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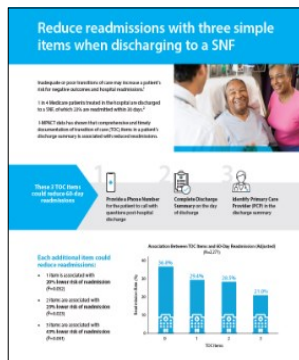
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E-Advisor Newsletter

General Updates



I-MPACT Team Update: Katie Moore joined I-MPACT as a database analyst on February 28th. Please join us in welcoming Katie to the team!



SNF Transition of Care Guide: The I-MPACT team has developed a handout to educate providers about the importance of including certain elements in the discharge documentation when patients leave the hospital to go to a skilled nursing facility (SNF). There is the potential to reduce readmissions within 60 days of discharge by including these elements. The SNF Transition of Care Guide is available on the [I-MPACT website](#).

I-MPACT Committee Updates

I-MPACT Steering Committee: The most recent meeting was held on February 7, 2022, and the focus of the meeting was to review goals for the year. Some of the 2022 goals included: reviewing factors affecting emergency department (ED) outcomes, engaging home health agencies to improve transitions of care, reviewing patient discharge instructions, and identifying ways to improve them, as well as a post-discharge deep dive plan to collect data about patients' care after leaving the hospital. The next meeting will be held in June 2022.

I-MPACT Data Review and Reporting Committee: Data committee members and provider champions have been attending our data analysis meetings every other month to provide input on data analysis results and to discuss possible future publication topics.

I-MPACT Publication Committee: New Publications!



Several members of the I-MPACT team (Dr. David Bozaan, Dr. Grace Jenq, Nkiru Okammor, and Karly Hendee) along with lead author Ji Youn Shin and fellow collaborative member Amber Pawlikowski published an article in JMIR Formative Research on *Development of the Socioeconomic Screening, Active Engagement, Follow-up, Education, Discharge Readiness, and Consistency (SAFEDC) Model for Improving Transitions of Care: Participatory Design*. The article showcases the interactive, patient-centered model (SAFEDC) I-MPACT utilized for onboarding new participants to the collaborative, and how it can be used by others in the future to improve patient's care transition experiences. Click [here](#) to view.

The I-MPACT team (Beth Jones, Pam James, Ganga Vijayasiri, Yiting Li, Dr. David Bozaan, Nkiru Okammor, Karly Hendee and Dr. Grace Jenq) published an article in JAMA Network Open on *Patient Perspectives on Care Transitions From Hospital to Home*. The article discusses the importance of understanding the patient's perspective on their care transition process from hospital or skilled nursing facility to home as a way to highlight potential gaps in care, understand social determinant needs and inform system improvements. Click [here](#) to view.

We continue to hold subgroup meetings to discuss potential new projects such as effect of kept follow-up appointments on reducing readmissions for heart failure patients and the use of transition of care bundles.

Next Steps for I-MPACT:



I-MPACT will be holding a collaborative-wide meeting in June 2022. We will present data, review I-MPACT's most recent publications, as well as provide presentations regarding VA's Life-Sustaining Treatment Decisions Initiative and palliative care.

We are in the process of scheduling and performing 2022 audits to maintain data accuracy of survey responses in the registry.

We continue to seek out meaningful topics to disseminate our work nationally by publishing our findings.

Throughout the rest of 2022, I-MPACT will be conducting a strategic planning process to review I-MPACT's purpose and vision in order to ensure we are providing the most useful data to our collaborative members and continue to improve transitions of care.

For additional I-MPACT related information, please visit the I-MPACT website at www.impactcqi.org, or for any questions, email i-mpactcc@med.umich.edu.

We appreciate the part you play as our patient/caregiver advisors.

Best Regards,

The I-MPACT Coordinating Center



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