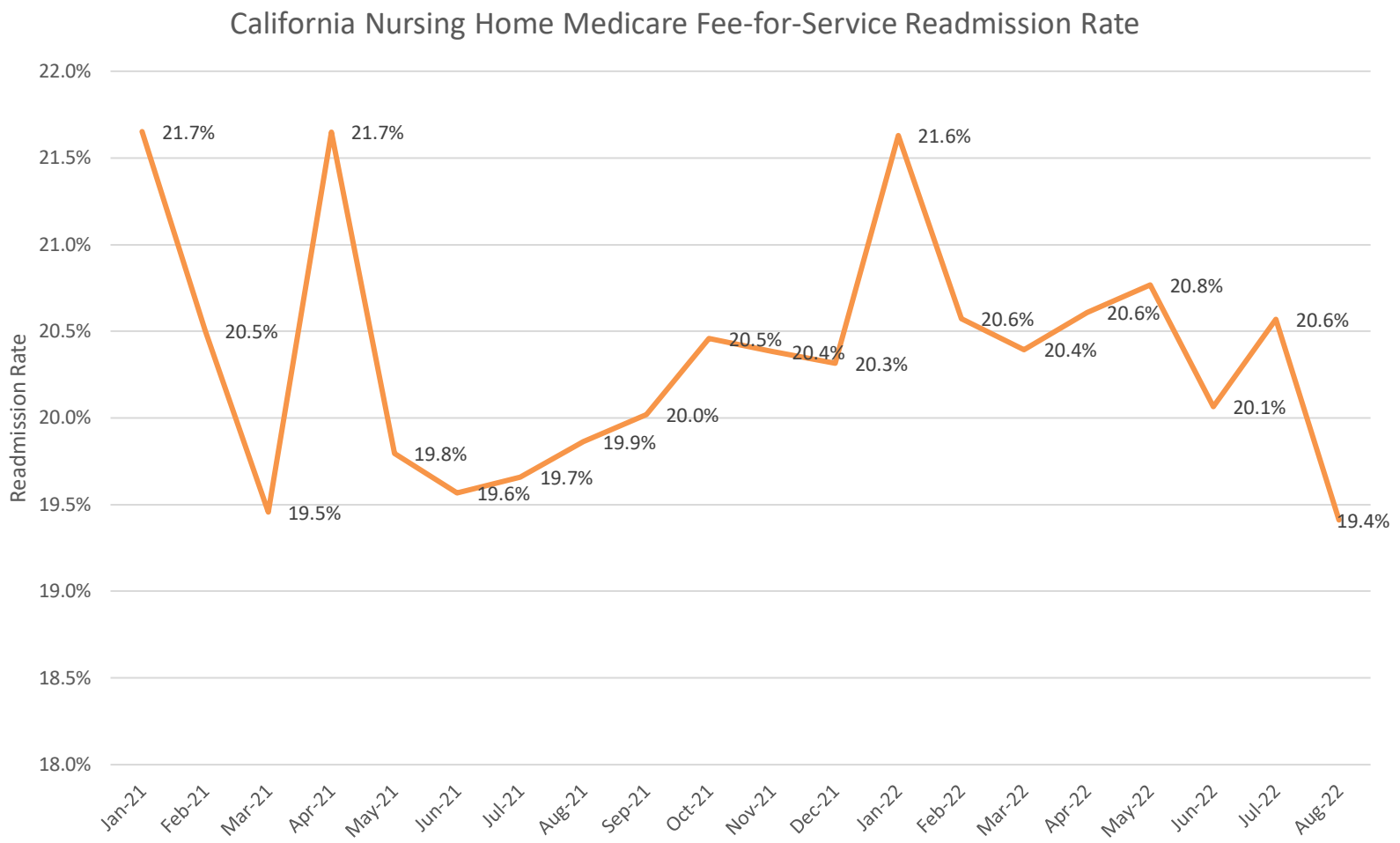
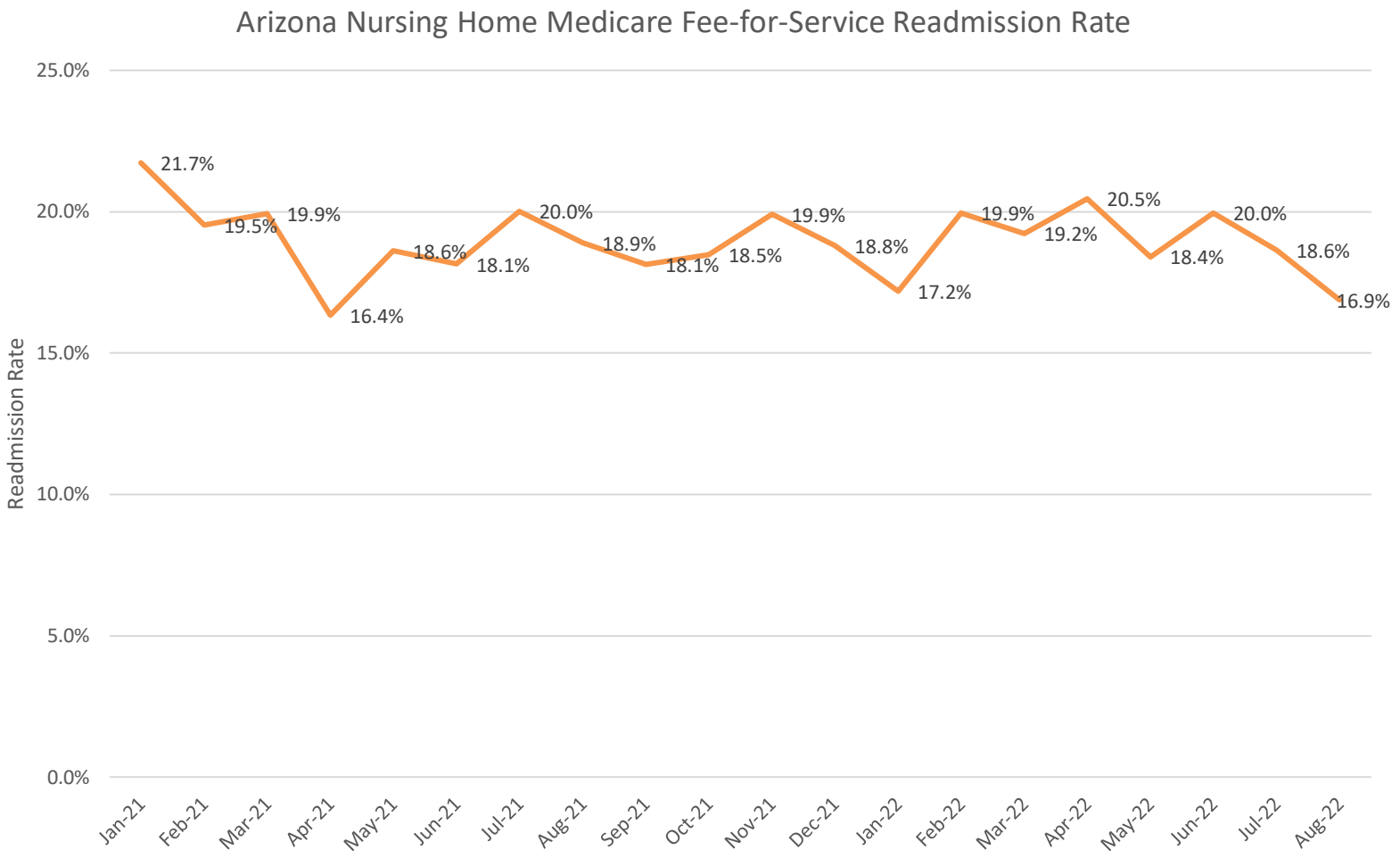
California Nursing Home Readmission Rate by Month (Jan. 2021–Aug. 2022)

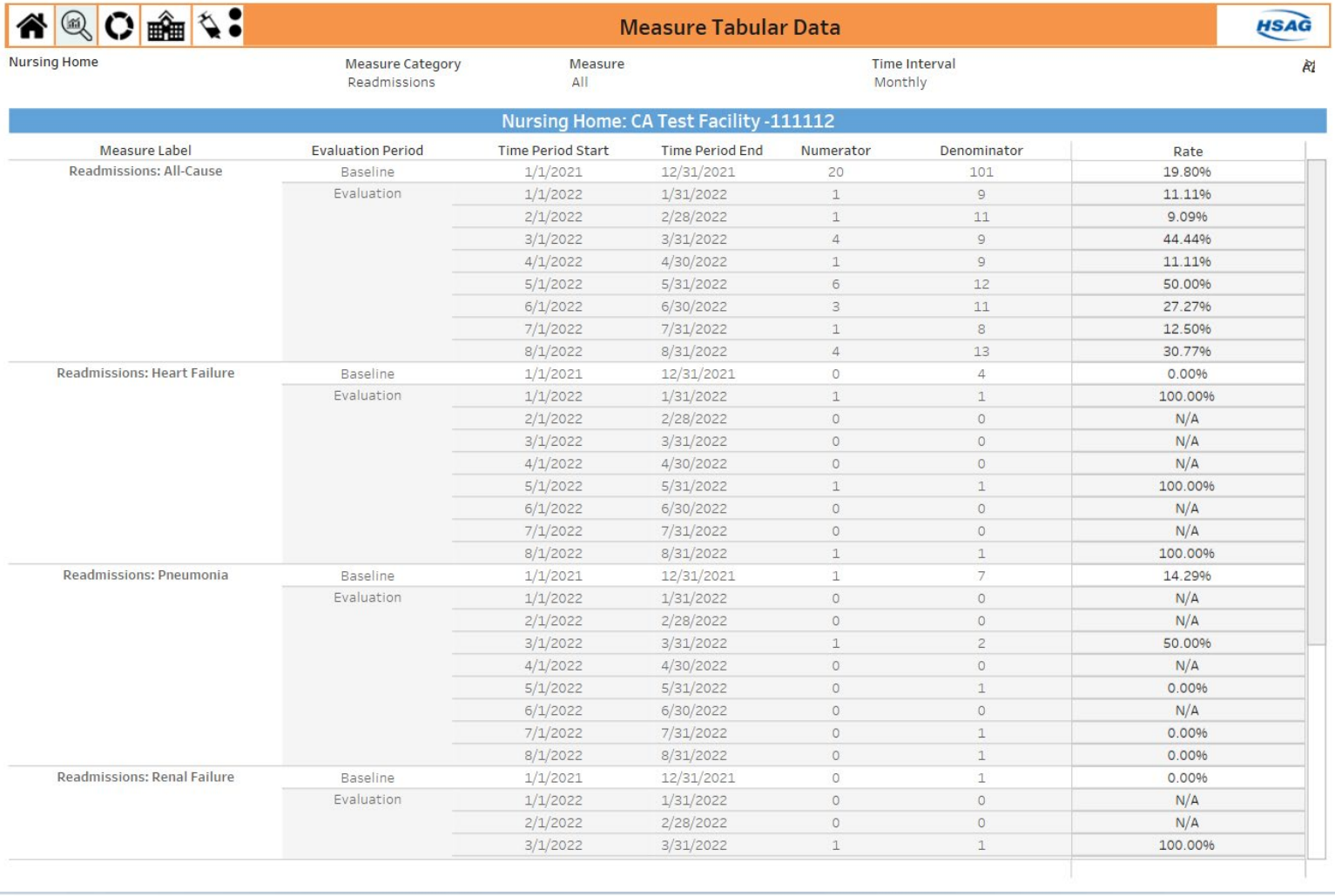


Arizona Nursing Home Readmission Rate by Month (Jan. 2021–Aug. 2022)



Readmissions Summary Data

Readmissions Tabular Data



Measure Tabular Data

HSAG

Nursing Home

Measure Category: Readmissions

Measure: All

Time Interval: Monthly

Nursing Home: CA Test Facility -111112

Measure Label	Evaluation Period	Time Period Start	Time Period End	Numerator	Denominator	Rate
Readmissions: All-Cause	Baseline	1/1/2021	12/31/2021	20	101	19.80%
	Evaluation	1/1/2022	1/31/2022	1	9	11.11%
		2/1/2022	2/28/2022	1	11	9.09%
		3/1/2022	3/31/2022	4	9	44.44%
		4/1/2022	4/30/2022	1	9	11.11%
		5/1/2022	5/31/2022	6	12	50.00%
		6/1/2022	6/30/2022	3	11	27.27%
		7/1/2022	7/31/2022	1	8	12.50%
		8/1/2022	8/31/2022	4	13	30.77%
Readmissions: Heart Failure	Baseline	1/1/2021	12/31/2021	0	4	0.00%
	Evaluation	1/1/2022	1/31/2022	1	1	100.00%
		2/1/2022	2/28/2022	0	0	N/A
		3/1/2022	3/31/2022	0	0	N/A
		4/1/2022	4/30/2022	0	0	N/A
		5/1/2022	5/31/2022	1	1	100.00%
		6/1/2022	6/30/2022	0	0	N/A
		7/1/2022	7/31/2022	0	0	N/A
		8/1/2022	8/31/2022	1	1	100.00%
Readmissions: Pneumonia	Baseline	1/1/2021	12/31/2021	1	7	14.29%
	Evaluation	1/1/2022	1/31/2022	0	0	N/A
		2/1/2022	2/28/2022	0	0	N/A
		3/1/2022	3/31/2022	1	2	50.00%
		4/1/2022	4/30/2022	0	0	N/A
		5/1/2022	5/31/2022	0	1	0.00%
		6/1/2022	6/30/2022	0	0	N/A
		7/1/2022	7/31/2022	0	1	0.00%
		8/1/2022	8/31/2022	0	1	0.00%
Readmissions: Renal Failure	Baseline	1/1/2021	12/31/2021	0	1	0.00%
	Evaluation	1/1/2022	1/31/2022	0	0	N/A
		2/1/2022	2/28/2022	0	0	N/A
		3/1/2022	3/31/2022	1	1	100.00%

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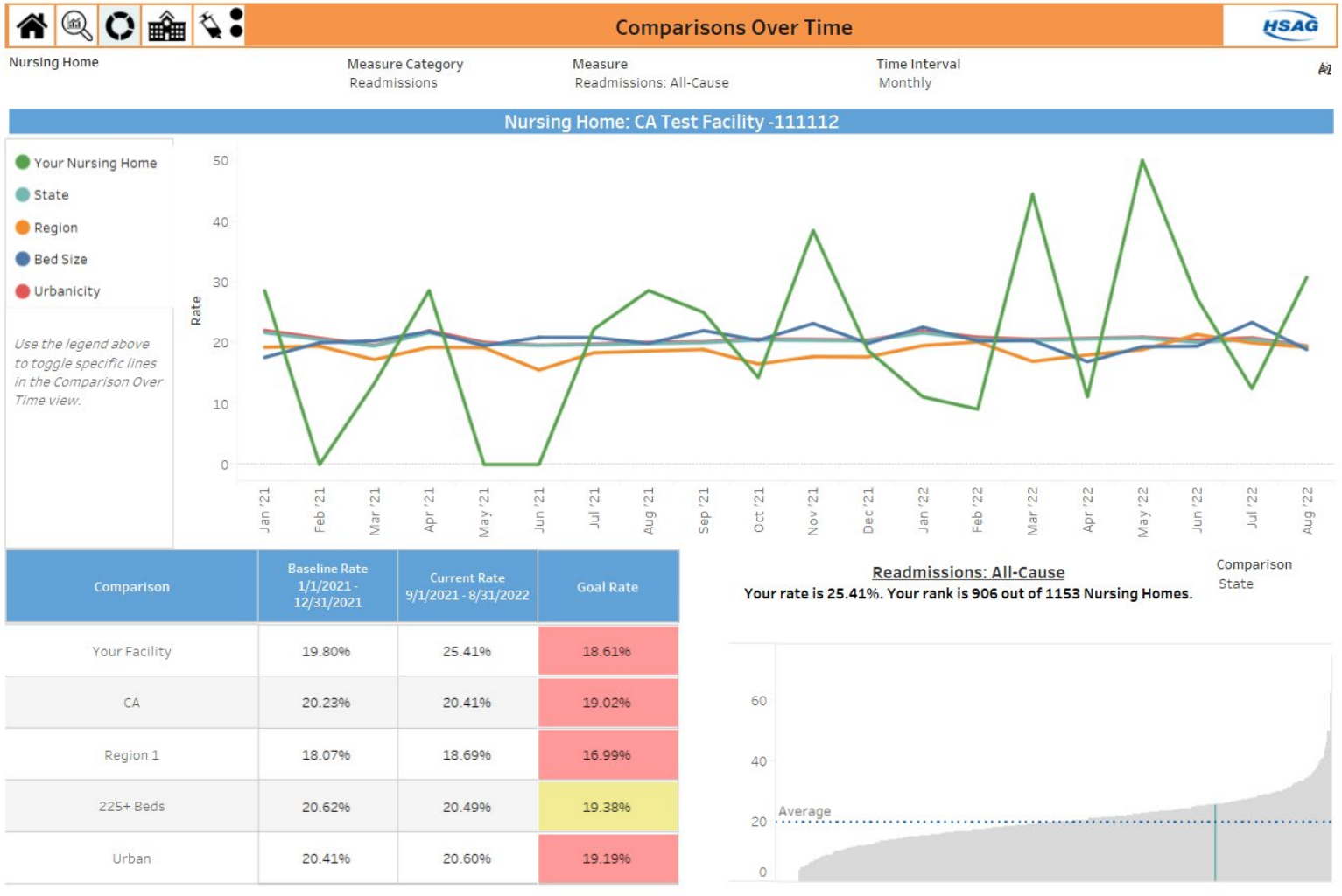
Readmissions Comparison Data



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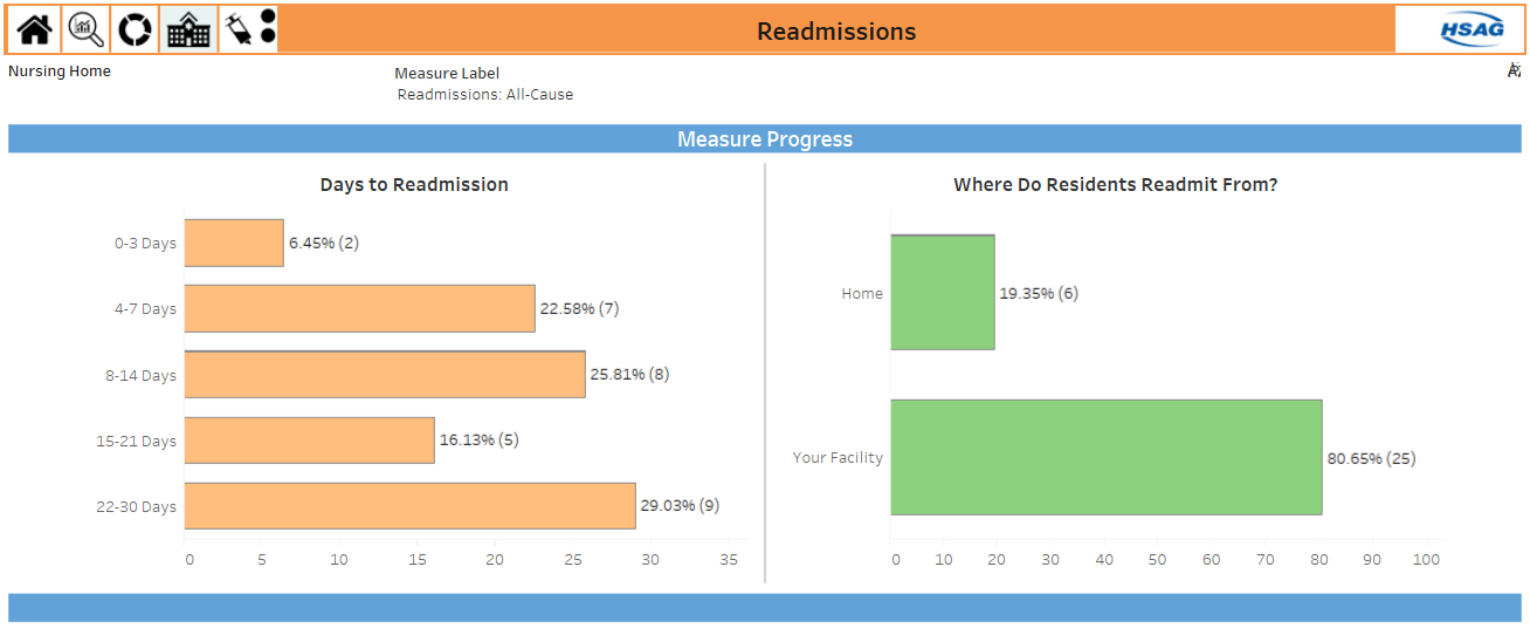
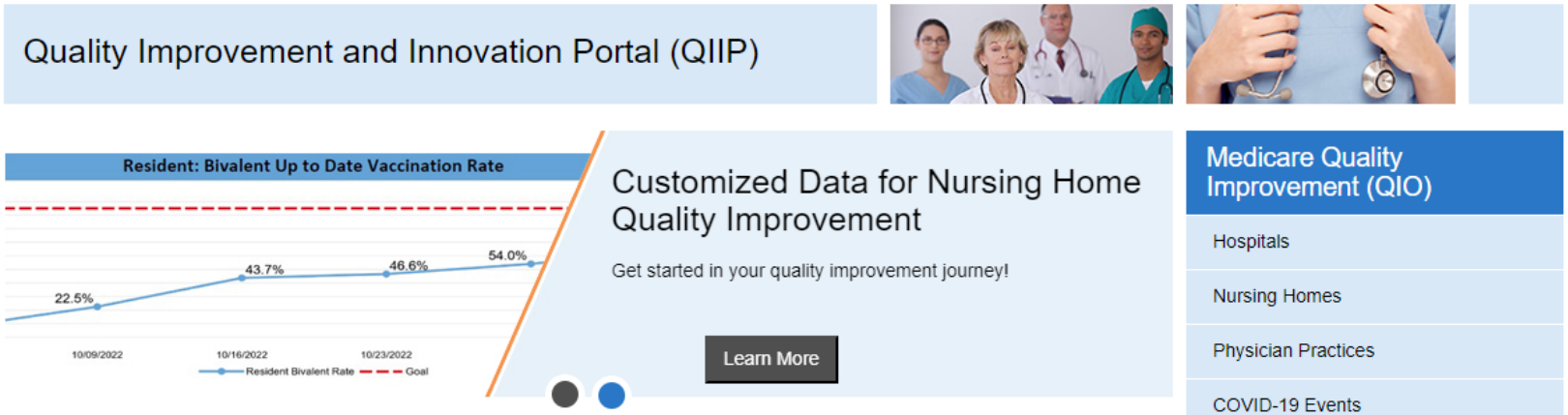


QIIP Data Portal Access

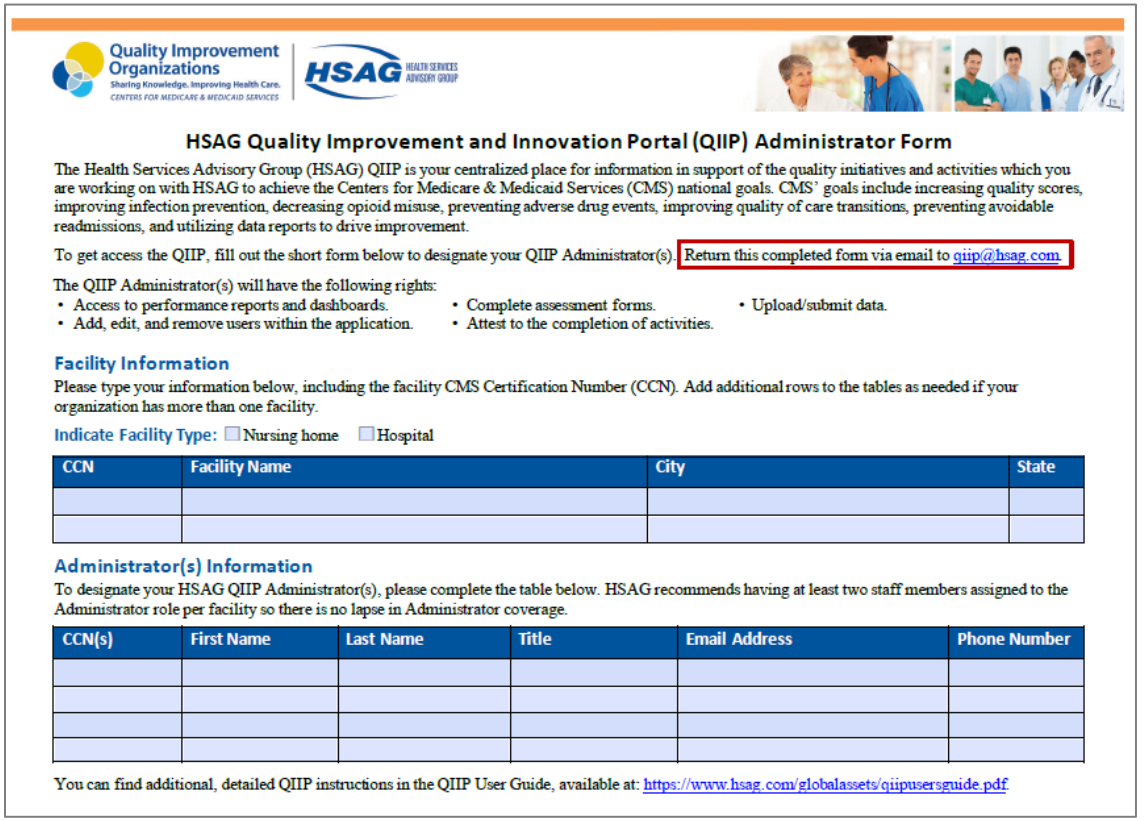


www.hsag.com/qiip-start

QIIP Registration Form

Registration form instructions:

1. Download form.
2. Complete facility information.
3. Include staff you wish to have access to the data portal.
4. Email completed form to **QIIP@hsag.com**.



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

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG Quality Improvement and Innovation Portal (QIIP) Administrator Form

The Health Services Advisory Group (HSAG) QIIP is your centralized place for information in support of the quality initiatives and activities which you are working on with HSAG to achieve the Centers for Medicare & Medicaid Services (CMS) national goals. CMS' goals include increasing quality scores, improving infection prevention, decreasing opioid misuse, preventing adverse drug events, improving quality of care transitions, preventing avoidable readmissions, and utilizing data reports to drive improvement.

To get access the QIIP, fill out the short form below to designate your QIIP Administrator(s). Return this completed form via email to qiip@hsag.com.

The QIIP Administrator(s) will have the following rights:
- Access to performance reports and dashboards.
- Add, edit, and remove users within the application.
- Complete assessment forms.
- Attest to the completion of activities.
- Upload/submit data.

Facility Information

Please type your information below, including the facility CMS Certification Number (CCN). Add additional rows to the tables as needed if your organization has more than one facility.

Indicate Facility Type: ☐ Nursing home ☐ Hospital

CCN	Facility Name	City	State

Administrator(s) Information

To designate your HSAG QIIP Administrator(s), please complete the table below. HSAG recommends having at least two staff members assigned to the Administrator role per facility so there is no lapse in Administrator coverage.

CCN(s)	First Name	Last Name	Title	Email Address	Phone Number

You can find additional, detailed QIIP instructions in the QIIP User Guide, available at: https://www.hsag.com/globalassets/qiipusersguide.pdf.

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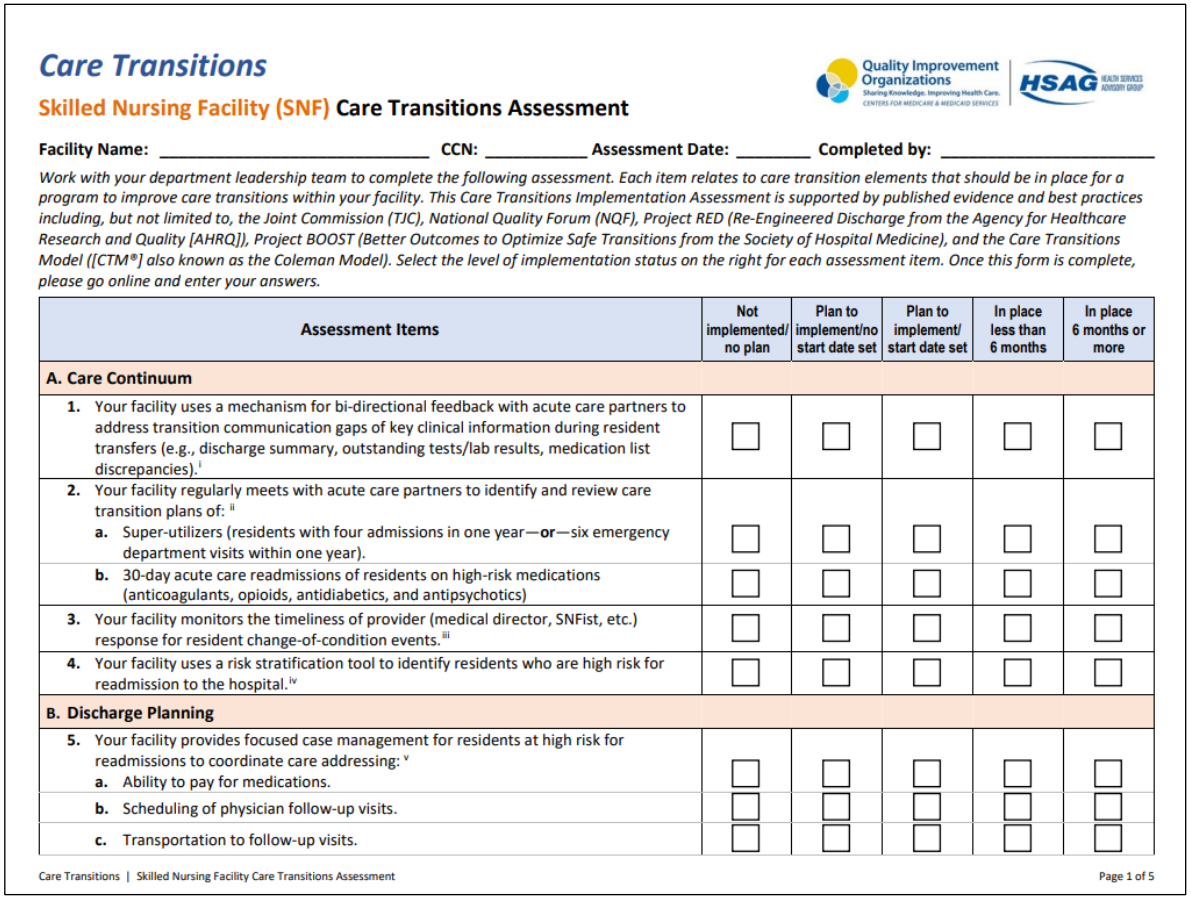
Turning Data Into Action

Care Transitions Assessment

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



Care Transitions

Skilled Nursing Facility (SNF) 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. 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.	☐	☐	☐	☐	☐

Care Transitions | Skilled Nursing Facility Care Transitions Assessment — Page 1 of 5

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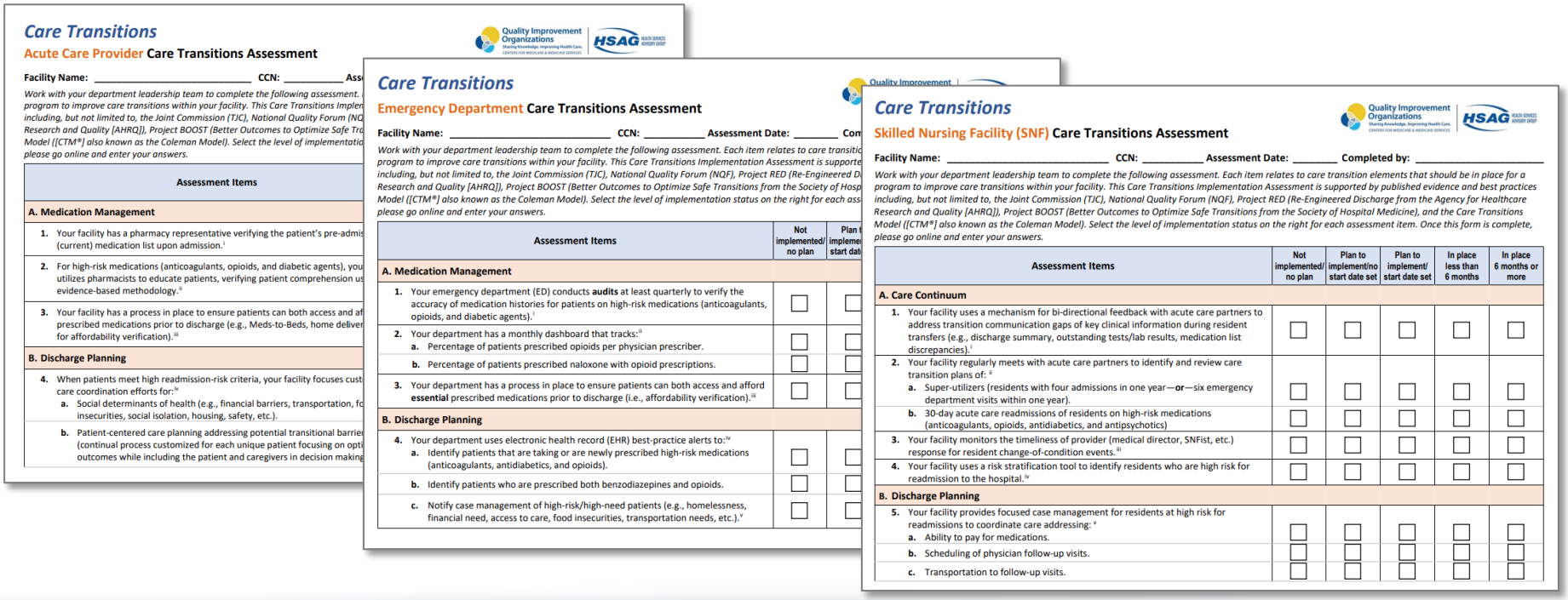
Who Are the Assessments For?

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

Acute Care → Emergency Department → Skilled Nursing



Care Transitions

Acute Care Provider Care Transitions Assessment

Facility Name: _____ CCN: _____ Ass

Work with your department leadership team to complete the following assessment. … program to improve care transitions within your facility. This Care Transitions Implen … including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQ … Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Tra … Model ([CTM®] also known as the Coleman Model). Select the level of implementatio … please go online and enter your answers.

Assessment Items
A. Medication Management
1. Your facility has a pharmacy representative verifying the patient's pre-admis … (current) medication list upon admission.[i]
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), you … utilizes pharmacists to educate patients, verifying patient comprehension us … evidence-based methodology.[ii]
3. Your facility has a process in place to ensure patients can both access and af … prescribed medications prior to discharge (e.g., Meds-to-Beds, home deliver … for affordability verification).[iii]
B. Discharge Planning
4. When patients meet high readmission-risk criteria, your facility focuses cust … care coordination efforts for:[iv]
a. Social determinants of health (e.g., financial barriers, transportation, fo … insecurities, social isolation, housing, safety, etc.).
b. Patient-centered care planning addressing potential transitional barrie … (continual process customized for each unique patient focusing on opti … outcomes while including the patient and caregivers in decision making

Care Transitions

Emergency Department Care Transitions Assessment

Facility Name: _____ CCN: _____ Assessment Date: _____ Com

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.

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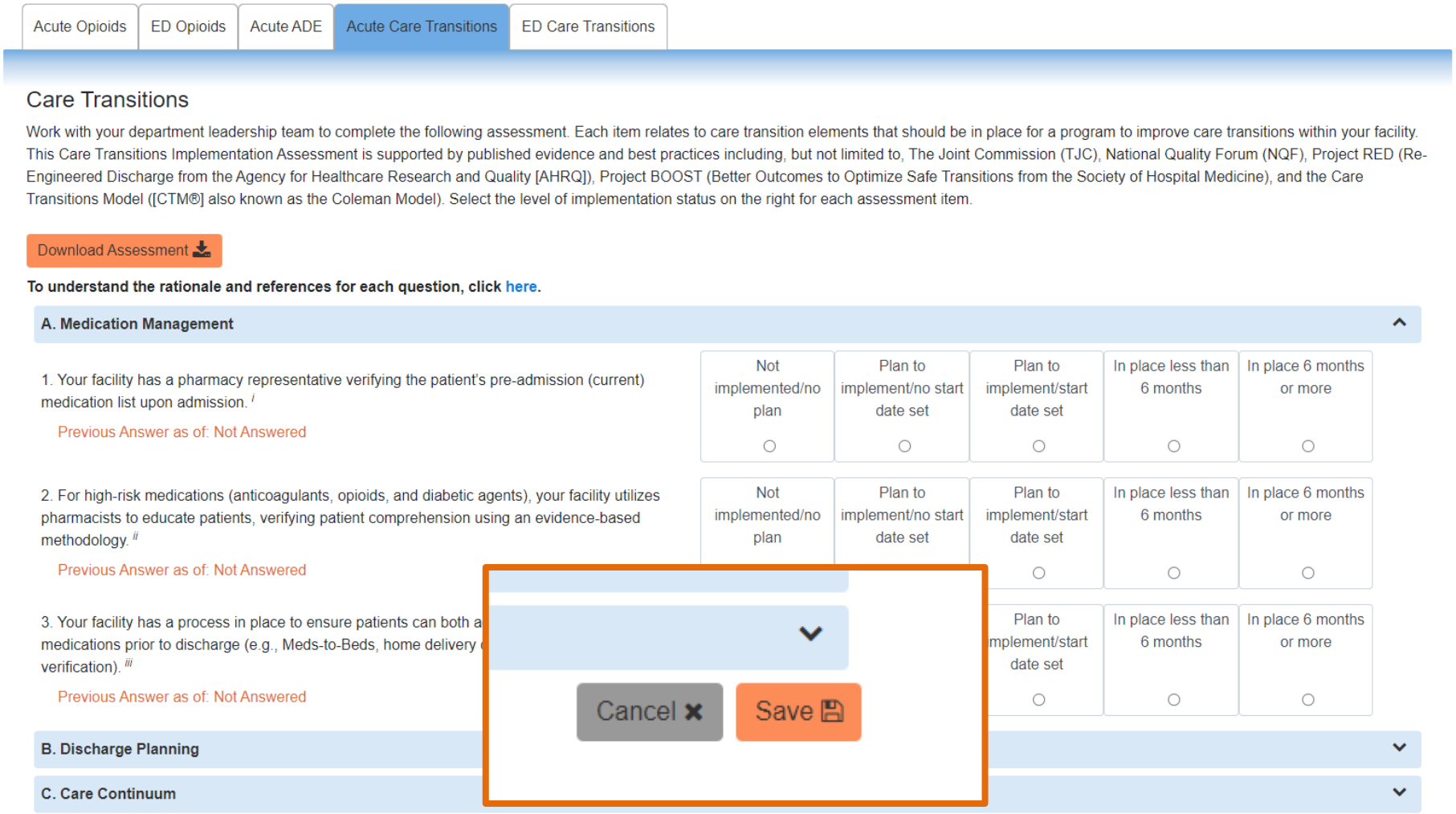
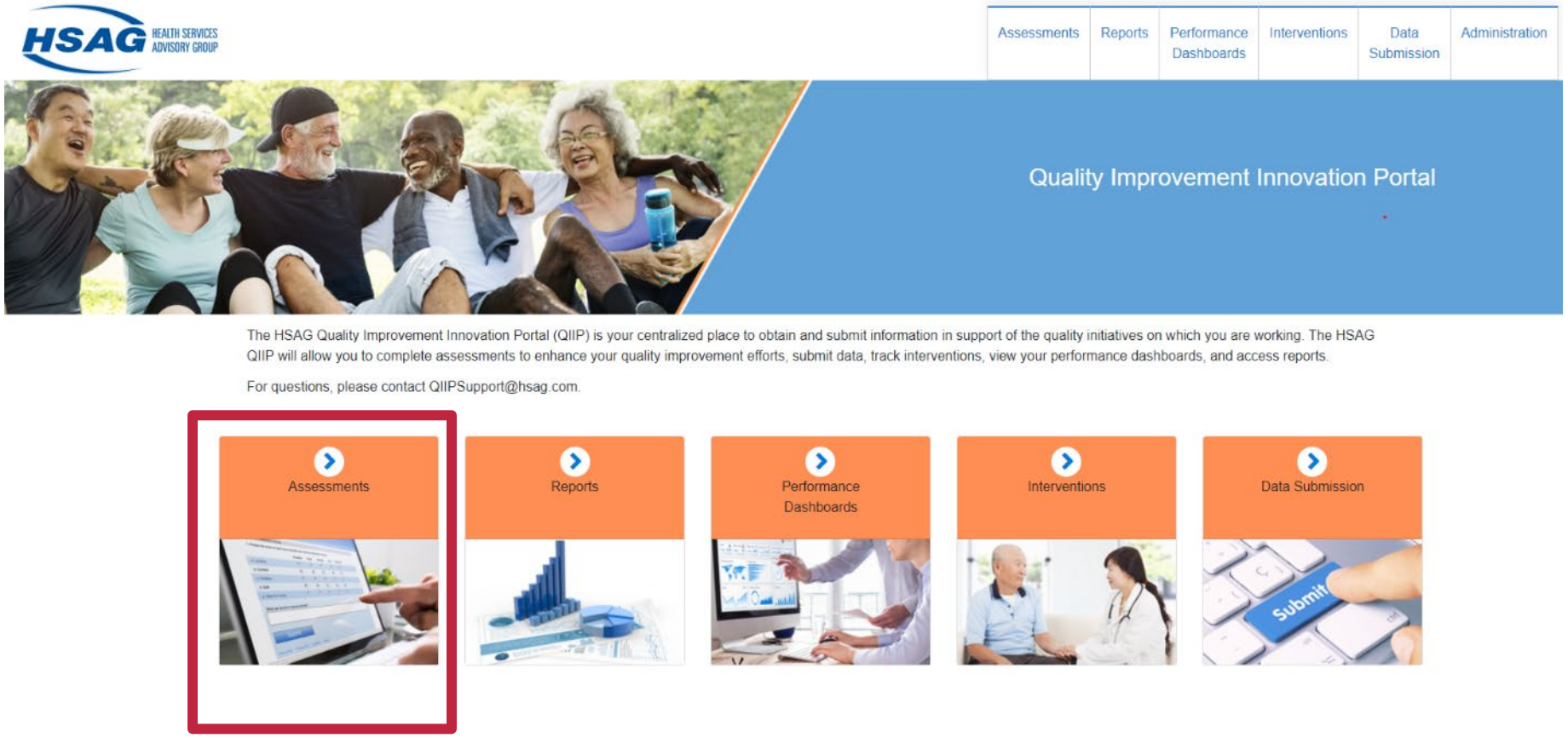
1. Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication gaps of key clinical information during resident transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies).[i]	☐	☐	☐	☐	☐
2. Your facility 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.	☐	☐	☐	☐	☐

Completing and Submitting the Care Transitions Assessment



Care Transitions Assessment Access in the QIIP



QIIP access link: https://qiip.hsag.com

Care Coordination Website

www.hsag.com/cc-resources

Root Cause Analysis and 7-Day Readmission Checklist

Gap/Root Cause Analysis (RCA) Sample

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)	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 resident at time of discharge

Component	Sample Activities Completed	Sample 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	Examples: • Analyzed HSAG's readmission report. • Analyzed data in HSAG's QIIP dashboard. • Analyzed internal report of readmissions. • Reviewed data from medical records for readmissions in the last month.	• HSAG's report shows 30% of readmissions were patients on high-risk medications. • 75% were identified as high-risk for readmissions. • 36% did not have a physician follow-up visit documented/scheduled before discharge. • 82% are prescribed take 13 or more medications • 68% of medical records indicated they were not asked about ability to pay for medications. • 79% did not have a caregiver that lived with them. • 59% has no personal way to get home and needed transportation arranged for them.
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys	• Observed the patient discharge process for 10 residents identified as high-risk.	• Resident education on diagnosis, treatment plan, new prescriptions, and signs and symptoms to watch out for was conducted in 15 or less minutes and during the last hour that the resident was in the facility. • 40% of the 10 observations did not incorporate teach-back and instead said, "Do you have any questions for me?" • Only one of the 10 observed discharges did the nurse ask if they had the money or

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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: _____

* Myocardial infarction (MI), heart failure (HF), pneumonia (ON), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), total hip/total knee arthroplasty (THA/TKA)

Page | 2

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Readmissions Performance Improvement Project (PIP)

Worksheet to Create a Performance Improvement Project Charter

QAPI

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:
Example: Reduction in use of position change alarms

Improving the accuracy of assessed acuity at admission to reduce readmissions

Problem to be solved:
Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.
Nursing home staff members are discovering some residents have a higher level of acuity than expected after they are admitted from the hospital; this creates an unexpected burden on staff members, patients, caregivers, and resources when caring for the resident.

Background leading up to the need for this project:
Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.
[Tip: Reference specific background documents, as needed.]
The admissions coordinator, nurses, and physicians have observed that when patients are evaluated after admission, co-morbid diseases, routine medication needs, wound care, recent infections, and antibiotic use are not completely known at the time of transfer.

The goal(s) for this project:
Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.
[Tip: See Goal Setting Worksheet]
Increase the completeness and accuracy of communication related to patients' clinical condition and care needs at transfer to ≥ 80 percent using a standardized tool (Skilled Nursing Facility [SNF] Transfer Checklist) by 12/31/22.

Scope—the boundary that tells where the project begins and ends.
The project scope **includes:**
Example: Use of position change alarms on XX unit.
The scope includes all patients transferred from one unit at Best Hospital Medical Center for skilled nursing care between 9/1, and 12/31.

PROJECT APPROACH

Recommended Project Time Table:

PROJECT PHASE	START DATE	END DATE
Initiation: Project charter developed and approved	10/2	10/4
Planning: Specific tasks and processes to achieve goals defined	10/7	10/18
Implementation: Project carried out	10/21	10/31
Monitoring: Project progress observed and results documented	10/21	10/31
Closing: Project brought to a close and summary report written	11/3	11/14

Project Team and Responsibilities:

TITLE	ROLE	PERSON ASSIGNED
Project Sponsor	Provide overall direction and oversee financing for the project	Joe Jones, NHA
Project Director	Coordinate, organize and direct all activities of the project team	Fred Kline, MD, Medical Director
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project	Sally Bailey, Admission Coordinator
Team members*	Carry out specific tasks based on action planning	Director of nursing (DON), discharge planner/case manager, nurse practitioner, staff nurse
Hospital team		Discharge team, Chief Medical Officer (CMO), case managers, nursing director of unit, care coordination staff members, unit hospitalist

*Choice of team members will likely be deferred to the project manager based on interest, involvement in the process, and availability.

Material Resources Required for the Project (e.g., equipment, software, supplies):

- Health Services Advisory Group (HSAG) SNF Transfer Checklist
- HSAG Nursing Home Readmissions Report
- Quarterly Certification and Survey Provider Enhanced Reports (CASPER) Confidential Feedback Report
- SNF 30-Day All-Cause Readmission Measure (SNF-RM) Baseline and Performance Period Rates
- Curaspan Referral Documentation Application
- Computer access and spreadsheet to track progress
- Hospital and Nursing Home Communication Log

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NEW

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- 16. Deeper Dive Into Readmission Data
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HSAG Health Services Advisory Group

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Questions?

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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