Super-Utilizer Coaching Package:
WHAT'S IN YOUR TOOLKIT?

Quality advisors (QAs) play a vital role in coaching providers on strategies to reduce readmissions and emergency department (ED) visits for patients who meet the super-utilizer criteria. The Centers for Medicare & Medicaid Services define super-utilizer patients as those who have been hospitalized four or more times or visited the ED four or more times in a year. This coaching package is a companion to the Impact Super-Utilizer Patients one-pager and bite-sized learning videos. It provides a framework for coaching providers on super-utilizer reduction strategies and best practices. In addition, it helps Alliant Health Solutions' new QA team members by highlighting the content of the super-utilizer toolkit.

Active engagement of ED, case management, IT and community partners is preferred, though it is not always possible. If active engagement is not possible, then start with smaller steps. For example, you can begin by reviewing data and refining the super-utilizer definition that the provider wants to use. Alternatively, you can collaborate with the provider to identify a best practice in this toolkit, such as Teach Back or Warm Hand-off, that aligns with their goals or opportunities and start from there.

TIPS

1. Define the value proposition for the provider you are working with:
    a. Tie readmissions to their existing dashboard or performance measure goals (i.e., census, length of stay, bed management, customer satisfaction, ED throughput).
    b. Review the community needs assessment before reaching out to the provider. Doing so will enable you to propose a tailored approach, identify community priorities, and align your project goals with the provider's objectives.

2. Review the bite-size learning videos for additional strategies.
    a. Reflect on the coordinating bite-sized learning segment for each of the five sections of the approach outlined below.

SUMMARY

The Impact Super-Utilizer Patients handout and Care Transitions Super-Utilizer Patients Bite-Sized Learning are tools that can help you and providers reduce readmission rates by focusing on super-utilizer patients. This guide provides extra tips for using these tools with individual providers, health systems and groups of nursing homes.

Focus Area	Strategies and Coaching Tips	Resource Links	Sample Tests of Change Measures
Gather and Analyze Data	• Define super-utilizer with the threshold the provider wants to set. • Identify the super-utilizers. • Set reduction targets.	ASPIRE	Number of super-utilizers reduced over the defined period.
Engage Patients To Determine Drivers of Needs	• It is critical to talk to and evaluate patients since chart reviews do not capture all the information needed to identify root causes. • Identify the root cause of each readmission (e.g., Five Whys interview with the patient). • Supplement patient interviews with information gathered from Social Determinants of Health (SDOH) screening tools to identify and address readmission drivers.	Social Determinants of Health (SDOH) Discharge Referral List Critical Access Hospital in Utah Focuses on Assessment of Social Determinants of Health to Reduce Readmissions Five Whys Tool for Root Cause Analysis	Number of patient interviews. Number of SDOH screenings completed.
Develop	• Personalized community plans of care. • Collaborate with teams to create ED Care Alerts so providers can implement the Community Care Plan upon arrival at the ED. • Implement an IDEAL Discharge process. **Develop discharge plans for each super-utilizer currently in the facility that:** • Includes patent and care partner input. • Centers on what matters most to the patient. • Actively connects the patient to providers and services. • Is shared with the patient in the preferred language and appropriate health literacy level.	AHRQ ASPIRE Tool 9 Transitions of Care: AHRQ Ideal Discharge Overview Transitions of Care: Utilizing the AHRQ IDEAL Discharge Process Implementing IDEAL Discharge Step 1: Form a Multidisciplinary Team & Examine Your Current Process Implementing the IDEAL Discharge Step 2: Creating Your Implementation Strategy Implementing the IDEAL Discharge Step 3: Implement and Evaluate Your Ideal Discharge Strategy Goals of Care: Be Conversation Ready Transitions of Care: Make Teach-Back an Always Event	Number of personalized community plans of care developed and shared with patients and care partners. Number of ED alerts (EMR system alerts) established for super-utilizers. Number of discharge plans developed using the IDEAL Discharge Framework. Number of discharge plans that: • Are developed with the input of the patient and care partner. • Center on what matters most to the patient. • Actively connects the patient with providers and services. • Are shared with the patient in the preferred language and appropriate health literacy level.

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Link Patients With Community Services	Use the AHRQ ASPIRE Community Resource Guide to stimulate the development of a broader set of community agency contacts, specifically agencies and providers that can meet the patient's post-hospital and ongoing clinical, behavioral, and social determinants of health needs. Make timely post-discharge follow-up calls, review care transition and answer questions.	AHRQ ASPIRE Tool 11 Social Determinants of Health (SDOH) Discharge Referral List Post Discharge Follow-Up Call Script Post Discharge Text Messaging Works	Number of partnerships with community providers and agencies. Number of post discharge follow-up calls.
Collaborate With Providers Across the Care Continuum	**Encourage effective collaboration across the continuum of care to include:** • Warm handoff to improve communication during care transitions. • Focus on medication reconciliation and management. ○ Collaborate with pharmacy on improvement of cross-setting management of high-risk medications (e.g., opioids, anticoagulants, and diabetes medications) during transitions of care to prevent adverse drug events.	Transitions of Care: Re-ignite the Warm Handoff to Reduce Readmissions Essential Communication Elements Toolkit Resources CDC Guidelines for Prescribing Opioids for Pain	Number of providers implementing warm handoff in at least one additional unit or service location.

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