Midwest QIN-QIO

The New Centers for Medicare & Medicaid Services (CMS) QIN-QIO for Region 6

MIDWEST
QIN-QIO

WELCOME

We are so glad you could join us today!

Raise your hand, hold up a finger **on a scale of 1 to 5**, how familiar you are with the Centers for Medicare & Medicaid Services (CMS) QIO program:

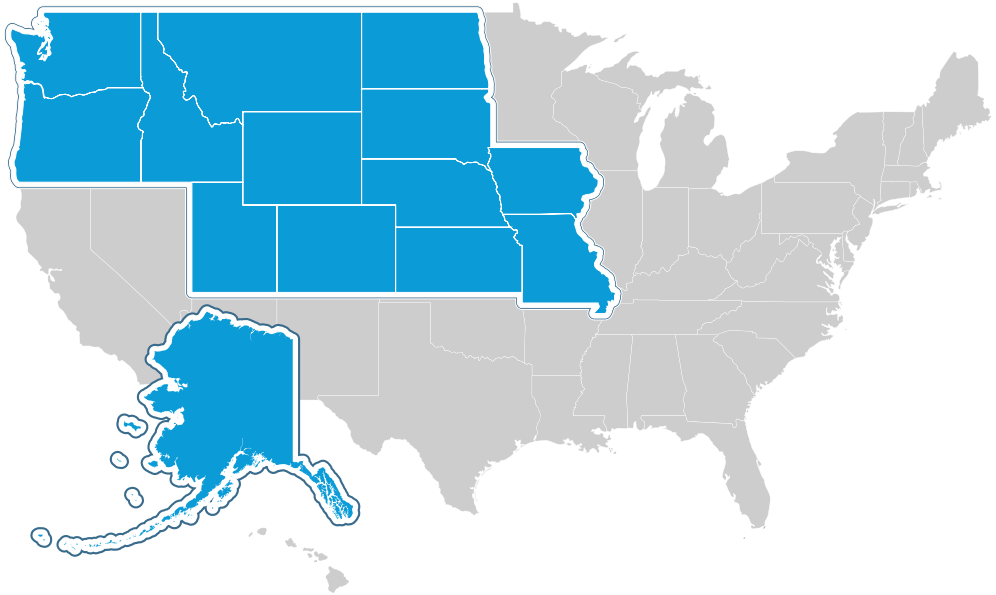
MEET THE PRESENTERS

Annie Miller
Quality Improvement Advisor
Outpatient Clinics

Lisa Barton
Quality Improvement Advisor
Hospital and Nursing Homes

Introducing the Midwest QIN-QIO

Midwest CMS QIN-QIO



The Quality Improvement Organization (QIO) Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy for providing better care and better health at lower cost.

Benefits of Enrolling in the Midwest QIN-QIO

Service	Enrolled Providers	All Providers
Dedicated QIA	✓	
Individual technical assistance (virtual or in-person)	✓	
Hands-on implementation support	✓	
Customized progress reports	✓	
Support with data use & interpretation	✓	
Benchmark reports	✓	
Facilitate care coordination	✓	✓
Access to QI tools & resources	✓	✓
Clinical guidelines & best practices	✓	✓
Connections to local and regional initiatives	✓	✓
Educational & peer-learning	✓	Limited
Mentorship & expert-led training	✓	Limited
Timely updates on trends & programs	✓	✓

Hospital Quality Improvement Focus Areas

VACCINATIONS

- Influenza vaccination among healthcare personnel (IMM-3)

CARE COORDINATION

- Hospital 30-day readmissions – all cause unplanned

INFECTION PREVENTION

- CAUTI
- CDI
- CLABSI
- SSI
- MRSA

SAFETY EVENTS

- Hospital Harm Pressure Injury (HH-PI eCQM)
- Median time from ED arrival to ED departure for discharged ED patients (OP-18)
- Patient Safety Index (PSI-90)

HEALTH IT

- Advance use of Health IT & Interoperability for improving outcomes

BEHAVIORAL HEALTH

- Follow-up after ED visit for alcohol & other drug abuse or dependence

QUALITY MANAGEMENT INFRASTRUCTURE

- Deficiencies related to 4 aims: prevention & chronic disease, behavioral health, patient safety, care coordination
- Deficiencies related to emergency preparedness
- Deficiencies in QAPI

ADVERSE DRUG EVENTS

- Safe use of opioids – concurrent prescribing (CMS 560 eCQM)

OTHER FOCUS AREAS

- Workforce challenges
- Emergency Preparedness
- Cybersecurity

eCQM = electronic Clinical Quality Measures, ED = Emergency Department, IMM = Immunization, OP = Hospital outpatient quality measure

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Outpatient Clinic Quality Improvement Focus Areas

PREVENTION & CHRONIC DISEASE MANAGEMENT

- Adult immunization up-to-date status*
- Body Mass Index (BMI) Screening & follow-up plan*
- Controlling High Blood Pressure*
- Diabetes: Glycemic Status Assessment >9%*
- Kidney Health Evaluation*
- Timely referral to Nephrologist
- Annual Wellness Visits

CARE COORDINATION

- 30-Day Readmissions per 1,000 Medicare beneficiaries*
- Chronic Ambulatory Care Sensitive Conditions (ACSC ED Visits per 1,000 Medicare beneficiaries

PATIENT SAFETY

- Adverse drug events among high-risk Medicare beneficiaries
- Falls Risk Assessment*
- Falls Plan of Care*

ADVANCING HEALTHCARE QUALITY THROUGH TECHNOLOGY (AHQT)

- Advance use of Health IT & Interoperability to improve outcomes

BEHAVIORAL HEALTH

- Screening & brief counseling for unhealthy alcohol use*
- Screening for depression & follow-up plan*
- Suicide Risk Assessment*

OTHER FOCUS AREAS

- Emergency Preparedness
- Cybersecurity
- Workforce challenges

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*Merit-based Incentive Payment System (MIPS) Measures

Join us!

- Thousands of healthcare providers are already improving care through QIN-QIO support, at no cost
- Participation is voluntary
- Learn more at CMS Quality Improvement Organizations or contact us directly:
  - https://www.cms.gov/medicare/quality/quality-improvement-organizations/current-work
  - https://www.cms.gov/files/document/qin-qio-fact-page.pdf
  - www.midwestcmsqinqio.com

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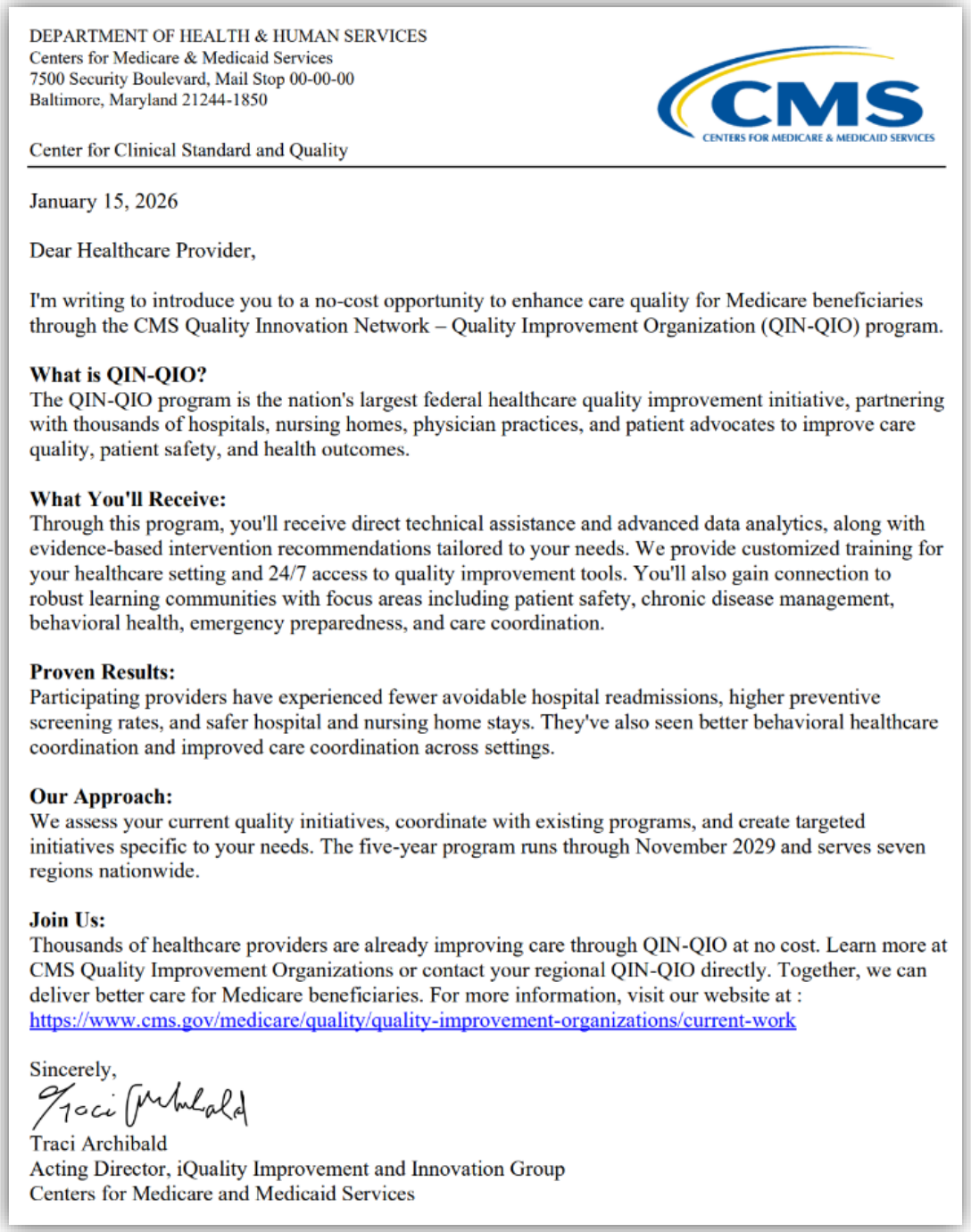


DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standard and Quality

January 15, 2026

Dear Healthcare Provider,

I'm writing to introduce you to a no-cost opportunity to enhance care quality for Medicare beneficiaries through the CMS Quality Innovation Network – Quality Improvement Organization (QIN-QIO) program.

What is QIN-QIO?
The QIN-QIO program is the nation's largest federal healthcare quality improvement initiative, partnering with thousands of hospitals, nursing homes, physician practices, and patient advocates to improve care quality, patient safety, and health outcomes.

What You'll Receive:
Through this program, you'll receive direct technical assistance and advanced data analytics, along with evidence-based intervention recommendations tailored to your needs. We provide customized training for your healthcare setting and 24/7 access to quality improvement tools. You'll also gain connection to robust learning communities with focus areas including patient safety, chronic disease management, behavioral health, emergency preparedness, and care coordination.

Proven Results:
Participating providers have experienced fewer avoidable hospital readmissions, higher preventive screening rates, and safer hospital and nursing home stays. They've also seen better behavioral healthcare coordination and improved care coordination across settings.

Our Approach:
We assess your current quality initiatives, coordinate with existing programs, and create targeted initiatives specific to your needs. The five-year program runs through November 2029 and serves seven regions nationwide.

Join Us:
Thousands of healthcare providers are already improving care through QIN-QIO at no cost. Learn more at CMS Quality Improvement Organizations or contact your regional QIN-QIO directly. Together, we can deliver better care for Medicare beneficiaries. For more information, visit our website at : https://www.cms.gov/medicare/quality/quality-improvement-organizations/current-work

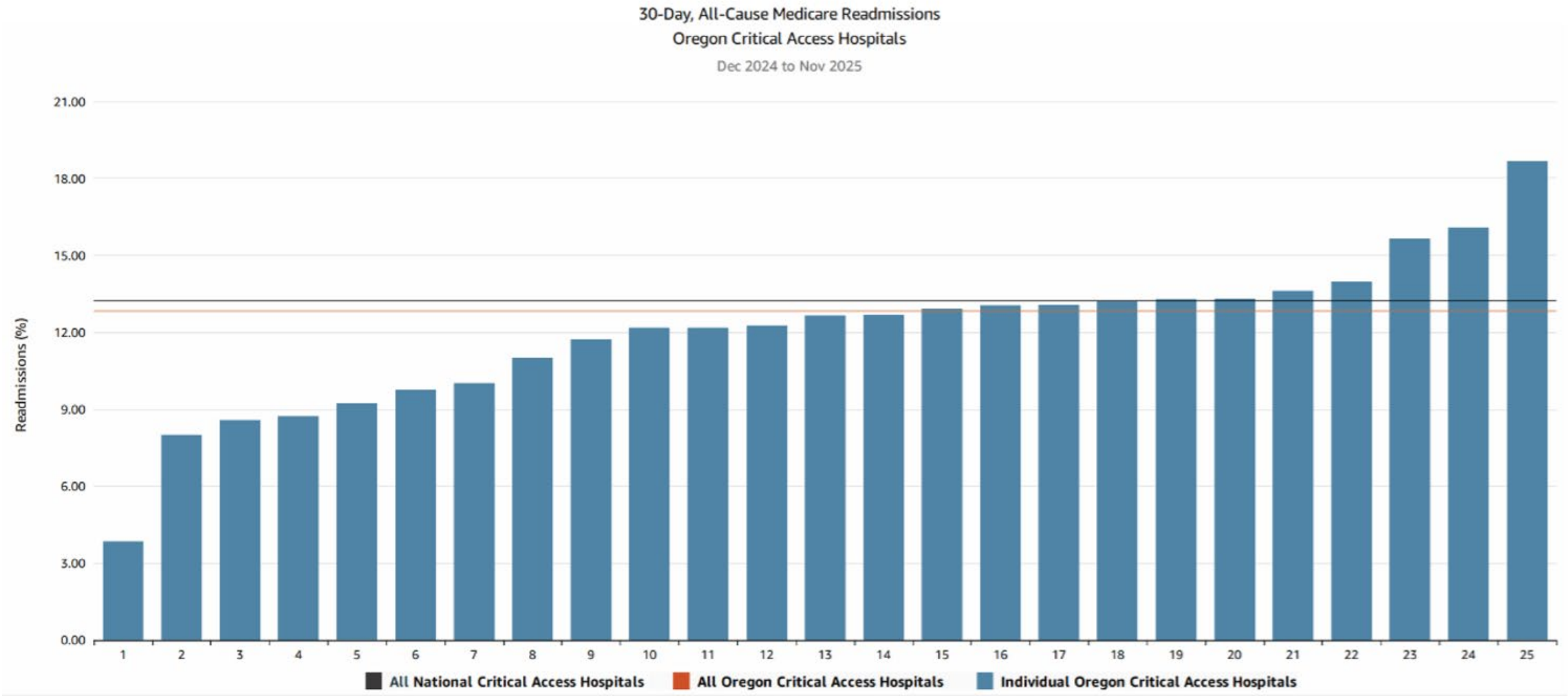
Sincerely,

Traci Archibald
Acting Director, iQuality Improvement and Innovation Group
Centers for Medicare and Medicaid Services

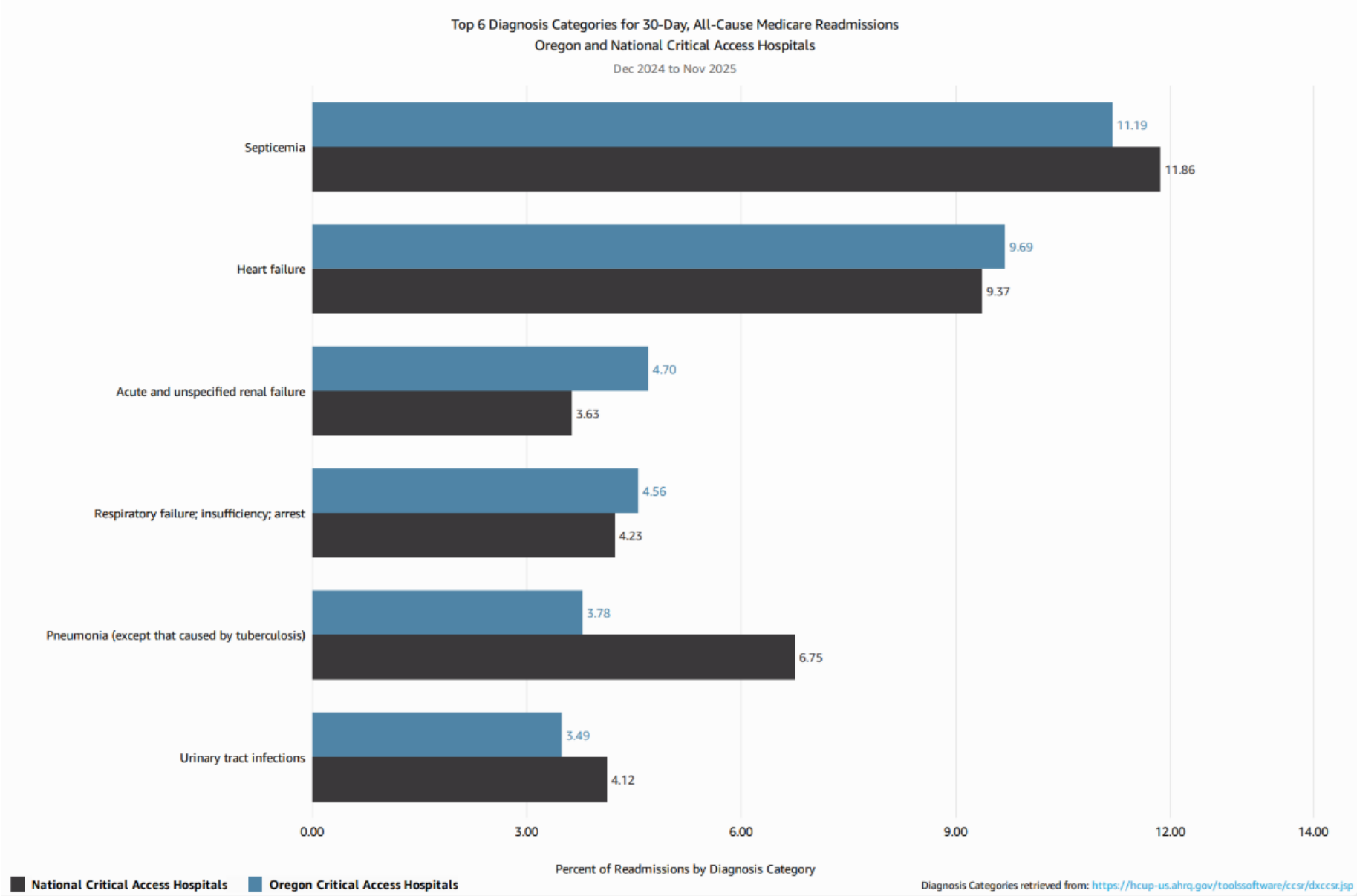
Using Root Cause Analysis (RCA) to Reduce Hospital Readmissions

Why focus on readmissions?

Comparison of Hospital All Cause Readmission Rates



Re-Hospitalization Diagnosis Drivers



Common Drivers of Preventable Readmissions

Inadequate Discharge Planning:

- Poor communication of discharge instructions to patients and their families.
- Lack of comprehensive discharge plans that include follow-up care and medication management.

Limited Access to Follow-Up Care:

- Limited access to timely follow-up appointments due to rural provider shortages.
- Transportation challenges for patients to reach healthcare facilities for follow-up visits.

Medication Management Issues:

- Inadequate patient education on medication regimens, potential side effects, and the importance of adherence.
- Lack of access to pharmacies or challenges in obtaining prescribed medications.

Chronic Disease Management:

- Insufficient support for managing chronic conditions such as diabetes, heart failure, and chronic obstructive pulmonary disease (COPD).
- Lack of resources for patient education and self-management programs.

Social Determinants of Health:

- Financial, lack of stable housing, and food insecurity that impact a patient's ability to adhere to treatment plans.
- Limited access to community resources and support services.

Communication Gaps:

- Poor coordination and communication between the hospital, primary care providers, and specialists.
- Lack of a standardized process for sharing patient information across care settings.

Patient Engagement and Health Literacy:

- Low health literacy levels that hinder patients' understanding of their conditions and the importance of adherence to treatment plans.
- Insufficient patient involvement in care planning and decision-making processes.

Inadequate Monitoring and Support for High-Risk Patients:

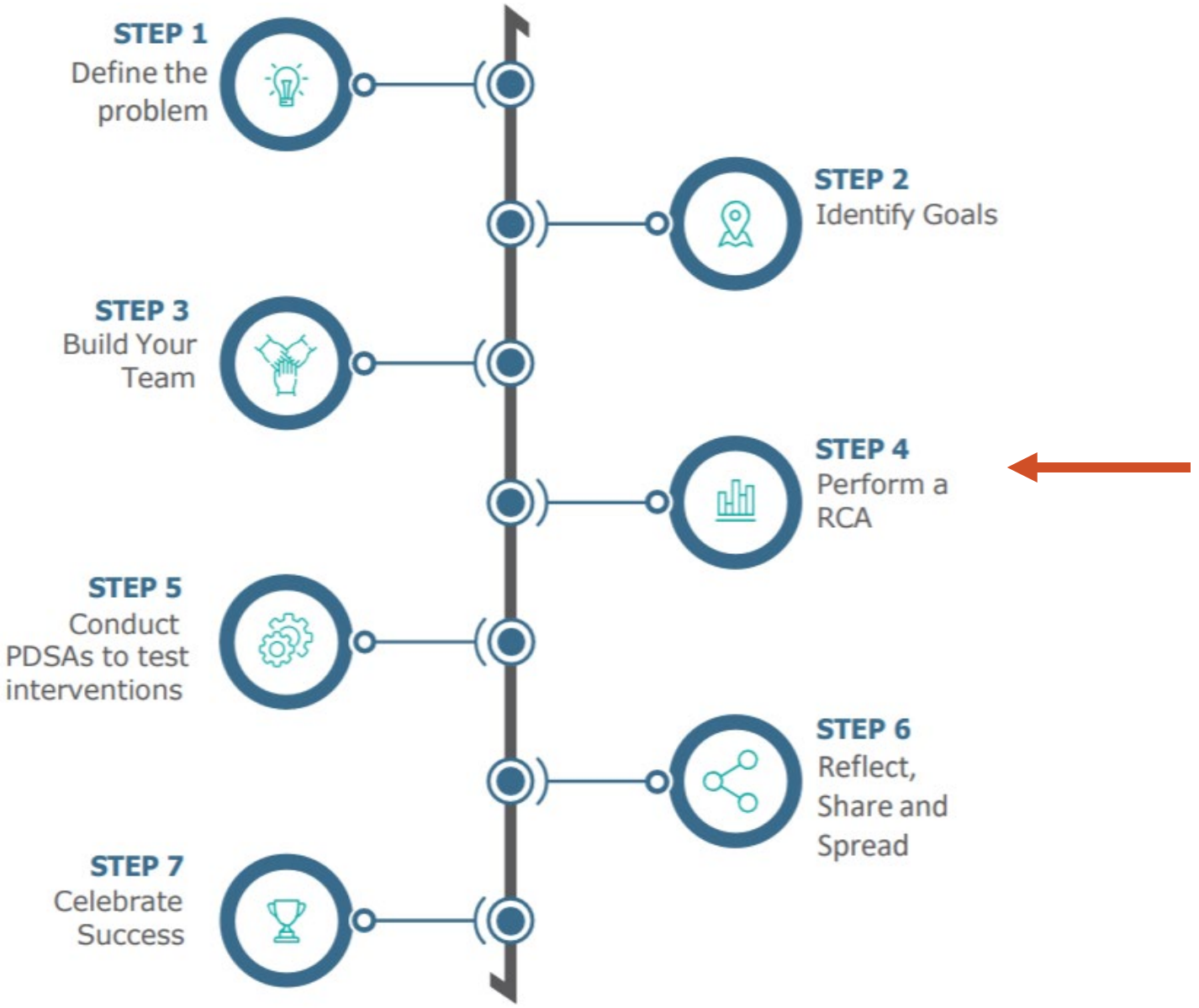
- Failure to identify and provide additional support for patients at high risk of readmission.
- Lack of remote monitoring technologies and telehealth services to support patients post-discharge.

What is Root Cause Analysis (RCA)?

- Root causes are unseen or unnoticed faults in the process or system leading to a harmful or unwanted event
  - Often there are several root causes
- RCA is a structured facilitated team process identifying root causes
  - What happened?
  - Why did it happen?
  - Identify breakdowns in processes and systems
  - Helps prevent future events
- RCA is a tool for mitigation strategy planning

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

Quality Improvement Journey



Who should be included in the RCA?

Core Team:

- Quality Director/Safety Personnel (Facilitates RCA): Ensures structured analysis and focuses on process improvement.
- Nursing Leadership & Staff: (CNO, DON, bedside nurses) Provides insight into care, education, and discharge readiness.
- Discharge Planners/Case Managers: Crucial for arranging post-discharge resources.
- Physicians/Providers: Addresses clinical decision-making, care transitions, and medication discrepancies.
- Data Analysts: Supplies data-driven insights on readmission trends and identifies patterns.
- Administrative Representative: (e.g., CEO/Administrator) Ensures the process has resources and leadership support.
- Ancillary/Support Staff (refer to Additional Key Participants)

Support & Systems Representatives:

- Health Information Management (HIM) (documentation issues)
- IT/EHR Specialist (alerts, workflows, order sets)
- Risk Management / Compliance

Additional Key Participants (Based on the Case):

- Emergency Department staff (if admission/readmission originated in ED)
- Pharmacy Representative if medications are involved
- Infection Preventionist (for sepsis, pneumonia, HAIs)
- Behavioral Health staff (if mental health/substance use involved)
- Social Worker (for discharge planning and social determinants)
- Home Health or Post-Acute Care Representative (if applicable)
- Primary Care Provider liaison (if communication gaps are suspected)

Optional but Valuable (When Appropriate):

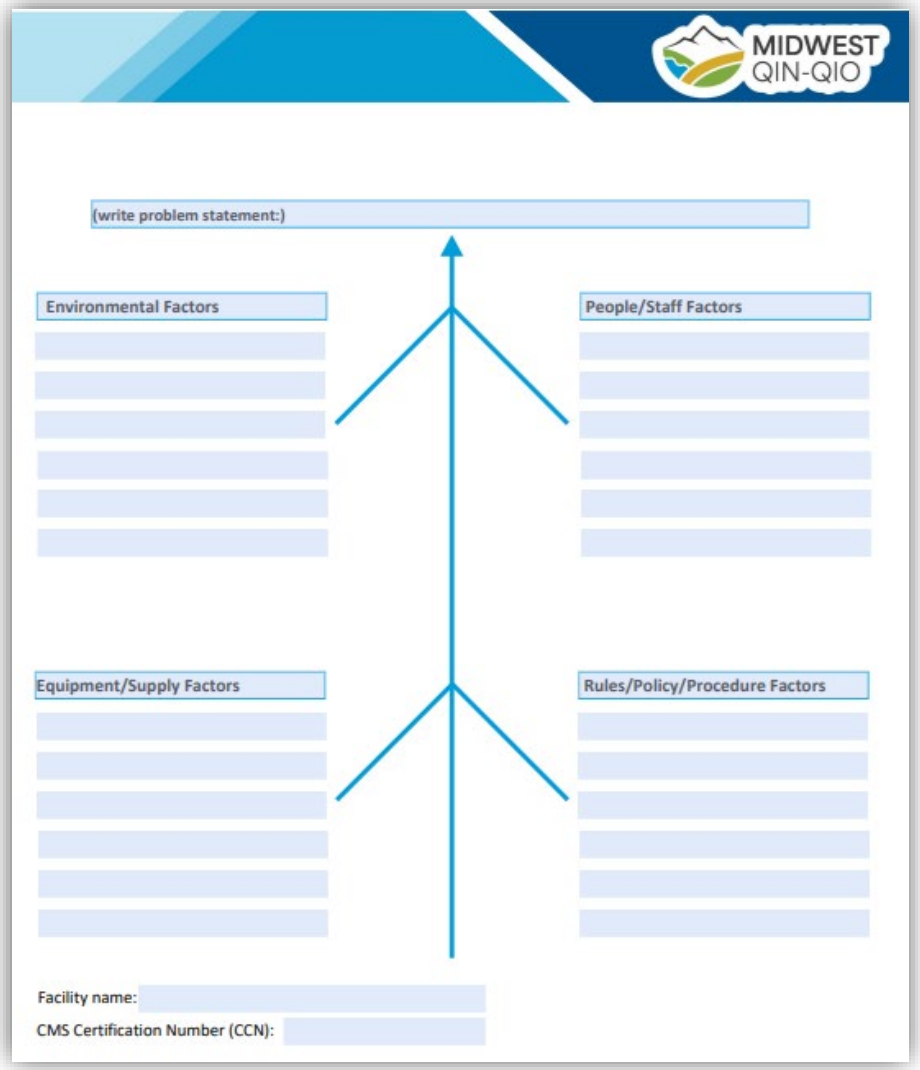
- Patient or Family Representative (offers unique perspective)
- Community Partners (e.g., EMS, long-term care, behavioral health agencies—especially important in rural settings)

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

Two Root Cause Analyses Tools

Fishbone Diagram

- Helps identify possible causes of a problem
- Organizes the cause into useful categories
- Brainstorming tool to generate ideas and share insights
- Used for major or likely to reoccur problems
- Sorts ideas into useful categories
- Fishbone Diagram Worksheet
- Example video:
  - http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx



https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fishbonerevised.pdf

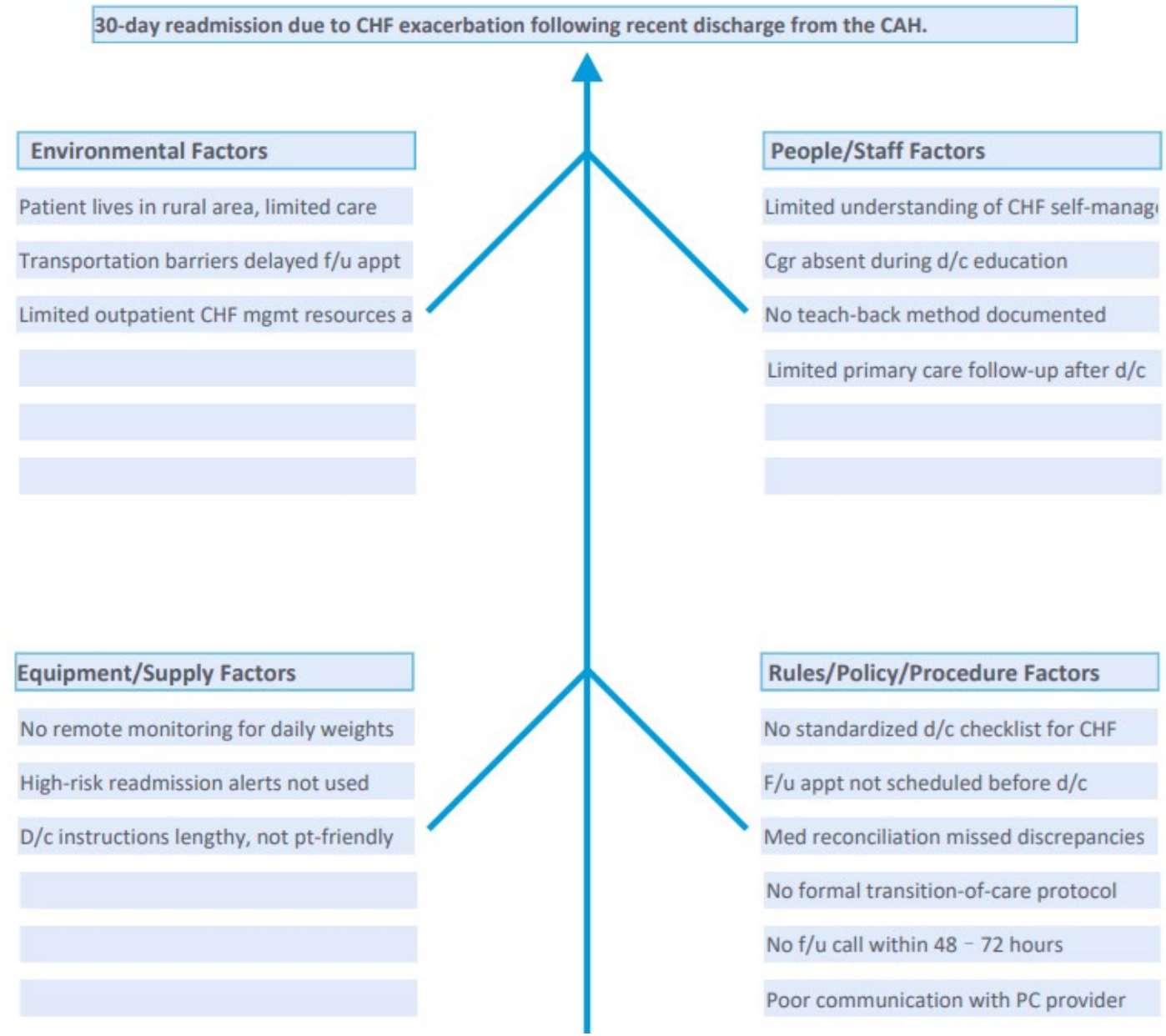
Fishbone Worksheet Example

Root Causes Identified

- Inconsistent discharge education and lack of teach-back
- Failure to ensure timely follow-up care
- Gaps in care coordination and communication
- Limited patient support and access to resources post-discharge

Action Plan

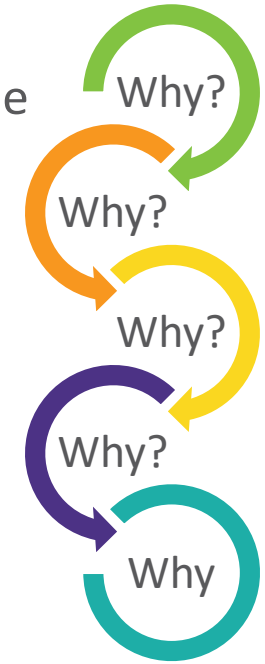
- Implement standardized CHF discharge checklist
- Require teach-back documentation for patient education
- Schedule follow-up appointments prior to discharge
- Initiate post-discharge follow-up calls within 48 hours
- Improve communication workflows with primary care providers
- Explore remote monitoring options for high-risk patients

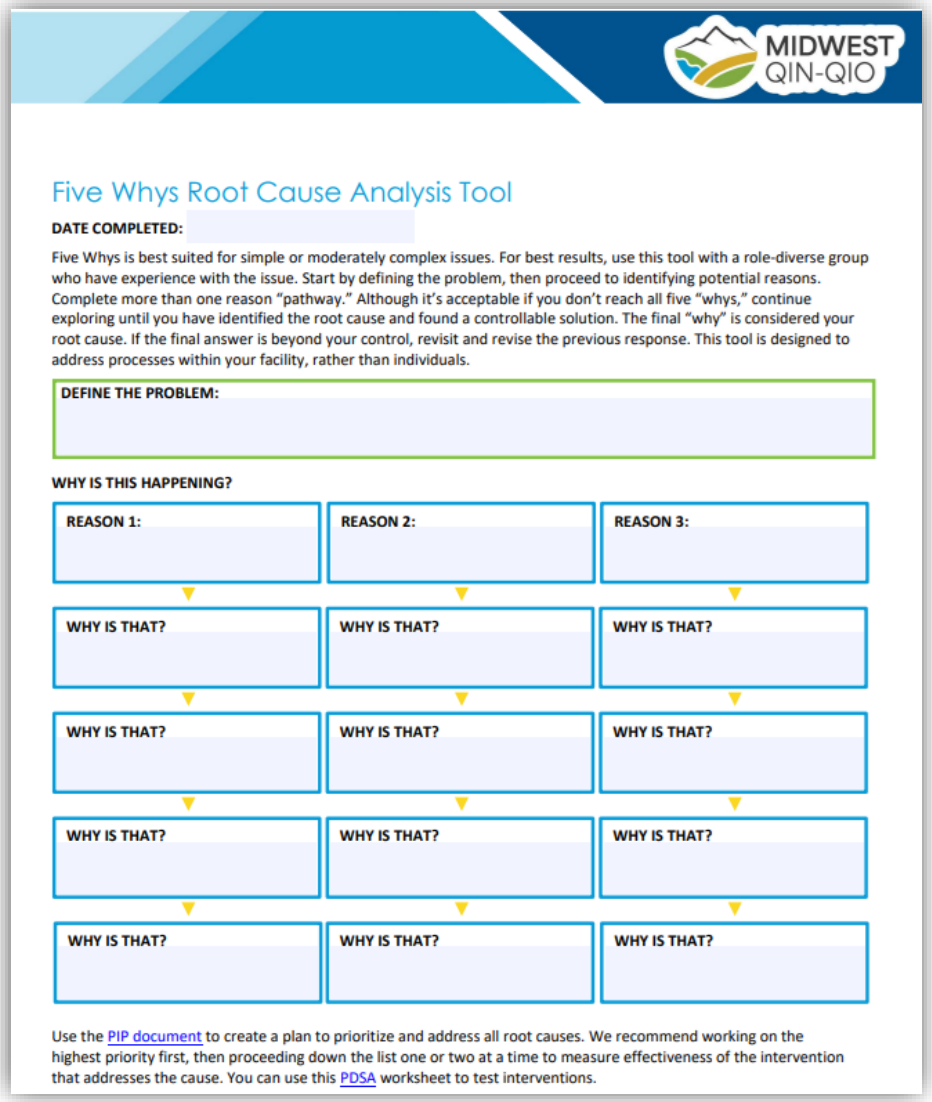


Two Root Cause Analyses Tools

Five-Why's

- Simple technique to get to the root of the problem quickly
- Drills down by asking "Why?"
- Each answer forms the foundation for
- Used for minor or isolated problem
- Five-Why's Worksheet
- Example videos:
  - https://www.youtube.com/watch?v=BEQvq99PZwo
  - https://www.youtube.com/watch?v=SrlYkx41wEE





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Five Whys Root Cause Analysis Tool

DATE COMPLETED:

Five Whys is best suited for simple or moderately complex issues. For best results, use this tool with a role-diverse group who have experience with the issue. Start by defining the problem, then proceed to identifying potential reasons. Complete more than one reason "pathway." Although it's acceptable if you don't reach all five "whys," continue exploring until you have identified the root cause and found a controllable solution. The final "why" is considered your root cause. If the final answer is beyond your control, revisit and revise the previous response. This tool is designed to address processes within your facility, rather than individuals.

DEFINE THE PROBLEM:

WHY IS THIS HAPPENING?

REASON 1:	REASON 2:	REASON 3:
WHY IS THAT?	WHY IS THAT?	WHY IS THAT?
WHY IS THAT?	WHY IS THAT?	WHY IS THAT?
WHY IS THAT?	WHY IS THAT?	WHY IS THAT?
WHY IS THAT?	WHY IS THAT?	WHY IS THAT?

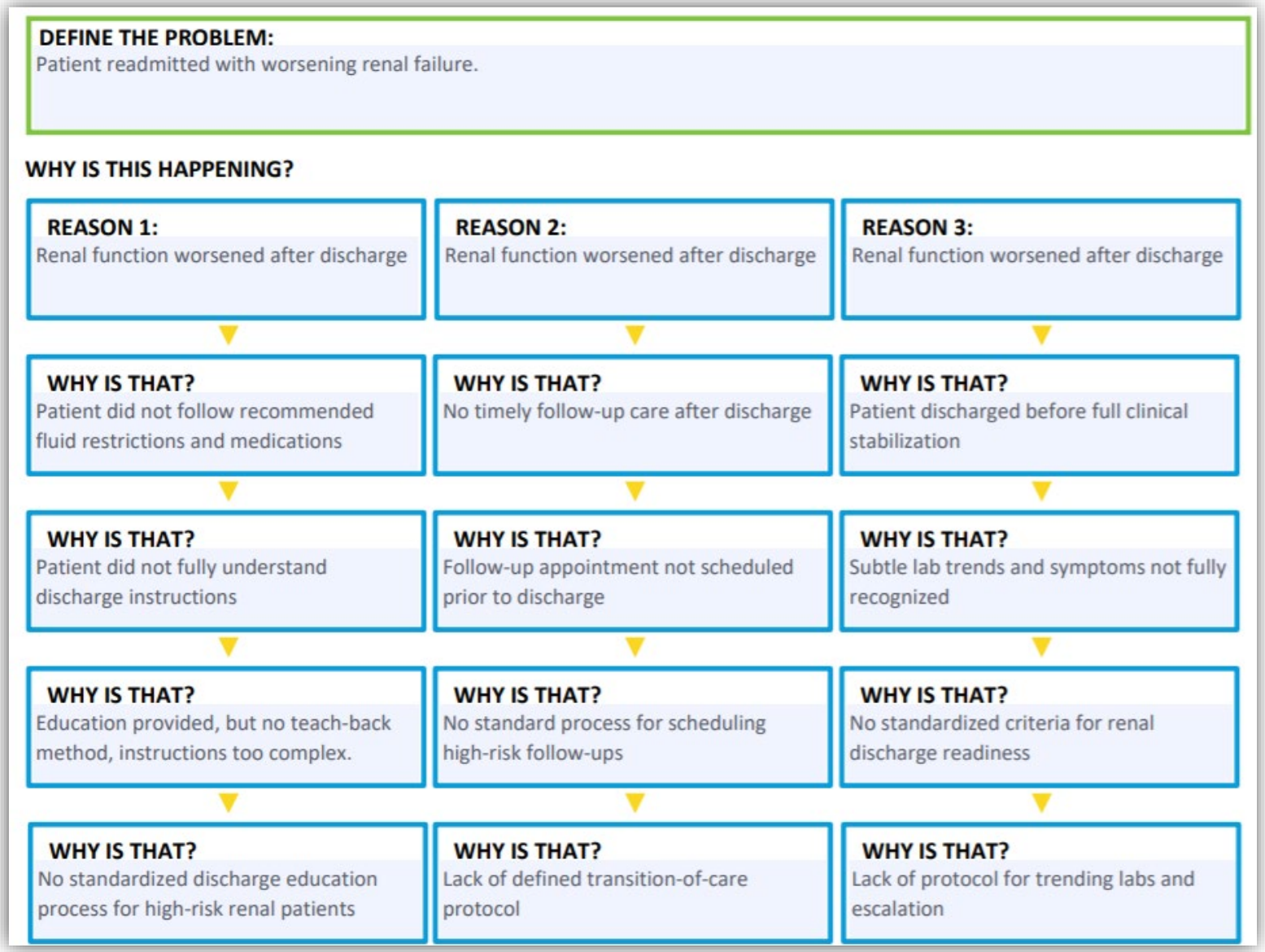
Use the PIP document to create a plan to prioritize and address all root causes. We recommend working on the highest priority first, then proceeding down the list one or two at a time to measure effectiveness of the intervention that addresses the cause. You can use this PDSA worksheet to test interventions.

Five-Why's Worksheet Example

Root Causes Identified
No standardized discharge readiness criteria for renal/AKI patients

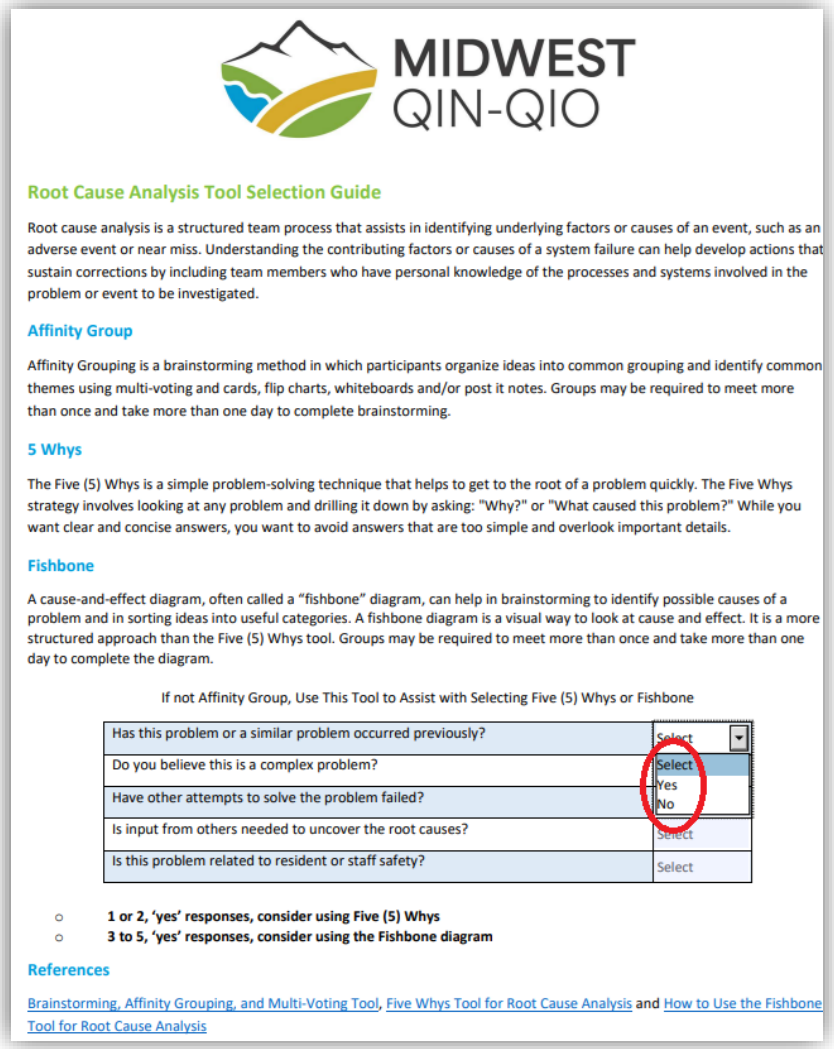
Contributing Factors
- Variability in provider assessment of stability
- Limited use of lab trending tools or protocols
- Time/resource constraints in CAH setting
- No secondary review for high-risk discharges

Action Plan
- Develop standardized discharge criteria for AKI/CKD patients
- Implement lab trending and clinical stability checklists
- Establish escalation protocols for abnormal trends
- Consider second-provider review for high-risk discharges
- Provide staff education on early signs of renal deterioration



Root Cause Analysis Selection Guide

How do I know which RCA tool to use?



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Root Cause Analysis Tool Selection Guide

Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections by including team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Affinity Group

Affinity Grouping is a brainstorming method in which participants organize ideas into common grouping and identify common themes using multi-voting and cards, flip charts, whiteboards and/or post it notes. Groups may be required to meet more than once and take more than one day to complete brainstorming.

5 Whys

The Five (5) Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling it down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details.

Fishbone

A cause-and-effect diagram, often called a "fishbone" diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than the Five (5) Whys tool. Groups may be required to meet more than once and take more than one day to complete the diagram.

If not Affinity Group, Use This Tool to Assist with Selecting Five (5) Whys or Fishbone

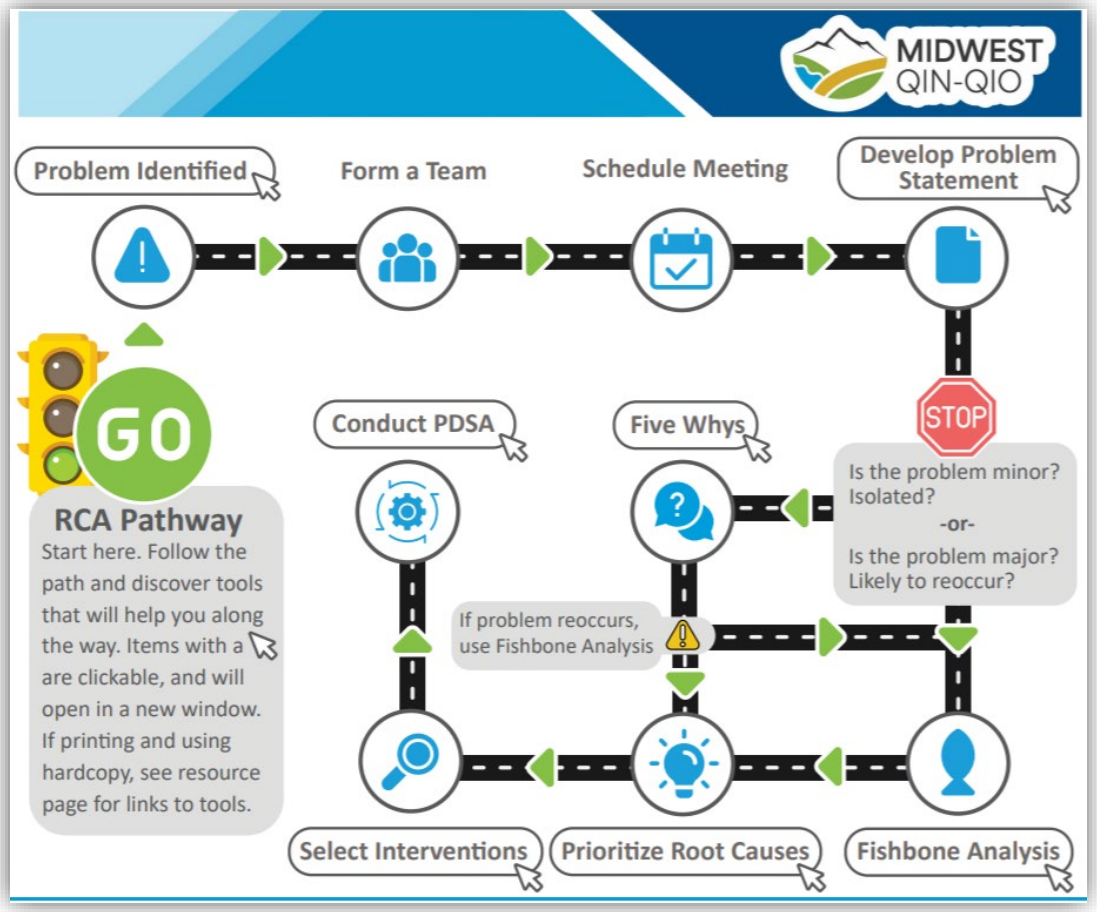
Has this problem or a similar problem occurred previously?	Select
Do you believe this is a complex problem?	Select / Yes / No
Have other attempts to solve the problem failed?	
Is input from others needed to uncover the root causes?	Select
Is this problem related to resident or staff safety?	Select

- **1 or 2, 'yes' responses, consider using Five (5) Whys**
- **3 to 5, 'yes' responses, consider using the Fishbone diagram**

References

Brainstorming, Affinity Grouping, and Multi-Voting Tool, Five Whys Tool for Root Cause Analysis and How to Use the Fishbone Tool for Root Cause Analysis

https://midwestcmsqinqio.com/resources/root-cause-analysis-tool-selection-guide/



https://midwestcmsqinqio.com/wp-content/uploads/2025/08/Midwest-QIN-RCA-Pathway.pdf

Activity

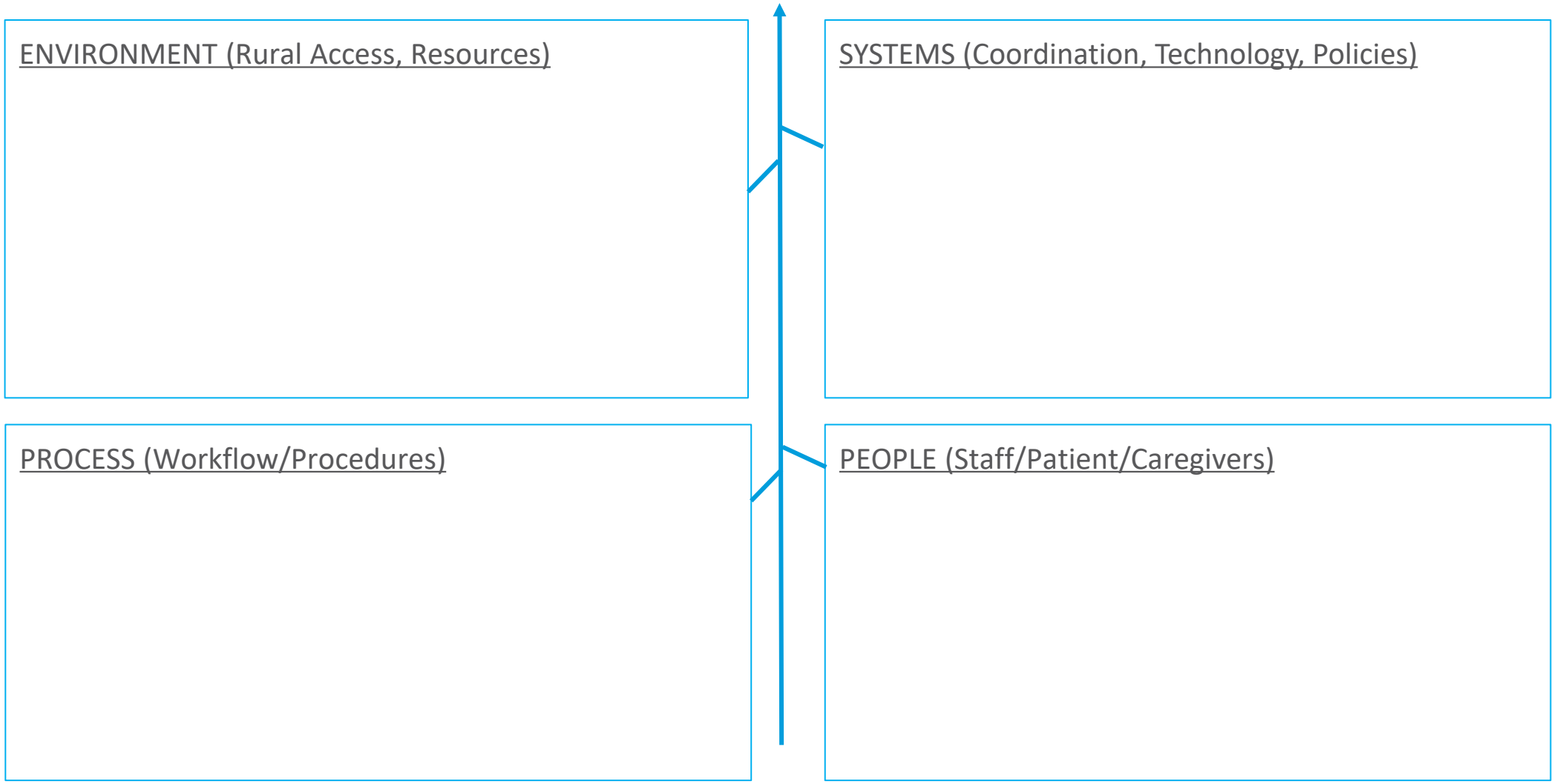
Fishbone Root Cause Analysis Exercise

Case Summary:
A patient was treated at a CAH for urinary tract infection (UTI) with early sepsis indicators, stabilized, and discharged home on oral antibiotics.

The patient was readmitted 7 days later with severe sepsis, requiring transfer to a higher level of care.

Fishbone Root Cause Analysis Exercise

Problem Statement:



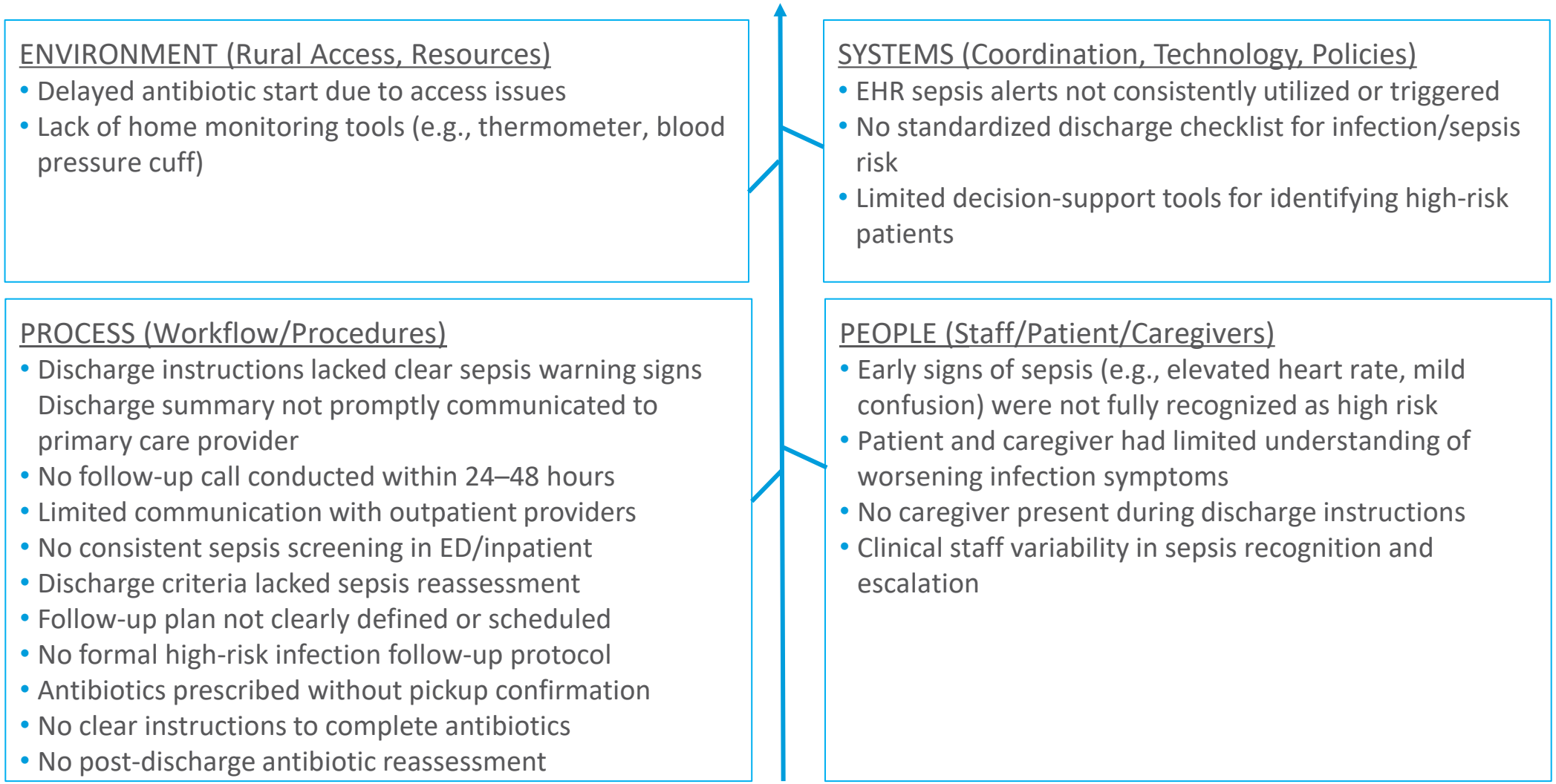
Fishbone Root Cause Analysis Exercise

Contributing Factors:

- Fill in Answers Here

Fishbone Root Cause Analysis Exercise - Compare

Problem Statement: 30-day readmission due to progression of infection to severe sepsis following recent CAH discharge.



Fishbone Root Cause Analysis Exercise

Contributing factors

- Delayed recognition of sepsis symptoms
- Incomplete discharge education
- No timely follow-up after discharge
- Medication access or adherence issues
- Poor care coordination/communication
- Limited access to care in rural setting

Root Causes Identified

- Inconsistent recognition and risk stratification of early sepsis
- Lack of standardized protocols for sepsis screening and discharge
- Gaps in patient education regarding warning signs
- Barriers to timely follow-up care and medication access
- Limited care coordination and communication post-discharge

Action Plan

- Implement standardized sepsis screening tools across care settings
- Develop clear discharge criteria and checklist for patients with infection/sepsis risk
- Require teach-back for infection warning signs and when to seek care
- Schedule follow-up (or telehealth check) within 24–48 hours for high-risk patients
- Conduct post-discharge follow-up calls
- Strengthen communication with primary care and community partners
- Explore use of home monitoring tools and/or home health referrals

Five-Why's RCA Exercise

Case Summary:
A 79-year-old patient with chronic obstructive pulmonary disease (COPD) was admitted to a Critical Access Hospital (CAH) for acute respiratory failure with hypoxia. The patient was treated with oxygen therapy, bronchodilators, and steroids, and showed clinical improvement.

The patient was discharged home on supplemental oxygen with instructions to follow up with their primary care provider.

Five days later, the patient was readmitted with worsening shortness of breath, low oxygen saturation, and respiratory distress, requiring transfer to a higher level of care for advanced respiratory support.

Five-Why's RCA Exercise

Problem Statement:
Why:
Why:
Why:
Why:
Why:

Five-Why's RCA Exercise - Compare

Problem Statement: Patient readmitted within 5 days due to worsening respiratory failure following recent discharge from CAH.
Why: The patient experienced worsening respiratory distress and hypoxia at home.
Why: The patient was not using oxygen therapy correctly and delayed seeking care.
Why: The patient did not fully understand oxygen use and warning signs of deterioration.
Why: Discharge education was provided but not reinforced with teach-back or demonstration.
Why: No standardized discharge education process for high-risk respiratory patients.

Five-Why's RCA Exercise

Contributing Factors

- No caregiver present during discharge education
- No post-discharge follow-up call
- Complex instructions for oxygen equipment use
- Limited access to respiratory therapy/home health in rural setting

Root Causes Identified:

- Lack of a standardized discharge education and competency verification process for respiratory patients

Action Plan:

- Implement standardized discharge education for respiratory patients
- Require teach-back and demonstration of oxygen equipment use
- Provide simplified, written and visual instructions
- Arrange home health or respiratory therapy when possible
- Conduct follow-up calls within 24–48 hours
- Ensure follow-up appointments are scheduled prior to discharge

ED Utilization Experience

Community Engagement Team (CET)

Who They Are

- A BestCare team embedded in the hospital & EHR
- Peer Support + Case Managers

What They Do

- Support patients with Substance Use Disorder (SUD) in the ED & hospital
- Provide real-time engagement, advocacy, and care coordination

Why It Matters

- Reaches patients during high-risk, high-impact moments
- Builds trust through peer support and lived experience
- Reduces gaps between hospital care and ongoing treatment
- Helps prevent repeat ED visits and hospitalizations
- Connects patients to recovery resources before discharge
- Supports whole-person care, not just the immediate crisis

https://www.bestcaretreatment.org/about-us/

Supportive Resources

Tools and tips to address the eight common drivers of preventable readmissions

Inadequate Discharge Planning:

- ❑ Teach-Back Method: This teach back resource will help address poor communication of discharge instructions to patients and their families.
  - Teach-back Interactive Learning Module – AUTB! Toolkit
- ❑ The Project Boost Model includes a specific resources such as the 8Ps , GAP checklist, PASS and DPET tools, and the MARQUIS toolkit, which can be used to address Lack of comprehensive discharge plans that include follow-up care and medication management.
- ❑ Taking Care of Myself: A Guide for When I Leave the Hospital

Limited Access to Follow-Up Care:

- ❑ A Process Map is helpful to identify breakdowns in discharge to follow up workflow (e.g., appointments scheduled before discharge, transportation screening, follow-up reminder system).

Medication Management Issues:

- ❑ Medication Reconciliation: An important tool/process to prevention medication errors during transitions of care. Standardized MedRec form at admission, transfer, and discharge. Electronic medication reconciliation tools can significantly reduce discrepancies and improve compliance.
  - The Impact of Meaningful Medication Reconciliation on Adverse Drug Events
- ❑ Medication Management Checklist / Discharge Checklist: Helps to standardize workflow process. Could be built into an EHR and printed out with the patient's admitting medications/meds in the system, so the patient could fill out the form with or without help.
- ❑ Medication Therapy Management (MTM) / Follow-up calls:
  - Adapted-IHI-Trigger-Tool-for-Measuring-Opioid-Related-ADEs_FNL.pdf
- ❑ Teach-Back Method: Ask patients to repeat what meds they take when/how to take them, and what changed after discharge.

Tools and tips to address the eight common drivers of preventable readmissions (cont.)

Chronic Disease Management:

- ❑ Chronic Care Model framework: Focuses on proactive, planned care vs. reactive care. It Emphasizes care coordination, self-management support, and community resources.
- ❑ Teach-Back with disease-specific action plans: Use plain language, have patients explain warning signs, what actions to take, and med changes. Simple written plans patients can follow at home.
- ❑ Care Transition Intervention model for early follow-up and phone calls: Standardize what happens after discharge (Follow-up appointment within 7 days, 48-72 hours follow up call, medication and symptom review)
- ❑ Leverage community partnerships for ongoing support

Social Determinants of Health:

- ❑ Care Transition Intervention model to assign responsibility (nurse, social worker, case manager) to ensure referrals are made before discharge, patient understands how to access services, and follow-up occurs post-discharge.
- ❑ Closed-Loop Referral Process: This process ensures that the patient actually received the help referred and ensure that the patient was not impacted by the common barriers such as transportation, a complex system
- ❑ Social Determinants of Health Screening Tools such as PRAPARE: Identifies key barriers like food insecurity, housing instability, financial strain. Focus on high-risk patients first.
- ❑ Resource Referral Platforms/Community Resource Lists: Utilize tools like Aunt Bertha (FindHelp) or a locally maintained resource directory such as 211info to connect patients to food banks, housing support, transportation services, and financial assistance. Maintain a simple, up-to-date spreadsheet or binder

Tools and tips to address the eight common drivers of preventable readmissions (cont.)

Communication Gaps:

- ❑ The INTERACT Stop and Watch Tool can be used to address poor coordination and communication between the hospital, primary care providers, and specialists AND Lack of a standardized process for sharing patient information across care settings
- ❑ The SBAR (Situation–Background–Assessment–Recommendation) for standardized communication. It can be used for discharge communication to PCPs, specialists, and post-acute providers.
- ❑ Post-Discharge Follow-Up Calls: Conduct within 48 – 72 hours and confirm the follow-up appointments, medication understanding, and any new or worsening symptoms. NOTE: This can identify communication failures early.

Patient Engagement and Health Literacy:

- ❑ Teach-Back Method: To confirm patient understanding in real time and reduce misunderstandings about medications, follow-up, and symptoms. Ask patients to explain in their own words their diagnosis, medication instructions, warning signs and what to do.
- ❑ Care Transition Intervention model to provide clear communication across settings, patient-centered care plan, medication self-management, and follow-up coordination.
- ❑ Shared decision-making: This increases engagement and patients are more likely to follow plans they helped to create. It also helps to build trust and accountability.
- ❑ Standardized discharge education checklist:
  - STAARHowtoGuide_TransitionsOfficePracticeReduceRehospitalizations.pdf
  - AHRQ RE-Engineered Discharge (RED) Toolkit
  - Implementation Guide to Improve Care Transitions
- ❑ Follow-up calls within 72 hours: Reinforces key education points and can catch confusion early.

Tools and tips to address the eight common drivers of preventable readmissions (cont.)

Inadequate Monitoring and Support for High-Risk Patients:

- ❑ Risk Stratification Tools: Identifies high-risk patients before discharge. Consider using a checklist or basic scoring tool rather than a complex software. Effective risk stratification tools for Critical Access Hospitals (CAHs) must be simple, actionable, and capable of being integrated into electronic health records (EHRs) or utilized as paper-based checklists to identify high-risk patients before discharge. Common risk factors include age (80+), history of heart failure or diabetes, multiple comorbid conditions, and social determinants of health (e.g., poor social support).
  - Charlson Comorbidity Index (CCI): Predicts the ten-year mortality for a patient who may have a range of comorbid conditions.
  - LACE_tool.doc: A validated, four-component scoring system used to predict the risk of 30-day unplanned readmission or death in adult medical/surgical patients, with scores ranging from 0 – 19. A score of 10 suggests a high risk.
  - The 8P Screening Tool: This tool assesses eight factors—Problems with medications, Psychological, Principal diagnosis, Physical limitations, Poor health literacy, Poor social support, Prior hospitalization, and Palliative care—to trigger targeted interventions.

- ❑ High-Risk Patient Registry/Tracking List: Maintain a centralized list of high-risk discharges. This is to ensure that no high-risk patient "falls through the cracks" and helps prioritize limited staff time. Track the diagnosis, risk factors, follow-up status, and outreach attempts.

- ❑ Care Transition Intervention model: For high-risk patients, add details about a follow-up appointment within 3-5days, warm handoff to PC or care manager, medication reconciliation and education, and a clear action plan.

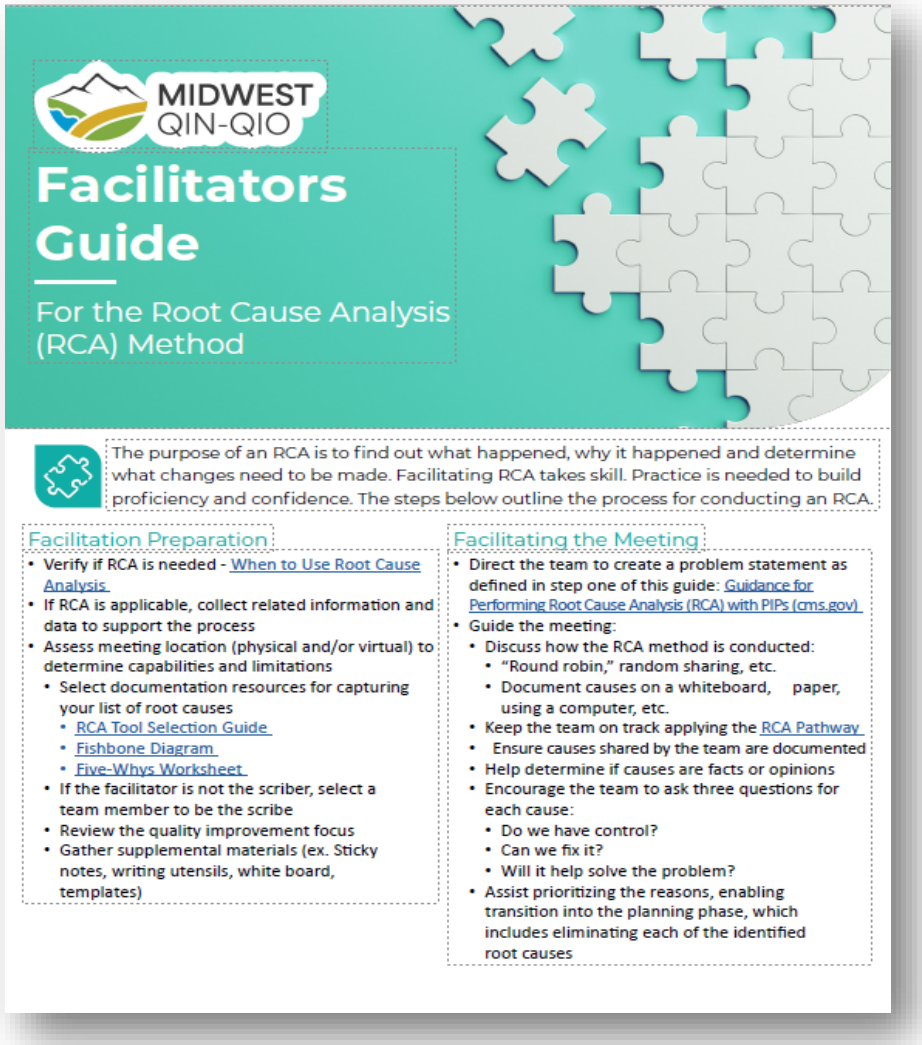
- ❑ Post-Discharge Follow-Up: An important process for high-risk patients that includes calling residents within 24-48 hours and additional calls at 7 and 14 days. Focus on symptoms worsening, medication adherence, and barriers (transportation, cost, confusion)

- ❑ Telehealth for remote patient monitoring and follow-up visits

Facilitators Guide to Root Cause Analysis

- Guides the RCA team meeting
- Keeps everyone on track
- Ensures key elements are incorporated during the RCA process

https://midwestcmsqinqio.com/wp-content/uploads/2026/04/Facilitators-Guide-for-the-RCA-Method-1.pdf



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Facilitators Guide

For the Root Cause Analysis (RCA) Method

The purpose of an RCA is to find out what happened, why it happened and determine what changes need to be made. Facilitating RCA takes skill. Practice is needed to build proficiency and confidence. The steps below outline the process for conducting an RCA.

Facilitation Preparation

- Verify if RCA is needed - When to Use Root Cause Analysis
- If RCA is applicable, collect related information and data to support the process
- Assess meeting location (physical and/or virtual) to determine capabilities and limitations
  - Select documentation resources for capturing your list of root causes
    - RCA Tool Selection Guide
    - Fishbone Diagram
    - Five-Whys Worksheet
  - If the facilitator is not the scriber, select a team member to be the scribe
  - Review the quality improvement focus
  - Gather supplemental materials (ex. Sticky notes, writing utensils, white board, templates)

Facilitating the Meeting

- Direct the team to create a problem statement as defined in step one of this guide: Guidance for Performing Root Cause Analysis (RCA) with PIPs (cms.gov)
- Guide the meeting:
  - Discuss how the RCA method is conducted:
    - "Round robin," random sharing, etc.
    - Document causes on a whiteboard, paper, using a computer, etc.
  - Keep the team on track applying the RCA Pathway
  - Ensure causes shared by the team are documented
  - Help determine if causes are facts or opinions
  - Encourage the team to ask three questions for each cause:
    - Do we have control?
    - Can we fix it?
    - Will it help solve the problem?
  - Assist prioritizing the reasons, enabling transition into the planning phase, which includes eliminating each of the identified root causes

Resources

- Midwest QIN-QIO's Resource Library and Tools
  https://midwestcmsqinqio.com/resource-library/

- Fishbone Diagram
  https://midwestcmsqinqio.com/wp-content/uploads/2025/08/Midwest-QIN-Fishbone-Worksheet_FNL.pdf

- Five-Why's Worksheet
  https://midwestcmsqinqio.com/resources/five-whys-root-cause-analysis-tool/

- Performance Improvement Project (PIP) Documentation
  https://midwestcmsqinqio.com/resources/performance-improvement-project-pip-documentation/

- AHRQ Team STEPPS
  https://www.ahrq.gov/teamstepps-program/index.html
  - TeamSTEPPS Pocket Guide
  - Hospital Guide to Reducing Medicaid Readmissions: Toolbox

Questions?

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Thank you!

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