ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

HQIC Patient Safety Network: Readmissions

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, chat to the 'Technical Support' panelist.
- Please be aware that this event will be recorded.

We will get started shortly!

HQIC Readmissions: Validating, Enhancing and Leveraging Local, Real-time Data

Presented by:
Melody Brown, MSM
Sarah Irsik-Good, MHA

December 1, 2021

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*

COLLABORATORS:

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

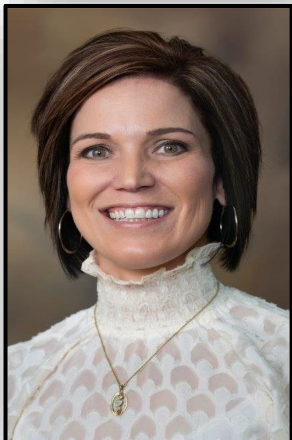
Hospital Quality Improvement

Welcome from all of us!

Readmission Co-Leads

Melody "Mel" Brown, MSM
Melody has over 40 years of healthcare experience, including varied roles at Alliant Health Solutions, working on the CMS contract for the Quality Innovation Network–Quality Improvement Organization (QIN–QIO). Coaching hospitals and nursing homes on all facets of healthcare quality improvement have been her focus as the Patient Safety Manager.

Contact: Melody.Brown@AlliantHealth.org



Sarah Irsik-Good, MHA
Sarah has over 20 years of healthcare experience. She has worked in nearly every healthcare delivery setting, including acute care (PPS and CAH), long-term care, behavioral health and ambulatory care. At KFMC, Sarah has managed QIN-QIO projects, including readmission reduction and care coordination projects.

Contact: sgood@kfmc.org

Learning Objectives

- Learn Today:
  - Identify and evaluate data readmission sources.
  - How to identify “who” is being readmitted.

- Use Tomorrow:
  - Develop a readmission data tracking and measurement strategy.
  - Begin to answer the question of “why” patients are readmitted.

Vision

Many characteristics and circumstances place individual patients at a higher risk of being readmitted soon after a hospital discharge. Among the influences for re-hospitalization are specific diagnoses, co-morbidities, emotional factors, personal issues, mental health factors, older age, multiple medications and associated reactions, level of caregiver and home support, history of readmissions, financial issues and deficient living conditions.

You must first identify which influences are at play in your community/patient population before you can enhance or add interventions to address those influences.

Only then can you identify patients at high risk for readmission **PRIOR** to discharge from their index admission and connect them with the appropriate interventions to avoid a readmission.

Recap: Session 1

- Conducted a deep-dive into the readmission metric for the HQIC Project/Readmission Reduction Program
- Defined measurement data versus improvement data
- Previous challenge: Identify your local sources of data

Poll – Please drop your answers in the chat.

Q1: Since our first session, have you accessed the Alliant/HQIC Partner Portal to identify your current readmission rate?

- Yes
- No

Q2: Since our first session, did you identify a potentially "new" source of readmission data that you did not previously have access to or know about?

- Yes
- No

Improvement Data = Actionable Data

Potential local, identifiable, real-time data sources

- Electronic Health Record
  - Canned Readmission Report (from ADT Data)
  - Customized Query/Report
- Health Information Exchange
  - Singular Patient look-ups
  - Dashboards/Reporting

Electronic Health Record Data

- EHR Reports and Claims Data
  - Snapshot data at one static point in time and therefore delayed
  - Available through canned EHR reports (Utilization Management) or ran as a customized query
- Admission, Discharge, Transfer (ADT) Data
  - More dynamic, available instantaneous on occurrence of a medical event/visit
  - Live notifications are based on data generated by the hospital's EHR
  - Real-time in nature, sent to update physicians and care management teams
  - Make sure secure email addresses are current in the NPPES database

Health Information Exchange

- Singular Patient Look-Ups
  - Assist with Root Cause Analysis (RCA) and evaluating risk for readmission
- Analytics Dashboard
  - Some HIEs are providing aggregate analysis of readmissions per facility
  - Deeper dive into readmissions to guide intervention selection

Internal Alerting

- Must know the “who” to figure out the “why”

- Internal reporting system for alerting, tracking and trending
  - Alert = root cause analysis
  - Track performance toward established improvement goals

Challenge: Identify where your admission, discharge, change of status alerts are going; direct them to persons who can respond to begin collecting the “why.”

What Data Do You Need?

- Patient encounter data
  - Encounter data provides information like patient class, event type, admission type, discharge disposition, hospital service, patient type.
  - Event type of a patient can refer to either an admission or a discharge or any other event.
- Demographics
- Diagnoses
- Procedures

Goal

1. Replicate the data locally.
2. Use the data to identify the causes of readmissions or the populations most likely to be readmitted (Root Cause Analysis).
3. Use data to drive intervention selection.
4. Use data to measure the success of intervention implementation.
5. Adjust approach based on remeasurement data (PDSA Cycles).

Step 1b: Validate/Leverage the data

Readmission Series

Session 1: Deep Dive into Data Access √ November 3, 2021

Session 2: Identify/Validate Local Readmission Data Sources

Session 3: Using Readmission Data to Conduct a Root Cause Analysis

Session 4: Intervention Exploration (Part 1)

Session 5: Intervention Exploration (Part 2)

Session 6: Remeasurement & Next Steps

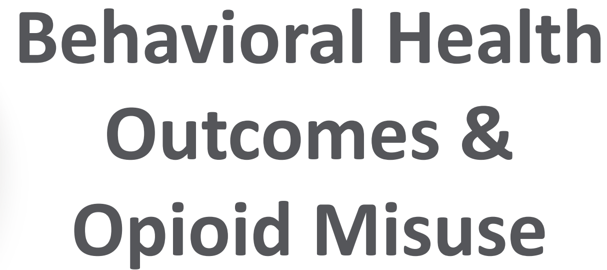
Key Takeaways

- Learn Today:
  - Identify and evaluate data readmission sources.
  - How to identify “who” is being readmitted.
- Use Tomorrow:
  - Develop a readmission data tracking and measurement strategy.
  - Begin to answer the question of “why” patients are readmitted.

Questions?

Email us at HospitalQuality@allianthealth.org or call us at 678-527-3681.

HQIC Goals



- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce *C. diff* in all settings

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Upcoming Events

January 5, 2022

2 p.m. EST

(Occurring the first Wednesday of each month)

HQIC Patient Safety Network

Using Readmission Data to Conduct a Root Cause Analysis

Melody Brown and Sarah Irsik-Good

[www.quality.alliantheatlh.org](http://www.quality.allianthealth.org)

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Thank you for joining us!
How did we do today?

Alliant Health Solutions

AlliantQIO

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