Welcome

• Logistics
• Introductions

• Theme for the day: RELATIONSHIPS

Objectives

• Understand the overall strategy for the collaborative
• Learn some behavior based tools for managing change
• Network and share ideas on improving care transitions
• Create an action plan to guide the project
Mission

To improve transitions in care and reduce avoidable hospital readmissions.
Methods

- Pilot Unit / Spread to other units
- Multidisciplinary tiered project team
- Assessment of 5 recent readmissions
- Observations
- Process maps
- Risk assessment
- Follow up appointments and follow up calls or visits
Methods

• Test improvement in 4 key areas:
  – Enhanced assessment of patient post-hospital needs
  – Effective teaching and enhanced patient learning
  – Ensuring post-hospital care follow-up
  – Providing real-time handover communications

• Implement and spread improvements
• Community engagement readiness assessment
• Community cross continuum team

NoCVA Hospital Engagement Network
Idea Sharing

- Note your dot color; that’s your group
- Note the tables around the room, with numbers
- You will rotate to each table, so you’ll have a chance to talk about all four topics
- Share freely, successes and barriers, ask questions
- 10 minutes at each table, then we’ll call time and rotate.
- Full debrief at the end
1. What is the one thing your hospital has done that had the biggest impact on reducing readmissions?

2. What are you finding to be the strongest factor contributing to patients readmitting?

3. Which community partner (SNF, HH, AAA, other) are you most successful in engaging, and how did you do that?

4. What are you currently doing to engage patients and families in reducing readmissions work? How did you get started?
Why readmissions?

Readmissions: 1-30 days (NoCVA)

<table>
<thead>
<tr>
<th>% Readmissions (All Cause, All Payer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>% Readmissions (All Cause, All Payer)</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>PforP Goal</td>
</tr>
<tr>
<td># Hospitals</td>
</tr>
</tbody>
</table>
Why readmissions?

• The facts… Readmit rates have decreased 5%
  – This is good!
    • Many patients helped (over 5000 patients)
    • Huge savings: 50 million dollars
  – But… progress is much slower than we’d like to see
Why readmissions?

Readmissions: 1-30 days (NoCVA)

% Readmissions (All Cause, All Payer)

<table>
<thead>
<tr>
<th></th>
<th>Jan-10</th>
<th>Apr-10</th>
<th>Jul-10</th>
<th>Oct-10</th>
<th>Jan-11</th>
<th>Apr-11</th>
<th>Jul-11</th>
<th>Oct-11</th>
<th>Jan-12</th>
<th>Apr-12</th>
<th>Jul-12</th>
<th>Oct-12</th>
<th>Jan-13</th>
<th>Apr-13</th>
<th>Jul-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>10.3%</td>
<td>10.5%</td>
<td>10.2%</td>
<td>10.2%</td>
<td>10.5%</td>
<td>10.4%</td>
<td>10.2%</td>
<td>10.4%</td>
<td>10.2%</td>
<td>10.1%</td>
<td>9.8%</td>
<td>10.1%</td>
<td>10.1%</td>
<td>10.0%</td>
<td>9.8%</td>
</tr>
<tr>
<td>PforP Goal</td>
<td>8.3%</td>
<td>8.3%</td>
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<td>8.3%</td>
<td>8.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td># Hospitals</td>
<td>105</td>
<td>105</td>
<td>105</td>
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<td>105</td>
<td>105</td>
<td>103</td>
<td>104</td>
<td>104</td>
</tr>
</tbody>
</table>
How to reduce readmit rates?

1. Identify high risk patients before discharge
2. Initiate enhanced f/u plan for high risk patients:
   - F/u visit with provider within 7 days & phone call/visit within 3 days

Fewer readmissions

Improve Internal Processes

Deepen Community Relationships
What process measures to use?

• % of patients given assessment for high risk of readmission – Goal: 95%
• % of high-risk patients whose f/u visit is scheduled within 7 days – Goal: 95%
• % of high risk patients who have a follow-up phone call within 3 days – Goal: 95%
• % of high-risk patients who cannot be reached – Goal: <5%
Readmit Rate (hospital-wide)

- Source: claims; hospital does not submit
- Brief definition: All payer, all-cause readmission rate—every patient, every reason, every time
- Not the same as the Medicare readmit rates
- Not risk-adjusted
- Observation patients not included
- Data available roughly 6 months after close of quarter
• Each hospital should calculate a readmit rate for the unit/population it is working with
  – Work with your hospital resources—are there available reports which (roughly) track this population?
• Each hospital will define its readmit measure slightly differently
  – Data will be used to track progress relative to your baseline, but not to compare hospitals
Considerations for unit/population readmit rates

• Include readmits back to any part of the hospital, not just back to your unit, if possible.
• Ideally, include readmits back to other hospitals (e.g., in your system).
• Talk to your hospital about how to handle same day ‘readmits’.
• Ideally, NoCVA suggests including observation patients.
Big picture:

- Use available hospital resources
- It’s okay if your internal readmit report doesn’t perfectly capture your specific unit/population
- Don’t get bogged down in readmit details—key question is whether your hospital can build/track a measure which will show movement in response to the work you do with this population/unit. You want feedback for your PI work!
• Some of these measures are new—there are things we haven’t thought of.
  – Your feedback makes these better and more meaningful!
• It is good to have questions—but we need them ASAP.
  – Your first data is due July 20th, so you will be data-collecting during June.
• Questions can go to coaches, Dean, Laura or myself: Erica Preston-Roedder eroedder@ncha.org
Data Submission Timeline

• Process measures
  – First submission July 20\textsuperscript{th} (June data)
  – Subsequent submissions monthly

• Readmit rate by unit/population
  – First submission on August 20 (April, May, and June data)
  – Okay to submit historical data back to 2010, if desired
  – Subsequent submissions monthly if possible, quarterly if necessary
What resources does NoCVA provide?

- Data manual
- Archived webinar, “Measurement” (May 19)
- Word of mouth
  - Use your coach/NoCVA: ask us questions!
  - Use each other—if you build a report in EPIC to get some of this data, send a note to the list-serve letting others know they can contact you to share ideas.
- Monthly feedback reports, starting July 30th.
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How do you make your data work for you?

You have two jobs…

• How can I collect & report meaningful data to NoCVA?

• What is my team actually going to do make this data meaningful to our PI efforts?
Making use of your data

- Collection: Who will collect it & how?
- **Make use of data:**
  - Where/how report? To the staff, to senior leaders, etc.?
  - Who is responsible for investigating any process or outcome measure gaps, e.g. who will find out WHY telephone calls aren’t being made? (Or, who is responsible for reviewing reports and identifying gaps for PI?)
  - What are our internal team targets? Which measures are we focused on first?
<table>
<thead>
<tr>
<th>Measure</th>
<th>Operational Definition</th>
<th>Method and Frequency of Data Collection</th>
<th>Who will collect?</th>
<th>Who will analyze and report?</th>
<th>What will be reported, to whom, and when?</th>
<th>How will results be used or shared with staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Readmit rate for unit/population</td>
<td>Defined by your hospital</td>
<td>Monthly, 20th of the month</td>
<td></td>
<td></td>
<td>Report rate for month, on run chart. Ideally, report any special reason why rate went up/down. Team will discuss as standing monthly agenda item.</td>
<td>Rates posted on white board in unit monthly, with goal line added after first quarter of data collected.</td>
</tr>
<tr>
<td>2. Readmit rate (all hospital)</td>
<td># of readmits/# of discharges</td>
<td>Quarterly; claims-based</td>
<td>NCQC</td>
<td></td>
<td>Project lead reviews quarterly to see if collab is on target; Biannual update w/snr leaders.</td>
<td>Posted on white board for staff.</td>
</tr>
<tr>
<td>3. Percent of patients given assessment/# of patients on pilot unit/population</td>
<td># of patients given assessment/# of patients on pilot Ex: July data due Aug 20th.</td>
<td>Monthly, due on 20th of the month</td>
<td></td>
<td></td>
<td>Rates will be reported to the Readmissions team (both unit-level and hospital level) on a monthly basis. Rates will be trended to show changes over time. Share with coach quarterly. Team's target is tool in place by July 1, 50% of patients by Aug 1, and 95% of patients by Sept 1.</td>
<td>Run chart will be posted on white board on unit, and shared at monthly staff meeting. Goal lines will be posted too.</td>
</tr>
</tbody>
</table>
Summary

• Process/Outcome measures look at whether care is transformed for high risk patients.
  – 2 outcome measures; 4 process measures

• Make your to-do list
  – Can you get unit/population readmit rates?
  – What questions do you have on process measure definition?
  – Who will collect process measures?
  – How will our team use the data?
Work with your data

- Hospital readmission rate
- Pilot unit or population readmission rate
- What’s your goal?
- How will you collect and use this data?
Diagnostic Assessment

- Chart review
- Interviews with patients, families, and caregivers
- 5 initial reviews
- Repeat as needed
- “Why?” conferences
Worksheet A: Chart Reviews of Patients Who Were Readmitted

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses from the hospital and community settings. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients.

<table>
<thead>
<tr>
<th>Question</th>
<th>Patient #1</th>
<th>Patient #2</th>
<th>Patient #3</th>
<th>Patient #4</th>
<th>Patient #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between the last discharge and this readmission date?</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
<td>_____ days</td>
</tr>
<tr>
<td>Was the follow-up physician visit scheduled prior to discharge?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, was the patient able to attend the office visit?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Were there any urgent clinic/ED visits before readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Functional status of the patient on discharge?</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Was a clear discharge plan documented?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Was evidence of “Teach Back” documented</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>List any documented reason/s for readmission</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
<td>Comments:</td>
</tr>
<tr>
<td>Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Worksheet B:
Interviews with Patients, Family Members and Care Team Members

- **Ask Patients and Families:**
  - How do you think you became sick enough to come back to the hospital?
  - Did you see your doctor or the doctor’s nurse in the office before you came back to the hospital?
    - Yes
    - If yes, which doctor (PCP or specialist) did you see?
    - No
    - If no, why not? Describe any difficulties you had to get an appointment or getting to that office visit.
  - Has anything gotten in the way of your taking your medicines?
  - How do you take your medicines and set up your pills each day?
  - Describe your typical meals since you got home.

- **Ask Care Team Members:**
  - What do you think caused this patient to be readmitted?
  - After talking to the provider and the care team about why they think the patient was readmitted, write a brief story about the patient’s circumstances that contributed to the readmission:
Dig a little deeper

What do the patient’s comments suggest about:
Discharge process including perceived readiness?
Educational or written materials?
Whether teach-back is targeted effectively?
Whether “whole person” needs are being identified?
Whether referrals for supports and follow up are made before discharge?
Whether there is any collaboration with post-acute or community providers?

Whether patients view readmissions as “bad” or as “ok”? What does that suggest for efforts to educate the public about effective transitions in care?
Working with your diagnostic assessment

- What did you learn?
- What new questions do you have?
- What needs to be improved?
- What should you do next?
Process Map of Discharge Process

- Insight
- Illustration
- Complete picture of current process
- Identify areas for improvement
- Comparison
Simple Tools

Flow charts use three shapes:

- **Activity or task**
- **Direction**
- **Question or decision point**

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Getting the most out of the map

- Map the current process—not what you want or what the protocol says
- Involve stakeholders from the beginning
- Map *only* the process you want to improve—boundaries
- Set expectation of safety
- Remember to cross department boundaries
- Verify process with other team members for accuracy
Working with your flowchart of discharge

- What did you learn?
- What do you want to improve?
- Did you include a patient advisor in making the flowcharts?
- Why or why not? What might be different if you did?
Assessing Risk of Readmission

- Post-hospital Care Access
- Diagnosis and Comorbidities
- Patient Activation
- Psychosocial Support
- High Utilization
# High Impact Target Population

<table>
<thead>
<tr>
<th>Metric</th>
<th>Virginia</th>
<th>North Carolina</th>
</tr>
</thead>
<tbody>
<tr>
<td># (%) of patients with ≥3 hospitalizations</td>
<td>23,682 (13%)</td>
<td>27,765 (12%)</td>
</tr>
<tr>
<td># (%) of hospitalizations used by H.U.</td>
<td>61,060 (22%)</td>
<td>108,814 (30%)</td>
</tr>
<tr>
<td># of readmissions among H.U.</td>
<td>36,998</td>
<td>42,204</td>
</tr>
<tr>
<td>% of readmissions that occur in H.U.</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>Readmission rate among H.U.</td>
<td>40%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Amy Boutwell, 3/27/14 webinar, based on Medicare Data from QIOs
Characteristics of “good” readmission risk assessments

• Good predictive ability
  – Considers relevant predictors related to both clinical and psychosocial factors of readmission

• Easily interpreted results
  – Stratification of risk groups
  – Targeted interventions

• Time-manageable

• Cost-manageable
• Some predictors used are affected by multiple factors
  – Polypharmacy and problem medications
  – PCP access, relationship, or history
  – Patient or caregiver activation
  – Length of stay
Working with your risk assessments

• If you are using a risk assessment, is it working as planned? If not, how will you improve it?
• If you are using a risk assessment in one unit, when and how will you spread it to others?
• If you are developing a risk assessment, when will you begin using/testing it?
The three questions provide the strategy:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

The PDSA cycle provides the tactical approach to work.

Source:
What are we trying to accomplish?

The Project AIM is:

• Not just a vague desire to do better
• A commitment to achieve measured improvement
  – In a specific **system**
  – With a definite **timeline**
  – And numeric **goals**

Hope is not a plan.
“Some” is not a number.
“Soon” is not a time.
How do we know a change is an improvement?

“You can’t fatten a cow by weighing it”

- Palestinian Proverb

• Improvement is not just about measurement

• However…
The purpose of measurement in QI work is for learning not judgment!

All measures have limitations, but the limitations do not negate their value for learning.

You need a balanced set of measures reported daily, weekly or monthly to determine if the process has improved, stayed the same or become worse.

These measures should be linked to the team’s Aim.

Measures should be used to guide improvement and test changes.

Measures should be integrated into the team’s daily routine.

Data should be plotted over time on annotated graphs.

Focus on the Vital Few!
What Changes Can We Make That Will Result in Improvement?

- Reduce readmission rate on unit 5W from 12% to 10% by December 2013.
- Arrange follow up visit within 7 days for high risk patients.
- Coordinate with physician practices to ensure access.
- Include patients in planning followup visit.
- Leverage existing followup resources (CCNC, etc.).
- Develop a team to determine who will make calls.
- Arrange follow up visit or call within 3 days for high risk patients.
The PDSA Cycle

**Plan**
- Objective
- Questions & predictions
- Plan to carry out: Who? When? How? Where?

**Do**
- Carry out plan
- Document problems
- Begin data analysis

**Act**
- Ready to implement?
- Try something else?
- Next cycle

**Study**
- Complete data analysis
- Compare to predictions
- Summarize

“Let’s try it!”

“Did it work?”

“What’s next?”

“What will happen if we try something different?”

NoCVA Hospital Engagement Network
AIM statements

- What will you accomplish?
- By when?
- For whom?
- Include how you will know it has improved (measures)
# Improvement Areas and Process Measures

<table>
<thead>
<tr>
<th>Improvement Area</th>
<th>Process Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner with Patient and Family to Determine Post Hospital Needs</td>
<td>Arrive follow-up physician visit within 7 days of discharge for high risk patients</td>
</tr>
<tr>
<td>Provide Effective Teaching and Facilitate Learning</td>
<td>Arrange follow-up call or visit within 3 days of discharge for high risk patients</td>
</tr>
<tr>
<td>Create and Activate Post Hospital Care Follow-up</td>
<td></td>
</tr>
<tr>
<td>Provide Real-time Handover Communications</td>
<td></td>
</tr>
<tr>
<td>Assess risk of readmission</td>
<td></td>
</tr>
<tr>
<td>Convene community cross-continuum team</td>
<td></td>
</tr>
<tr>
<td>Assess and address causes of readmission</td>
<td></td>
</tr>
<tr>
<td>Include patient and family in all processes</td>
<td></td>
</tr>
</tbody>
</table>
Partner with Patient and Family to Determine Post-Hospital Needs

• Involve the patient, their family, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient’s home-going needs.
• Reconcile medications upon admission.
• Include patients and families in scheduling follow up appointment and follow up visit/call.
Provide Effective Teaching and Facilitate Learning

- Involve all learners in patient education.
- Always use Teach Back throughout the hospital stay to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care.
- Increase awareness of and sensitivity to cultural differences, literacy, social needs, and behavioral health concerns.
Video on Health Literacy

- Show video here...embed it, with the reference link visible also

- http://www.youtube.com/watch?v=ImnlptxlMXs
Working with the key areas

• Partner with Patient and Family to Determine Post-Hospital Needs

• Provide Effective Teaching and Facilitate Learning

• Goals and PDSA worksheets
Create and Activate
Post-Hospital Care Follow-up

- Review daily the patient’s medical and social risk for readmission and finalize the customized post-hospital follow-up plan
- Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the identified post-hospital needs and the capabilities of patients and family caregivers
- Arranging follow up appointment in 7 days for high risk patients
- Arranging for follow up visit/call for high risk patients
Provide Real-Time Handover Communications

• Give patient and family members a patient-friendly, post-hospital care plan which includes a clear medication list.
• Provide customized, real-time critical information to the next site of care
• If transferring to SNF, HH, or other facility, this includes informing them of high risk status and need to access appointment in 7 days and have follow up “visit”
Working with the key areas

• Create and Activate Post-Hospital Care Follow-Up
• Provide Real-Time Handover Communications
• Goals and PDSA worksheets
Attend to non-clinical issues

- There is an integral role of community based support services

Reducing readmissions is a cross-continuum effort

- QIO 10th SOW, “Integrating Care for Populations and Communities”
- Focused on engaging numerous providers within a community
- SNF and HH readmission penalties are proposed
Community Organizing and Engagement

A shared story and a shared commitment

Originally adapted from the work of Marshall Ganz of Harvard University and adapted by Risa Hayes and the CFMC team for a guide.
Sharing the story

• Three stories
  – Story of self
  – Story of us
  – Story of now

Always include Challenge, Choice and Outcome
Building Relationships

Identify and Recruit leaders
Build community
Turn community resources into power
Interests and Resources

What change do we want? (What is our interest?)

Interests

Our Campaign

What resources do we have that they want?

Resources

Who has the resources to create that change?

Commitment

What do they want? (What is their interest?)

Leadership
Constituency
Support
Competition
Opposition

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Develop a shared purpose

- Who
- What
- How
- Why
- When
Create an **Organizing Sentence** that translates your shared purpose into a strategy.

- **“We are organizing:** (WHO: people, resources)
- **To do:** (WHAT: measurable goal)
- **By:** (HOW: tactic 1, 2 etc)
- **In order to:** (WHY: motivating vision)
- **By:** (WHEN: timeline)
Planning for community engagement

Who is your community?

What are the causes of readmissions in your community?

How can community partners work together?
• What is a project?
  – A temporary endeavor undertaken to create a unique product or service

• What is Project Management?
  – The application of knowledge, skill, tools, and techniques to project activities to meet the project requirements

• Project Phases: Initiation, Planning, Implementation, and Closeout

• Project Plan- key activities, milestones, dates, status, and task assignments
<table>
<thead>
<tr>
<th>Task Name</th>
<th>Due Date</th>
<th>Start Date</th>
<th>End Date</th>
<th>Assigned To</th>
<th>Status</th>
<th>Notes/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prework</td>
<td>06/18/14</td>
<td>03/03/14</td>
<td>06/18/14</td>
<td></td>
<td></td>
<td>Prework Materials</td>
</tr>
<tr>
<td>Attend Jun 18 In person Learning Session</td>
<td>06/18/14</td>
<td>06/18/14</td>
<td>06/18/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Period 1</td>
<td>06/19/14</td>
<td>01/30/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in Learning Session #2</td>
<td>01/05/15</td>
<td>01/30/15</td>
<td></td>
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<td>Exact Date TBD</td>
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<tr>
<td>Action Period 2</td>
<td>01/12/15</td>
<td>06/30/15</td>
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<tr>
<td>Participate in Learning Session #3</td>
<td>06/01/15</td>
<td>06/30/15</td>
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<td>Exact Date TBD</td>
</tr>
<tr>
<td>Post Work/Project Closeout</td>
<td>07/01/15</td>
<td>02/22/16</td>
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<tr>
<td>Data Submission</td>
<td>07/01/14</td>
<td>02/22/16</td>
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<td>Data Manual</td>
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</tbody>
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NoCVA Hospital Engagement Network
Project Management Tool

- **SmartSheet**: [http://www.smartsheet.com](http://www.smartsheet.com) (requires free login account)
- Web-based project management tool
- Individualized and customizable project plan
- Full admin control
- Setup upon request: dhiggins@ncha.org
Objectives

• Understand the overall strategy for the collaborative
• Learn some behavior based tools for managing change
• Network and share ideas on improving care transitions
• Create an action plan to guide the project
Evaluation

• What went well today? What worked?

• What didn’t go so well today? What could work better?

• What could we have done differently to improve the day?

• What can we do to support you going forward?
### Upcoming webinars and coaching

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>“Catch up” Webinar</td>
<td>July 16, 11:30 – 1:00</td>
</tr>
<tr>
<td>Group Coaching Calls</td>
<td>August 11, 1:30</td>
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<tr>
<td>Webinar: Data Update</td>
<td>September 8, 1:30</td>
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<td>Webinar</td>
<td>October 13, 1:30</td>
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<tr>
<td>Group Coaching Calls</td>
<td>November 10, 1:30</td>
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<tr>
<td>Webinar</td>
<td>December 1, 1:30</td>
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</table>
For more information, contact:

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Dean Higgins, Project Manager, dhiggins@ncha.org