

Agenda

- Welcome and Announcements
- + Featured topic: Creating a Bright Spot: Collaboration Across the Continuum
- + Data and Program Updates
- + Resources, Upcoming events and Next Steps

January 26, 2022

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR



Presenters





Eric Cook-Wiens
Data & Measurement Director





Special guest:



Kim Werkmeister Senior Vice President, Improvement & Implementation Cynosure Health



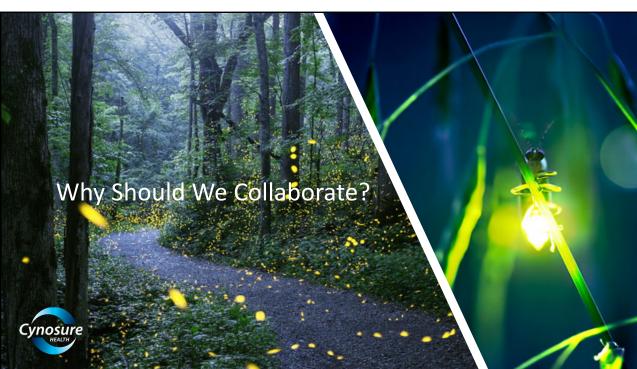






Polling Question: What is the greatest challenge to effectively collaborate across the continuum?

- A. We just don't have time to reach out and meet with others
- B. We don't really know who to reach out to and meet
- C. There isn't anyone willing to collaborate
- D. There aren't enough services across the continuum to collaborate with in my area



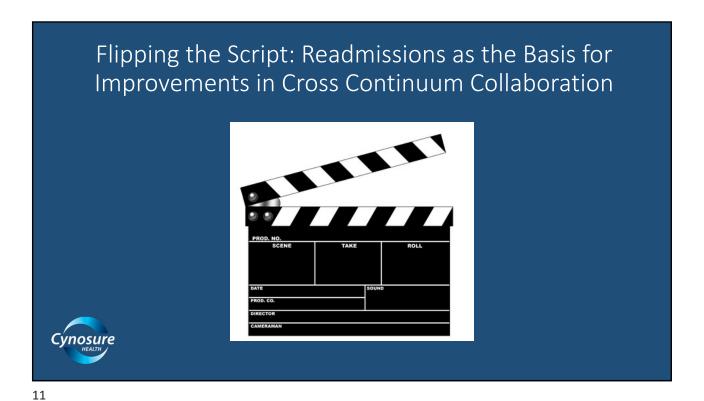




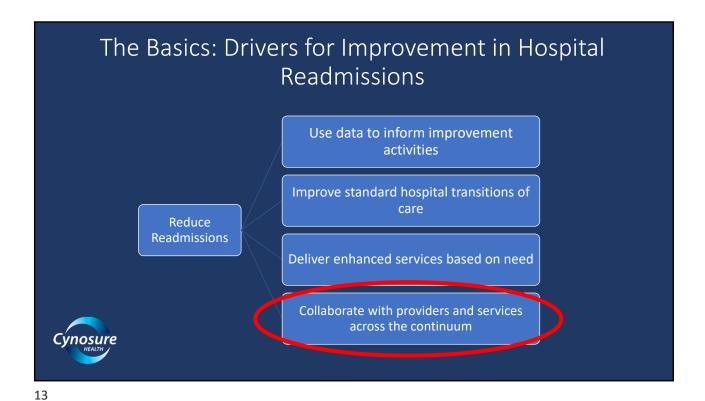












Driver #4: Collaborate with Providers and Agencies Across the Continuum

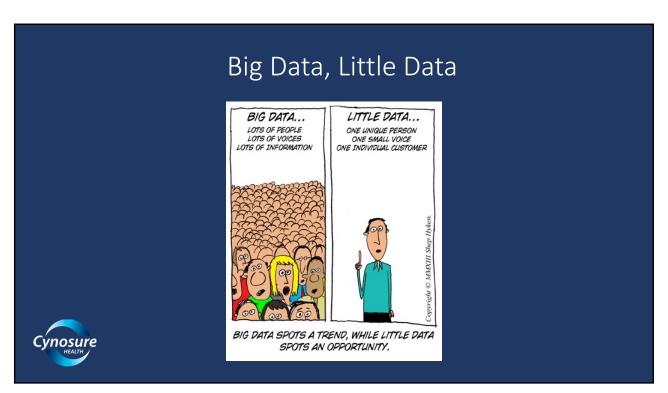
Identify clinical, behavioral, social and community-based support organizations that share the care of your high-risk patients

Convene a cross continuum of providers and agencies agencies across the continuum

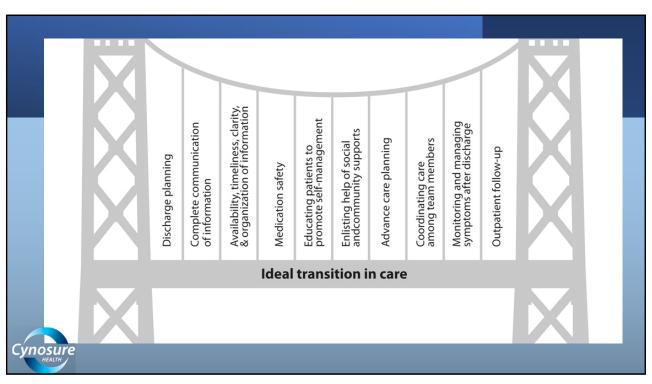
Convene a cross continuum of providers and agencies that share the care of your high-risk patients

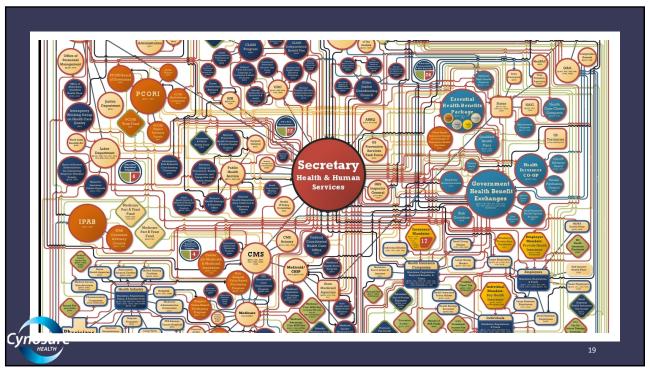
Improve referral processes to make linking to social, behavioral and community-based services more effective and efficient

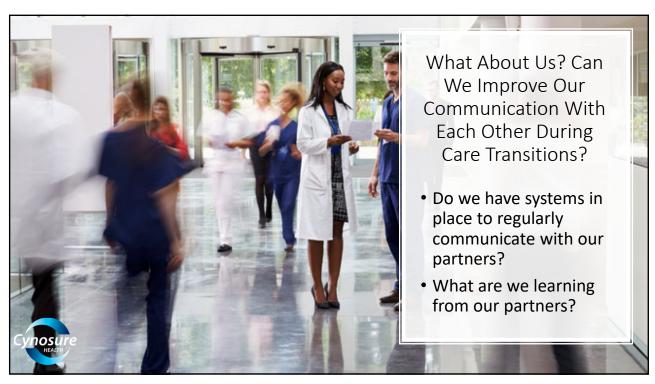






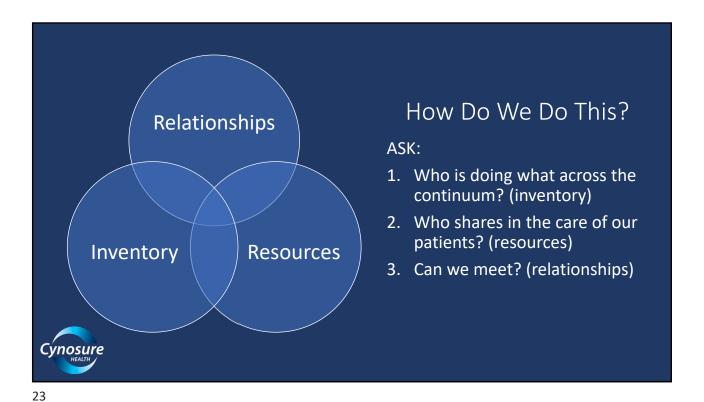






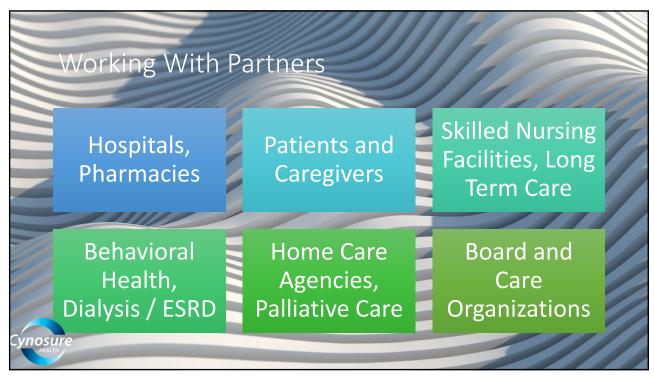






Finding Agencies for Collaboration

HIGHEST UTILIZATION REFERRAL SOURCES COMMUNITY AGENCIES
FOR YOUR POPULATION



What Services Exist That I Am Not Aware Of?

- Community-based elder care services:
 - Area Agency on Aging
 - Senior Centers
- Behavioral Health Services
 - Clinics, Drop in Centers
 - Referral Lines, NAMI
- Social Services
 - YMCA
 - Shelters
 - Food, Transportation, Utilities Assistance, 2-1-1



Prepare to Partner with Other Organizations

- Reach out to a service provider, or group of providers who provide similar services, to initiate a transparent, data-informed planning discussion to explore improving linkages to services for patients. Set up a meeting.
- Prepare data on your hospitals' target population, how many target population discharges there are per day/week, and a description of your working understanding of what factors contribute to readmissions.
- Prepare questions to learn more about the services they offer and their capabilities.

Cynosure

27

Ask

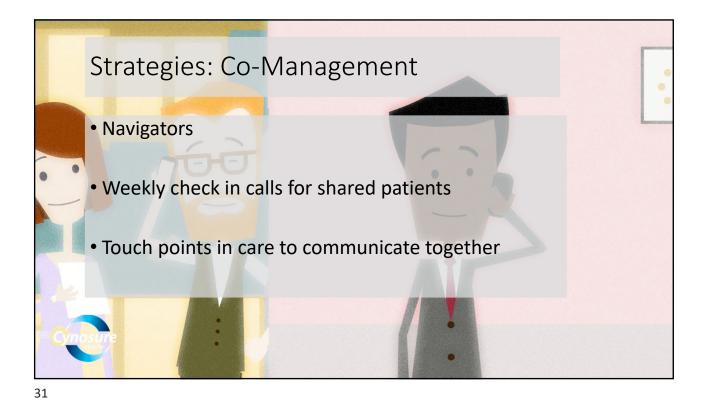
- Capacity: Ask the provider/agency to consider whether they have capacity to accept a consistent volume of referrals. What volume of referrals could they absorb?
- **Timeliness:** Timely post-hospital contact is a priority, ask the provider/agency to work with you on developing a process to ensure linkage to services, optimally prior to discharge or within 1-2 days.
- Getting started: Ask the provider/agency if you can test the new process of linking high-risk patients to their services on the next 10 patients who have a need for their services.

Build the Relationships

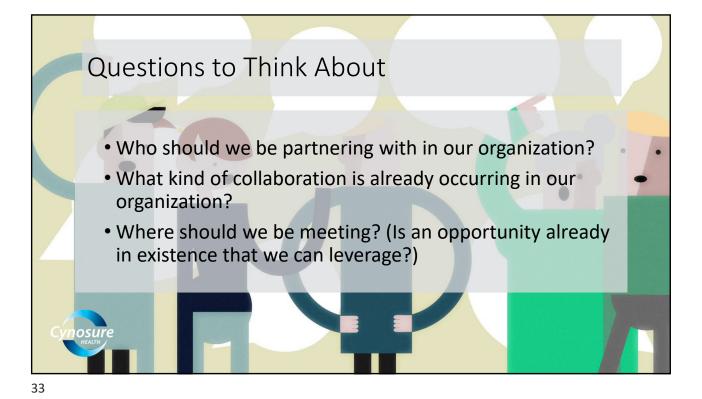
- · Hold regularly scheduled monthly meetings.
- Start with a "coalition of the willing"—doesn't need to be perfect.
- Invite new partners/ agencies as you learn about them.
- Allow 3-4 months for the group to gel.
- Start with common agenda items:
 - Readmission data.
 - Readmitted patient stories.
 - Readmission stories from "receiver" perspective.
 - · Handoff communication.
 - What information do "receivers" need that they frequently don't have?

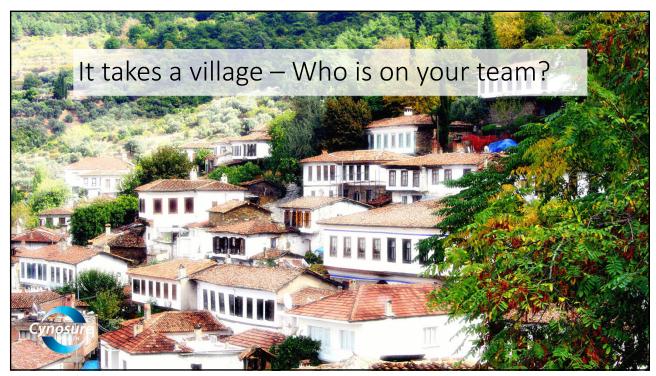
29

Strategies: Circle Back Follow up call to receiving provider of care: • Did patient arrive safely? • Did you have all the information you needed at time of transfer? • Were medication orders correct? • Did the patient's presentation accurately reflect the information received? • Is the patient and/or family satisfied with the transition? • Have we provided everything you need to care for the patient?









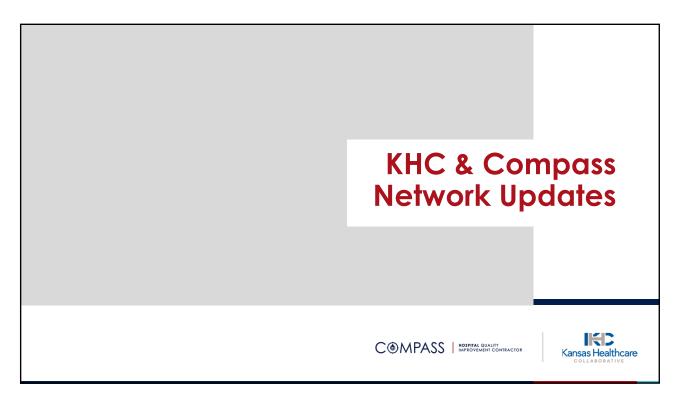


Get Started

- Identify YOUR cross-continuum collaboration goal
- Identify YOUR target population
- Apply population-specific strategies
- Choose one new idea to test



Thank You! Kim Werkmeister, MS, RN, CPHQ, CPPS Cynosure Health kwerkmeister@cynosurehealth.org



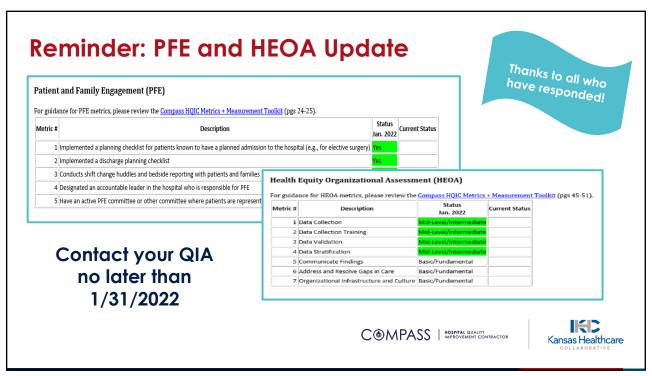
Compass Measure Set and Toolkit Updates

Updates will be released in the February 1st Compass Navigator

- + High-dose Opioid Prescribing Self-Reporting is now optional
- Primary data source changed to Medicare Part D
 Claims
- + ICD-10 code list added to the toolkit

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2022 Quality Improvement Work Plans (QIWPs)

- + It is now time to update your QIWP to include 2022 goals.
- Your QIA will submit any necessary QIWP changes to the IHC data portal on your behalf.
- + Contact your QIA to set a meeting soon, if not already scheduled.

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41

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: 1/10/2022
 - Next Refresh: On or around February 8, 2022

Next month, the data snapshot will be little earlier than normal: March 4, 2022

- + Reports Emailed from your QIA (Erin, Heidi or Michele)
 - · Compass HQIC Data Completeness Report
 - KHC Compass Data Snapshot Report

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QHi Data Submission Page Update



In the past, users were responsible for "activating" any data that they submitted on their Data Submission page so that the data would be available for reporting. Because activation of data has been an ongoing issue, we have made the following change:

Effective immediately, when a new Data Submission page is generated, ANY DATA ENTERED WILL AUTOMATICALLY BE "ACTIVATED". If the user wishes to deactivate the data, click on the checkmark in the activate box, click Save and the data will be deactivated and a message will appear providing the user with two options ("Activate Data" or "Continue With Inactive Data").

If any questions, contact Stu Moore at smoore@kha-net.org









43

QHi Training Session



MyQHi.org

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





KHC & Compass Resources, Updates, and **Upcoming Events**

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45

Achieving Health Equity by Leveraging Diversity, Inclusion + Patient-Centered Care

JOIN US Today, January 26th 1:00 - 2:00pm

Speakers



Chris Moreland

Chris is the Chief Diversity Officer and Managing Partner of Diversity Crew. Previously, Chris served as the Chief Diversity Officer of Vizient, a major healthcare organization. At Vizient, Chris created the Office of Diversity and inclusion, characteristic of the control of the properties of the control of the chief of the chief of the properties of properties properties of properties properties

Chris received a Bachelor of Science degree in Engineering from the United States AF Force Academy, a Moster's in Business Administration from Central Michigan University, Certificate of Inclusion and Diversity from Comell University and a DBI Certification from Divensity Crew



+ Overview

The COVID-19 pandemic has brought to light long-standing issues with health equity and the stark disparities in health outcomes for vulnerable populations. At the same time, social unrest has highlighted the need for increased diversity, equity, and inclusion in our nation's criminal justice, political, and education systems. The principles of diversity, equity and inclusion can and should be leveraged in the healthcare setting to create an environment that is patient-centered and provides an equal opportunity for patients to achieve their best outcome and healthcare organizations to improve their performance.

+ Target Audience

Hospital leadership, board of directors and quality

+ Objectives

- 1. Define diversity, inclusion and patient-centered
- care in relation to health equity

 2. Explain how principles of diversity and inclusion can be leveraged in the healthcare setting
- 3. Discuss the results of health equity focus groups conducted with HQIC participants

 4. Describe common themes and challenges facing
- hospitals in pursuit of health equity

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ASPIRE+ to Reduce Readmissions Learning and Action Network Series

Overview

The ASPIRE+ Method is an evidence-based, locally adaptable method to improve outcomes for populations experiencing high rates of readmissions. in this intensive series, we will move quickly through core elements of the ASPIRE+ Method to help teams identify a subpopulation(s) that experience poor outcomes because of structural issues in the healthcare system and take specific, feasible, action-oriented steps forward to make improvement. This series will catalyze your equity work in 2022, laying a foundation for data-informed, root cause analysis-based work to enhance equity and value in healthcare delivery.

Use the Hashtaa:

#ASPIREtoReduceReadmissions to help spread the word about this series!

4 Live Webinars

https://us06web.zoom.us/webinar/register/WN_igOghC87TyeijUSk4E2Vwg

- February 4
- March 4
- April 1
- May 6

4 Live Coaching Calls

https://us06web.zoom.us/meeting/register /tZYsduisqDwsEtZCDHXdh9jePdh2pULj2hkb

- February 11
- March 11
- April 8
- May 13



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47

Establish New PFAC Track - On Demand

Value of PFACs to Hospital Staff, Patients + Families

Setting the Stage for a New PFAC

1:00 - 2:00 PM (CDT)

Overview

Develop the strategic and governance framework for a new

Objectives

- Describe the key components that each hospital should internally discuss and address for a PFAC Review the PFAC Foundation checklist of key components that should be addressed by different administrative and clinical areas Develop guidelines for the PFAC to ensure PFAC members are believed by the property of the prop

Engaging PFAC Members

December 16 1:00 - 2:00 PM (CST)

Explore strategies for engaging PFAC members continuously throughout their term

- Explain the importance of each meeting in terms of providing information and soliciting input
- information and soliciting input and solutions Review the key guidelines including the importance and appreciation of everyone's voice reflective of the diversity of the
- Identify key areas of input needed by PFAC and plan meetings



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Upcoming Compass Education Events

Achieving Health Equity by Leveraging Diversity, Inclusion and Patient-January 26 1:00 to 2:00 p.m. **Centered Care** Registration link: https://us06web.zoom.us/webinar/register/WN_wlmnX-H9QDiGnCbB8b4kjw February 4 ASPIRE+ to Reduce Readmissions Learning and Action Network Series Registration link: 12:00 to 1:00 p.m. https://us06web.zoom.us/webinar/register/WN_igOghC87TyeijUSk4E2Vwa February 2022 **Pressure Ulcer and Injury TBA** March 8, 2022 **Exploring Strategies to Prevent Opioid Morbidity and Mortality**

Registration link: 12:00 to 1:00 p.m.

https://us06web.zoom.us/webinar/register/WN_BVIIIazcQAqQFhscKkDdUA

March 2022 CLABSI

TBA

See Compass Navigator newsletter on Feb. 1.





49

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



Grant Opportunity Now Available through June 2022

Align All Health

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

- Learn ways to optimize use of your facility's 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

For more information, please reach out to your KHC Quality Improvement Advisor





51

Upcoming Events

KHC Office Hours

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

- February 23
- July 27
- March 23
- August 24
- April 27
- September 28
- May 25
- + October 26
- June 22

KHC Office Hours series registration link:

https://us06web.zoom.us/webinar/register/WN 3wt40 adg\$2aQmYjbO3mIng

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

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Next Steps

- + Ensure data entry is current and timely
- + Schedule next coaching call (if not already set)
- + Review your Q.I. Work Plan and update for 2022 goals
- + Log into iCompass Forum and iCompass Academy to engage and learn.
- + Watch your inbox for the Compass Navigator on February 1st.



53

Have Questions, Need Help?

Kansas Healthcare Collaborative

Heidi Courson

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

Erin McGuire

Quality Improvement Advisor emcquire@khconline.org 785-231-1333

Michele Clark

Senior Director of Quality Initiatives mclark@khconline.org 785-231-1321

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

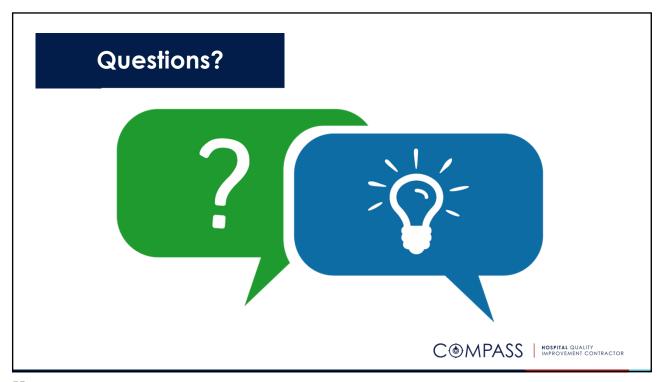
Manager of Client Services jmosier@khinonline.org 785-260-2761

Rhonda Spellmeier

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

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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.

https://www.surveymonkey.com/r/KHC-office-hours-01-26-2022

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Connect with us on:



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

ASPIRE+ to Reduce Readmissions Learning and Action Network Series

January - May 2022

Overview

The ASPIRE+ Method is an evidence-based, locally adaptable method to improve outcomes for populations experiencing high rates of readmissions. in this intensive series, we will move quickly through core elements of the ASPIRE+ Method to help teams identify a subpopulation(s) that experience poor outcomes because of structural issues in the healthcare system and take specific, feasible, action-oriented steps forward to make improvement. This series will catalyze your equity work in 2022, laying a foundation for data-informed, root cause analysis-based work to enhance equity and value in healthcare delivery.

Use the Hashtag:

#ASPIREtoReduceReadmissions to help spread the word about this series!

Target Audience

This webinar series is open to providers, quality and utilization review staff, care managers, patient navigators, health coaches, clinic care team, transition care staff, pharmacy and other readmission reduction hospital team members.

Learning Objectives

- + Know your data
- Understand root causes
- Identify cross-continuum partners
- + Collaborate to test changes
- Measure implementation to close gaps

5 Webinars | Register

 $https://usO6web.zoom.us/webinar/register/WN_igOghC87TyeijUSk4E2Vwg \ (Link)$

Webinars are hosted on the first Friday of each month at 12:00 PM (CST). Dates are listed below.

- + January 7
- + February 4
- March 4
- + May 6





Speaker

Dr. Amy Boutwell, MD, MPP

Amy Boutwell is the founder of Collaborative Healthcare Strategies. Dr. Boutwell is a nationally recognized thought leader in the field of reducing readmissions and improving care for high utilizers, advising statewide initiatives to reduce readmissions and improve care for high utilizers in several states as well as nationally. Dr. Boutwell was the co-designer of the Institute for Healthcare Improvement's STate Action on Avoidable Rehospitalizations (STAAR) Initiative and subsequently the co-author of the Agency for Healthcare Research and Quality's "Hospital Guide to Reducing Medicaid Readmissions" (the "ASPIRE" Guide). Dr. Boutwell co-designed the New York State MAX program.

5 Coaching Calls | Register

https://us06web.zoom.us/meeting/register/tZYsduisqDwsEtZCDHXdh9jePdh2pULj2hkb (Link)

Coaching calls are hosted on the second Friday of each month at 12:00 PM (CST). Dates are listed below.

- January 14
- + March 11
- + May 13

- February 11
- + April 8
 - HOSPITAL QUALITY



This material was prepared by Compass HQIC Network a Hospital Quality Improvement Contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW Compass HQIC Network/Hospital Quality Improvement Contractor – [0083] – 01/04/2022.

Exploring Strategies to Prevent Opioid Morbidity - Mortality

March 8, 2022 from 12:00 - 1:00 PM (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.

Learning Objectives

- Discuss measures to reduce, recognize, and manage opioidrelated adverse drug events
- Identify strategies to prevent opioid mortality at hospital discharge and beyond
- + Describe the role of health equity in the opioid epidemic and how to decrease health disparities

Target Audience

- + Physicians
- Nurses
- Pharmacists
- + Quality improvement staff

Continuing Education

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the lowa Medical Society (IMS) through the joint providership of UnityPoint Health – Des Moines and Iowa Health Collaborative. UnityPoint Health – Des Moines is accredited by IMS to provide continuing medical education for physicians. "UnityPoint Health – Des Moines designates this live activity for a maximum of 1.00 AMA PRA Category 1 CreditTM. Physicians should claim only the credit commensurate with the extent of their participation in the activity."



Event Speaker

Rachael Duncan, PharmD BCPS BCCCP

Rachael is a senior consultant for Stader Opioid Consultants based in Colorado. She has spent the past six years focused on policy, advocacy, and educational work surrounding opioid stewardship and treatment at both the state and national level.

She practices as an emergency medicine and critical care clinical pharmacist at Swedish Medical Center in Englewood, Colorado. In addition, she is the 340B drug program supervisor for Heart of the Rockies Regional Medical Center in Salida, Colorado.

Rachael graduated with her doctor of pharmacy degree from Ohio Northern University in 2011, then completed a PGY1 and PGY2 pharmacy critical care residency at Duke University Hospital in Durham, North Carolina.

Register

https://us06web.zoom.us/webinar/register/WN_ BVIIIazcQAqQFhscKkDdUA (Link)

















Overdose Data to Action (OD2A) Program

The Kansas Healthcare Collaborative (KHC) is working with the Kansas Department of Health and Environment (KDHE) on the Overdose Data to Action (OD2A) project. KHC is accepting applications from hospitals and/or clinics in high risk areas interested in participating in a quality improvement project related to preventing and/or decreasing harms associated with opioids and other controlled substances.

Focus areas may include:

- Decrease providers' self-reported opioid and/or other controlled substance prescribing rates;
- Increase the number of patients receiving non-pharmacological treatments;
- Decrease problematic co-prescribing (e.g. concurrent benzodiazepines and opioids); and
- Increase providers' access to Kansas's Prescription Drug Monitoring Program, K-TRACS.

Project Timeline

Application Period: Accepted on a first come basis, as funding is available.

Last Date to Start: June 1, 2022 Wrap-Up Period: August 31, 2022

Hospital and/or Clinic Responsibility

- 1) Assign a point of contact for the project and meet regularly with a KHC Quality Improvement Advisor in person or virtually during the project period.
- 2) Work with KHC to implement quality improvement cycles, change concepts, policy development and implementation around safe prescribing, screening processes, and/or increasing referrals to evidence-based treatment and other community-based resources, including the use of K-TRACS.
- 3) Agree to share details of the quality improvement project and create a storyboard with indiviulaized data for tracking progress (with the assistance of KHC staff) to be shared with KDHE and potentially other Kansas practices.

Benefits of Participation include:

- Alignment with other KHC Quality Initiatives such as the HQIN and Compass HQIC initiatives' strategies for Behavioral Health, with a focus on Opioids and Patient Safety categories:
 - o Implement best practices for opioid and other controlled substance medication prescribing.
 - Decrease opioid-related adverse drug events for patients who take high-risk medications or have a behavioral health diagnosis.
- A small financial stipend upon completion of the project and submission of the storyboard.

For more information contact your KHC Quality Improvement Advisor or visit www.khconline.org/od2a