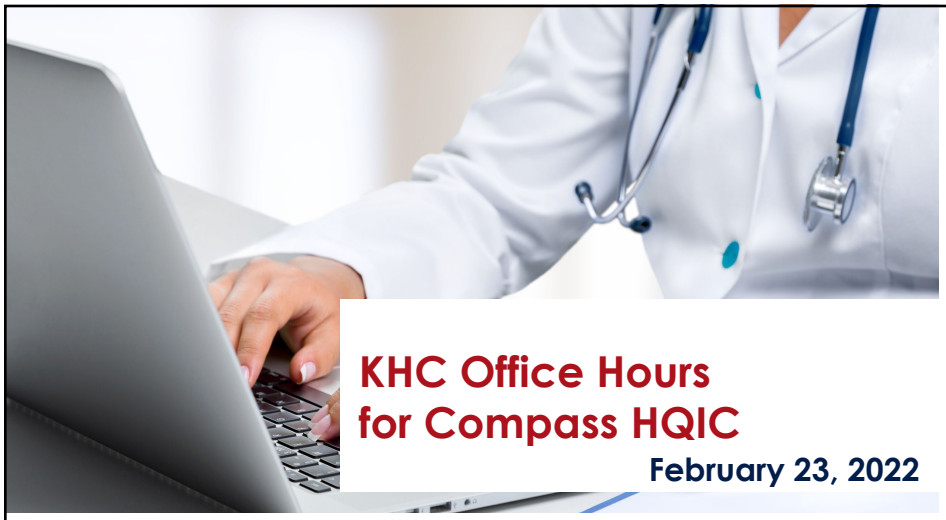


KHC Office Hours for Compass HQIC

February 23, 2022

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

1

Agenda

- Welcome and Announcements
- Featured Topic: *Strategies for Effective Care Coordination to Advance the Integration of Behavioral Health Across the Continuum*
- Data and Program Updates
- Resources, Upcoming Events, and Next Steps

February 23, 2022

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

2

v
(

KHC Compass HQIC Team and Presenters:

Eric Cook-Wiens
Data & Measurement Director

Heidi Courson
Quality Improvement Advisor

Erin McGuire
Quality Improvement Advisor

Patty Thomsen
Quality Improvement Advisor

Special guest:

Jeff Capobianco, PhD
Senior Consultant
National Council for Mental Wellbeing

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

3

Align All Health – Grant Opportunity Available

A targeted intervention for hospitals and community mental health centers to improve health outcomes and care transitions for high-risk and behavioral health patients

- Learn ways to optimize use of the KHIN dashboard and alerting technology.
- Test and implement data-driven strategies for identifying your organization's high-risk patients with behavioral health needs.
- Review and strengthen workflows with health care partners.
- Support your organization's 2022 goals for improving care transitions, reducing readmissions, improving interoperability, and advancing community partnerships for behavioral health.

Enrollment Deadline – February 25, 2022

For more information, please reach out to your KHC Quality Improvement Advisor or register at: www.khconline.org/AlignAllHealth.

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

4

v
(

Today's special guest

Jeff Capobianco, PhD
Senior Consultant
National Council for Mental Wellbeing

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

5

REDEFINED NATCON22

NATIONAL COUNCIL for Mental Wellbeing

Strategies for Effective Care Coordination

Jeff Capobianco, Ph.D.
February 23, 2022

6

v
(

First Thoughts?

Defining our Terms

- Care Management
- Care Coordination
- Transitions of Care

Care Management

Activities performed by health care professionals with a goal of achieving person-centered treatment to target outcomes with the consumer while providing cost effective, non-duplicative services.

- Examples include:
  - ✓Screening & assessment
  - ✓Care planning health literacy education
  - ✓Medication management & adherence support
  - ✓Treatment provision
  - ✓Risk stratification
  - ✓Population management
  - ✓ ***Care coordination/care transitions***

Source: AHRQ
https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html#:~:text=Care%20management%20is%20a%20promising,to%20help%20manage%20chronic%20illness.

9

Care Coordination

"the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services."

- Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

10

v
(

Transitions of Care

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

- **Across health states**: e.g., palliative care to hospice, or personal residence to assisted living
- **Between providers**: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- **Within settings**: e.g., primary care to specialty care team, or intensive care unit to ward/department
- **Between settings**: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

Source: NTOCC
Source: https://www.aaacn.org/sites/default/files/documents/cctm-definitions.pdf

11

Perspectives on Care Coordination & Transitions of Care

Patient & Family ask…

✓ How easy is it for me to get the care I need or my loved one needs?

Health Care Provider asks…

✓ How easy is it for me to do my work?

System Representatives ask…

✓ How easy is it for me to know care is effective & efficient?

Source: McDonald KM, Schultz E, Albin L, Pineda N, Lonhart J, Sundaram V, Smith-Spangler C,Brustrom J, and Malcolm E. Care Coordination Atlas Version 3 (Prepared by Stanford University under subcontract to Battelle on Contract No. 290-04-0020). AHRQ Publication No. 11-0023-EF. Rockville, MD: Agency for Healthcare Research and Quality. November 2010.

12

v
(

Characteristics of Re-admitted Patients

- Inadequate information and preparation for post-discharge care and self-care.
- Poor transmission of hospital records and discharge instructions to primary care clinicians who manage post-discharge recovery or to organizations which authorize or provide post-discharge care.
- Untimely and uncoordinated post-hospital care in their community.
- Preventable medical errors/complications during the first hospital stay.
- The highest rates of readmitted patients:
  - Have heart failure, chronic obstructive pulmonary disease (COPD), psychoses, intestinal problems, and/or have had various types of surgery (cardiac, joint replacement, or bariatric procedures).
  - Take six or more medications, have depression and/or poor cognitive function, and/or have been hospitalized in the previous six months.
  - Are discharged on weekends and holidays.

Source: National Priorities Partnership Compact Action Brief, "Preventing Hospital Readmissions: A $25 Billion Opportunity"

Core Requirements of Effective & Efficient Care Coordination

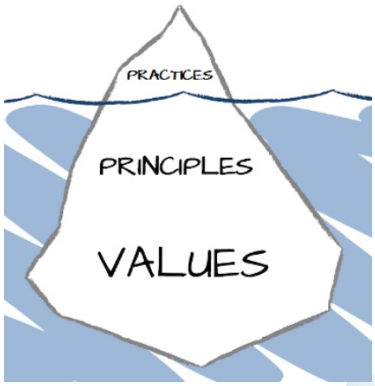
1. Alignment between Coordinating Agencies on Shared Values, Principles, and Practices
2. Data Sharing and Care Process Agreements with Target Metrics
3. Mapping of Current and Future State Care Coordination Workflows
4. Ongoing Monitoring and Continuous Quality Improvement

v
(

1. Values => Principles & Practices

Values (*What matters most*):

- Timeliness
- Effectiveness
- Measurement
- Person Centered
- Respect
- Shared Accountability
- Equitable
- Consumer Voice/Engagement
- Safe



Principles (*Agreed upon Rules & Resulting Practices*):

- Data sharing agreements will be created & followed
- Data will be used for monitoring & to trigger continuous Quality Improvement
- Care Coordination roles are defined & processes mapped
- Regularly scheduled coordination team meetings to review data, review incidents, etc.
- Continuous Quality Improvement

NatCon22.org

REDEFINED NATCON22 | NATIONAL COUNCIL for Mental Wellbeing

15

2. Care Coordination Agreements

- **One-off Referral Process:**
  - Driven by Provider, Patient, or Natural Support
  - Individual Consents Allowing for Data Sharing
  - Unknown if Patient Makes Referral Appointment
- **Informal Referral Agreement between Providers**
  - May Include Rapid Referral (Access-in/Refer-out)
  - Individual Consents/Possibly Shared Consents Allowing for Data Sharing
  - May Include Referral Confirmation, Ongoing Care Coordination Meetings, and CQI Protocols
- **Business Associates Agreement**
  - Legal Agreement
  - Typically Includes Shared Consent/Data Sharing/Rapid Referral and Confirmation
  - Typically does *not* include mention of Care Coordination Meetings and CQI Protocols

NatCon22.org

REDEFINED NATCON22 | NATIONAL COUNCIL for Mental Wellbeing

16

v
(

2. Care Transition Elements & Associated Metrics

Elements

1. Medication Management
2. Transition Planning
3. Client and Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Health Care Provider Engagement s/p Referral
7. Shared Accountability across Providers and Organizations

Metric Examples

1. Prescriptions filled by client
2. Number of CT meetings between CMH/hospital
3. Number of CT meetings with client/family/CMH/Hospital staff
4. CCD shared between providers
5. Appt scheduled within 7 days of hospitalization
6. Number of no-shows
7. Metrics defined in agreement

17

2. Care Coordination Data Dashboard

TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

Click here for Patient Tracking Spreadsheet Template resources

1) EVERY time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+J" to refresh the page.
2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet.
3) Do NOT change the number of rows or columns. If you need to make any changes to the table whatsoever (other than sort and filter), use the de-identified template provided at the link to the left.
4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload Overview.

			Treatment Status					Transitions of Care Status				PHQ-9				GAD-7				Psychiatric Case Review	
			! The most recent contact was over 1 month (30 days) ago ⚑ The next follow-up contact is past due					✓ CT meeting occurred within 7 days ! CT meeting didn't happen / Not seen within 7 days				✓ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score) ! The last available PHQ-9 score is more than 30 days old				✓ The last available GAD-7 score is at target (<10 or 50% decrease from initial score) ! The last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Date of Admit to ABC Hosp	Date of D/c from ABC Hosp	CT Meeting	7 day f/u appt	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
#N/A	Active	Beverly B	11/1/2016	11/12/2017	11/25/2017	0	3	11/15/2017	11/22/2017	11/20/2017	yes				No Score	-100		4274300%	10/24/2016	0	
View	RP	John Doe	1/15/2016	! 11/16/2016	⚑ 12/16/2016	12	53					20	✓ 0	✓ -100%	! 11/16/2016	14	✓ 1	✓ -93%	! 11/16/2016		11/1/2016
View	Active	Susan Test	5/20/2016	! 1/2/2017	⚑ 1/16/2017	10	35					22	15	-32%	! 1/2/2017	18	14	-22%	! 1/2/2017	Flag for discussion & safety	9/15/2016
View	Active	Joe Smith	11/1/2016	! 1/8/2017	⚑ 1/22/2017	5	11					15	9	-40%	! 1/8/2017	11	✓ 7	-36%	! 1/8/2017		10/24/2016

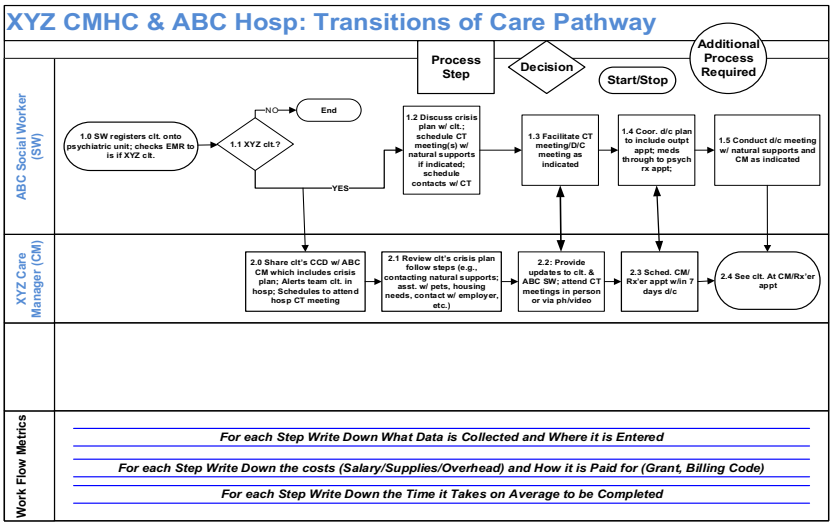
Dashboard with Care Transition Data

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

18

v
(

3. Mapping Current & Future State



NatCon22.org

REDEFINED NATCON22 — NATIONAL COUNCIL for Mental Wellbeing

19

4. Ongoing Monitoring & Continuous Quality Improvement

- Update/Develop Policies/Protocols detailing Agency Care Coordination standards
- Include Care Coordination in all job descriptions, supervision, and staff training
- Include Consumer and Natural Support education about care coordination in treatment planning (e.g., Make Effective use of Safety/Crisis Planning Process/Documents)
- Include Care Coordination Metrics/Targets in Executive and Care Provider Team Dashboards
- Conduct Community Mapping to identify which agencies with whom you should develop Care Coordination Agreements (see mapping tool)
- Annually, or when metrics indicate Coordination is out of specification, Review/Update Care Coordination Workflows

NatCon22.org

REDEFINED NATCON22 — NATIONAL COUNCIL for Mental Wellbeing

20

v
(


Thank You!
Questions?
Comments?
Suggestions?
NatCon22.org
REDEFINED NATCON22
NATIONAL COUNCIL for Mental Wellbeing

21


Care Coordination Resources:
National Quality Forum Care Coordination Consensus Measure
http://www.qualityforum.org/Projects/c-d/Care_Coordination_Endorsement_Maintenance/Care_Coordination_Endorsement_Maintenance.aspx
http://www.qualityforum.org/Publications/2010/10/care_coordination_full.aspx
AHRQ Care Coordination Atlas
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html
Commonwealth Fund Making Care Coordination Critical Component of Pediatric Health
https://www.commonwealthfund.org/publications/fund-reports/2009/may/making-care-coordination-critical-component-pediatric-health
CHCS Center for Health Care Strategies, Inc. Care Management Framework
https://www.chcs.org/media/Care_Management_Framework.pdf
A systematic review of the care coordination measurement landscape
https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-119
Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs
http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx
Reducing Care Fragmentation: A Toolkit for Coordinating Care, is supported by The Commonwealth Fund
http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf
Reducing Avoidable Readmissions Effectively (RARE)
http://www.rarereadmissions.org/areas/index.html
National Quality Forum Preferred Standards for Care Coordination
http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx
NatCon22.org
REDEFINED NATCON22
NATIONAL COUNCIL for Mental Wellbeing

22

v
(

KHC & Compass Data Updates

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

23

Data Updates

+ Data are due at the end of the following month.
+ Data Refresh
  - Administrative Claims and NHSN transferred to QHi
  - QHi data are sent to Compass
  - Current Data Refresh: 2/10/2022
  - Next Refresh: ***On or around March 4, 2022***

NOTE: EARLIER THAN USUAL

Important Evaluation Time Point next month

Please submit your QHi data by March 4, 2022

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

24

v
(

Data Reports

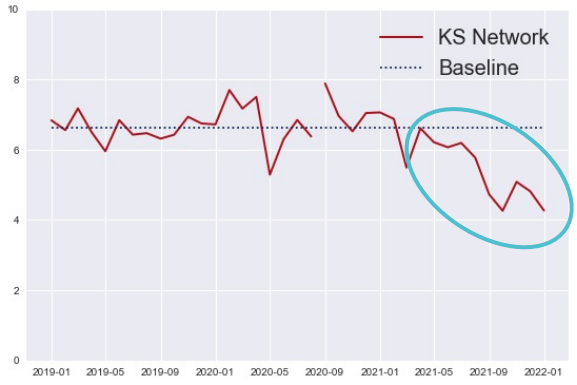
- **You may receive an email from us soon asking for missing NHSN data**
  - Critical HQIC evaluation time point
  - Focusing on facilities with no baseline data
  - If you receive an email, **please enter data in QHi *if you have it***
    - Although NHSN is still the official data system for these measures
  - Providing missing 2019 – 2021 NHSN data will help us meet our HQIC evaluation targets
- Data Completeness
  - Fixed a problem relating to marking claims data as missing "yellow" during months with zero discharges
- Snapshot Reports
  - Baseline definitions are in flux right now, look for an update next month

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

25

Readmissions

Unplanned, All-Cause 30-day Readmission to Same Hospital



- Run Chart Rules
  - ***Shift: 6 or more consecutive points above or below the median***
  - Run: 5 more consecutive points increasing or decreasing
  - Too many runs or too few
  - Astronomical data point
- Baseline median rate: 6.6%
- Project median rate: 6.2%
- Last 6 months median: 4.8%

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

26

v
(

QHi Training Session

MyQHi.org

HEALTHWORKS
KANSAS HOSPITAL ASSOCIATION

Date: Thursday, February 24

Time: 1:00 – 2:00 CT

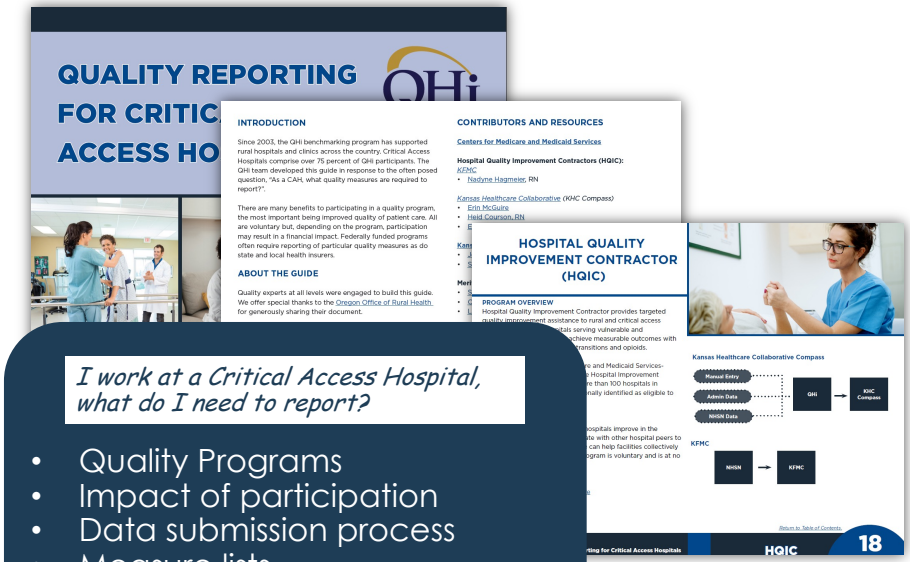
Here is the link to register: https://cc.readytalk.com/r/3tmpvjov789l&eom

- Adding New Users
- Select Measures
- Entering and Importing Data
- Running Reports

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

27



I work at a Critical Access Hospital, what do I need to report?

- Quality Programs
- Impact of participation
- Data submission process
- Measure lists
- Resources
- Acronyms

MyQHi.org

HEALTHWORKS
KANSAS HOSPITAL ASSOCIATION

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

28

v
(

KHC & Compass Resources, Updates, and Upcoming Events

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

29

2022 Quality Improvement Work Plans (QIWPs)

- Please update your QIWP to include 2022 goals.
- Your QIA will submit any necessary QIWP changes to the IHC data portal on your behalf.
- 2022 Updates needed to be submitted by 3/4/2022.

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

30

v
(

KHC Office Hours

- Register once for all remaining sessions.
- Save recurring appointment to your calendar.
- Keep abreast of KHC program updates.
- Learn from subject matter experts and peers.

Up Next!

March 23, 2022 | 10:00-11:00a.m.
KHIN Deep Dive with Rhonda Spellmeier.

KHC Office Hours series registration link:
https://us06web.zoom.us/webinar/register/WN_3wt40adgS2aQmYjbO3mlng

All sessions are held from 10 to 11 a.m. CST.
Sessions will be recorded and posted to KHC Education Archive at www.khconline.org/archive.

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

31

Upcoming Compass Education Events

March 4 12:00 to 1:00 p.m.	**ASPIRE+ to Reduce Readmissions Learning and Action Network Series** Registration link: https://us06web.zoom.us/webinar/register/WN_igOghC87TyeijUSk4E2Vwg
March 8, 2022 12:00 to 1:00 p.m.	**Exploring Strategies to Prevent Opioid Morbidity and Mortality** Registration link: https://us06web.zoom.us/webinar/register/WN_BVIIlazcQAqQFhscKkDdUA
March 28th 1:00 to 2:00pm	**Pressure Injury Prevention 2022-** Building Adaptability and Reliability **Registration Link:** https://us06web.zoom.us/webinar/register/WN_rQUEsjnqTcayAGy8t6Vxrg
March 2022 TBA	**CLABSI**

See Compass Navigator newsletter March 1.

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

32

v
(

Exploring Strategies to Prevent Opioid Morbidity + Mortality

March 8 | 12:00 – 1:00pm (CST)

Overview

Join us for a presentation on useful approaches to prevent opioid morbidity and mortality in your healthcare system. Strategies discussed will include how to reduce morphine milligram equivalents (MMEs) prescribed at hospital discharge, how to screen for patients at highest risk of developing an opioid-related adverse drug event (ORADE) or opioid use disorder (OUD), implementation of a take-home naloxone program, and buprenorphine induction and transition to outpatient treatment. A bonus topic at the end will introduce the concept of health equity in the opioid epidemic and what your hospital and clinics can be doing to decrease health disparities in this area.

Rachael Duncan
PharmD BCPS BCCCP
Stader Opioid Consultants

Register: https://us06web.zoom.us/webinar/register/WN_BVIIlazcQAqQFhscKkDdUA

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

33

Pressure Injury Prevention 2022
Building Adaptability and Reliability

March 28 | 1:00 – 2:00pm (CST)

Overview

Pressure Injury Prevention (PIP) in 2022 is more challenging than we have seen in our lifetime. Workforce shortages, absence of family at the bedside, supply chain issues, prone positioning, COVID skin manifestations and the increased use of medical devices for oxygen therapy have impacted hospitals' ability to reliably deliver preventative care. In this interactive session, subject matter expert, Jackie Conrad will share newly emerging best practices from the field to address these challenges and engage participants in harvesting best practices from within the Kansas hospital peer group.

Click Here to Register

Featured Speaker

Jackie Conrad MBS, BS, RN, RCC
Improvement Advisor + Leadership Coach
Cynosure Health

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

34

v
(

Now enrolling up to 8 facilities for 2022 project

Overdose Data to Action

KHC and KDHE are inviting applications from hospitals and clinics to join a clinical quality improvement project to prevent and decrease harms associated with controlled substances, such as opioids and Substance Use Disorder (SUD).

Eligible hospitals and clinics:

- *Serve a high-risk population*
- *Have a need for education, training, policy development and technical assistance around safe prescribing*

For more information, visit
www.khconline.org/od2a
and contact Mandy Johnson, MBA, CRHCP
KHC Program Director
Desk: (316) 681-8200
mjohnson@khconline.org

OD2A Project
Goals Summary

1. Increase provider and health system awareness of and support for guidelines
2. Decrease high-risk opioid and/or high-risk controlled substance prescribing
3. Support development of clinical quality improvement around substance use disorder screening, referral, overdose management and linkage to care for patients presenting in the clinic or emergency department.

Project ends August 31, 2022

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

35

Next Steps

+ Ensure data entry is current and timely.

+ Review your Q.I. Work Plan and update for 2022 goals — please submit to your QIA by 3/4/22.

+ Log into iCompass Forum and iCompass Academy to engage and learn.

+ Watch your inbox for the Compass Navigator on March 1.

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

36

v
(

Have Questions, Need Help?

Kansas Healthcare Collaborative

Heidi Courson
Quality Improvement Advisor
hcourson@khconline.org
785-231-1334

Erin McGuire
Quality Improvement Advisor
emcguire@khconline.org
785-231-1333

Patty Thomsen
Quality Improvement Advisor
pthomsen@khconline.org
785-231-1331

Eric Cook-Wiens
Data and Measurement Director
Ecook-wiens@khconline.org
785-231-1324

Kansas Hospital Association/QHi

Sally Othmer
Senior Director Data & Quality
sothmer@kha-net.org
785-276-3118

Stuart Moore
Program Manager QHi
smoore@kha-net.org
785-276-3104

KHIN/KONZA

Josh Mosier
Manager of Client Services
jmosier@khinonline.org
785-260-2761

Rhonda Spellmeier
HIE Workflow Specialist
rspellmeier@khinonline.org
785-260-2795

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR
Kansas Healthcare COLLABORATIVE

37

Questions?

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

38

v
(

Thank you for joining us.

We invite your feedback.

What was a key take-away?
What are 3 next steps based on the information shared?

Please complete our brief feedback survey.

www.KHConline.org/feb-survey

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

39

Kansas Healthcare COLLABORATIVE

Connect with us on:

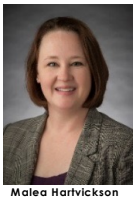
KHCqi

@KHCqi

KHCqi

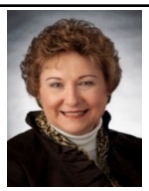
Sign up for the KHC email newsletter at:
www.KHConline.org/newsletter

Find contact info, bios, and more at:
www.KHConline.org/staff



Malea Hartvickson
Executive Director

Mandy Johnson
Program Director of Quality Initiatives



Rhonda Lassiter
Director of Operations

Eric Cook-Wiens
Data & Measurement Director

Treva Borcher
Project Coordinator

Phil Cauthon
Communications Director

Heidi Courson
Quality Improvement Advisor

Jill Daughhetee
Quality Improvement Advisor

Azucena Gonzalez
Health Care Quality Data Analyst

Erin McGuire
Quality Improvement Advisor

Patty Thomsen
Quality Improvement Advisor

40