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: Intervention Exploration (Part 1)

Melody Brown, MSM

Sarah Irsik-Good, MHA

February 2, 2022

ALLIANT HEALTH SOLUTIONS

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!

ALABAMA HOSPITAL ASSOCIATION

ALLIANT HEALTH SOLUTIONS

Comagine Health

GHA Georgia Hospital Association

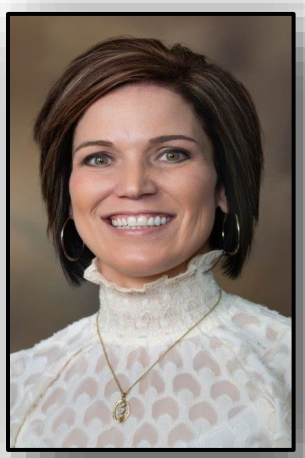
kfmc HEALTH IMPROVEMENT PARTNERS

KONZA

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 has 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 and has worked in nearly every healthcare delivery setting including acute care (both PPS and CAH), long term care, behavioral health, and ambulatory care. At KFMC, Sarah has managed QIN-QIO projects including both readmission reduction and care coordination projects.

Contact: sgood@kfmc.org

Learning Objectives

- Learn Today:
  - Identify how to use the RCA results to identify a target root cause and/or contributing factor to be addressed.
  - Understand how to develop an action plan to address the targeted root cause and/or contributing factor.
- Use Tomorrow:
  - Evaluate and select an intervention for implementation to address your identified root causes of unplanned readmissions.

Vision

There are many characteristics and circumstances that 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.

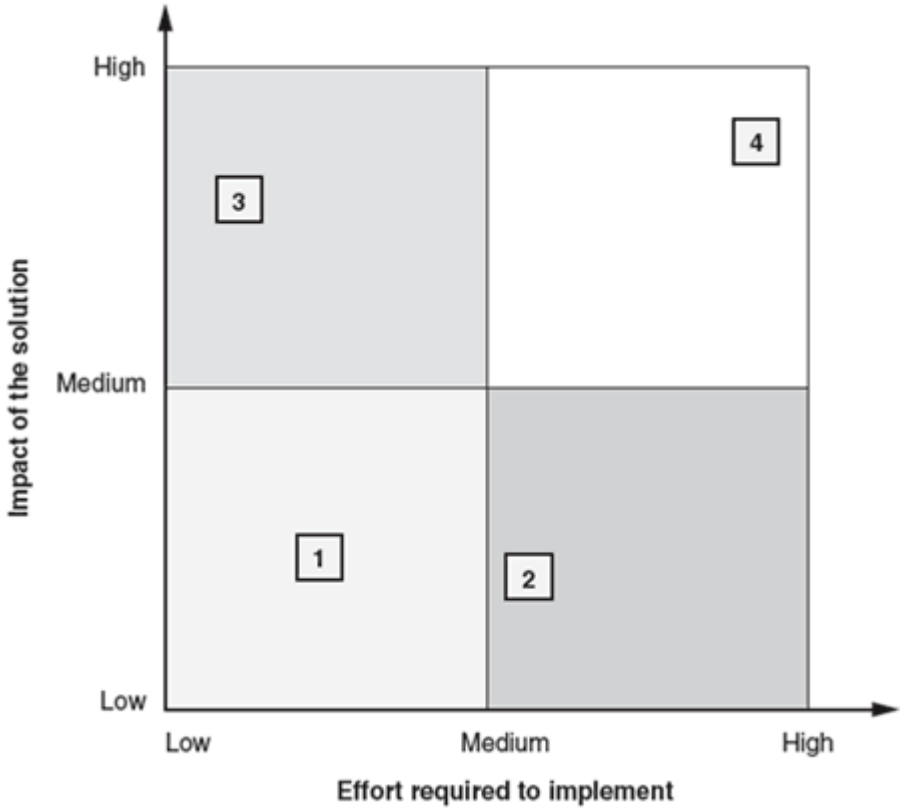
Recap: Sessions 1, 2 and 3

- Conducted a deep-dive into readmission metrics, defined measurement data and improvement data and identified local sources of data
- Evaluated identified readmission data sources and identified how to identify “who is being readmitted
- Reviewed the tools available to assist you in identifying “why” your patients are being readmitted.

Evaluating the Root Causes

You must prioritize the root causes for action:

By impact and effort….



…or by more than just impact and effort.

Prioritization Matrix

Options/Focus Areas	Strategic connection to overall grant goals and objectives	Parents/families indicate a need for improvement in this area	Data demonstrates a gap exists in this area	Strong support from steering committee, community leaders, and parents to make changes	Resources and assets exist to make changes	Cost to implement changes	Small scale-it will show results within the next 3-6 months	"Early win"-it will build buy-in and create momentum	Your criteria	Your criteria	Total Score
Assign value to each column based on a 1-5 scale (1=poor and 5=excellent)											
											0
											0
											0
											0
											0
											0
											0
											0
											0
											0
											0
											0
											0
											0

Intervention Selection

This is a two-step process:

1. Design/Select and implement changes (Interventions) to eliminate the root causes (Development of an action plan or project plan)

2. Measure the success of the changes

Where the Rubber Meets the Road…

Two different perspectives from the field:

- Coffee Regional Hospital
- Konza

Readmission Reduction Plan

Wendy Griffis, BSN,RN

Shan Fields, BSN, RN, CCM

February 2, 2022

ALLIANT HEALTH SOLUTIONS

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

COFFEE REGIONAL MEDICAL CENTER

Purpose:

To Serve. To Heal. To Save.

Vision:

Healthy Lifestyles. Better Lives.

Mission:

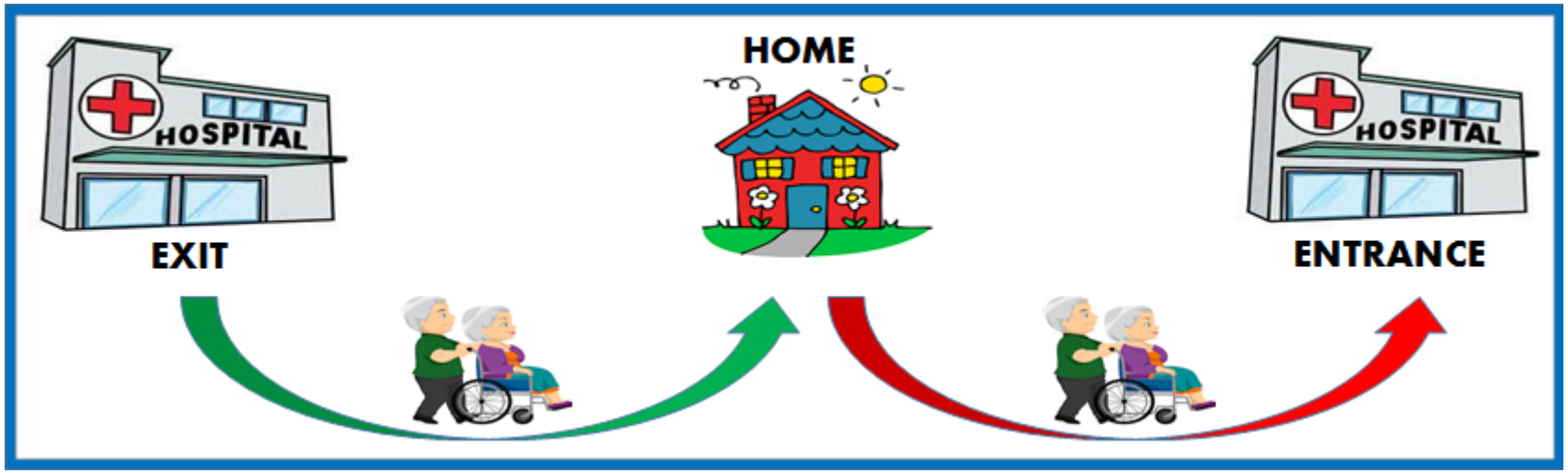
To Provide Exceptional Care and Wellness Close to Home.

Values:

Trust, Partnership, Connection, Knowledge, Excellence & Service

To learn more, visit us online at CoffeeRegional.org

Readmission Reduction Plan



- Decreasing the rate of hospital readmissions has been a challenge to hospitals for several years. Finding the right antidote to stop the revolving door of readmissions has become complex.
- As a 98 bed Acute Care Facility in a rural community with limited resources, we developed new processes and initiatives collaborating with our post acute care providers to help combat avoidable readmissions and provide the necessary resources for our patients.
- Many efforts have been put into place to assure the patient has a safe transition and the necessary resources to prevent an avoidable readmission.

Challenges and Barriers

- Inefficient Discharge Process
- Inadequate coordination with clinicians and providers
- Insufficient follow-up appointments
- Medication Management after discharge from hospital
- Patient lack of knowledge with new diagnosis or new medication
- Socioeconomic barriers/Cultural barriers
- Care Management model
- Inadequate community collaboration

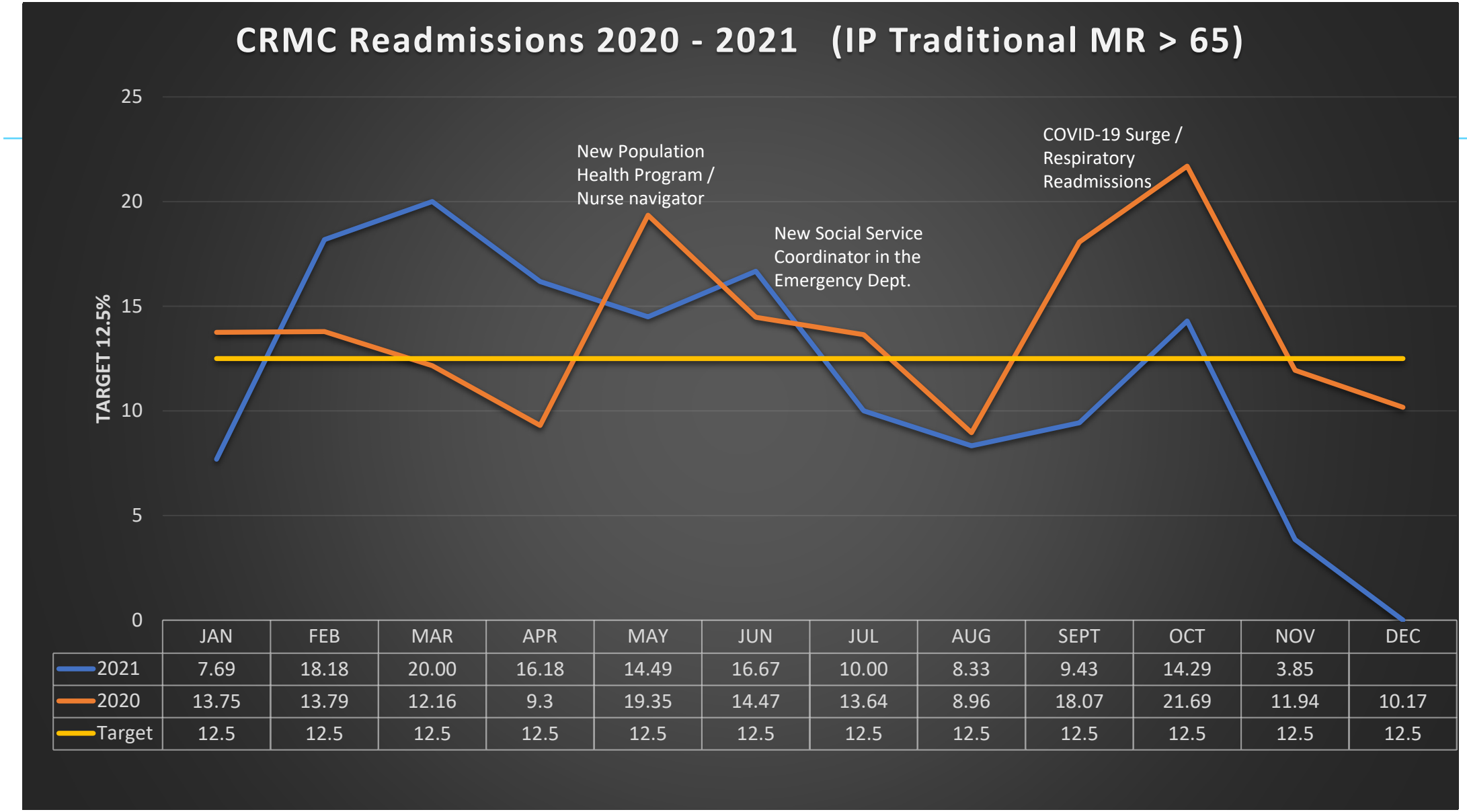
New Initiatives/New Processes

- New Care Management Model: Discharge Planner and Social Worker
- Addition of a Social Worker in the Emergency Department
- Revised Discharge Planning Assessment to include a risk for readmission risk score tool
- Discharge Planning interview conducted on all readmissions
- Multidisciplinary team daily huddle
- New Nurse Navigator/TC2 Care Coordinator
- Discharge post acute call backs within 24 – 48 hours of discharge and then weekly calls for 30 days

New Initiatives/New Processes

- Weekly transition of care calls with HHNS and SNFS
- Quarterly post-acute care transitions meetings including post acute providers, Director of Care Management, Social Workers, Senior Leadership, and Clinical Service Directors. Emphasis on process improvements, new service's, education, local/state/national compliance updates, and any other pertinent changes
- Para-medicine EMS pilot study with proven success
- Meds-to-Bed program
- Internal readmissions team lead by CMO
- Review real-time readmission data

CRMC Readmissions 2020 - 2021 (IP Traditional MR > 65)



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
2021	7.69	18.18	20.00	16.18	14.49	16.67	10.00	8.33	9.43	14.29	3.85	
2020	13.75	13.79	12.16	9.3	19.35	14.47	13.64	8.96	18.07	21.69	11.94	10.17
Target	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5

Readmission Monthly Data

Sep-21	MR IP / IP > 65	9%	
Readmissions		5	
Discharges		53	
Discharge Disposition of Home on Initial Visit	**40.00%**	**Discharge Disposition of Home on 2nd Visit**	**20.00%**
# Discharges to Home	2	# Discharges to Home	1
# Readmissions	5	# Readmissions	5
Discharge Dispostion of SNF on Initial vist	**20.00%**	**Discharge Disposition of SNF on 2nd Visit**	**20.00%**
# Discharges to SNF	1	# Discharges to SNF	1
# Readmissions	5	# Readmissions	5
Discharge Dispostion of HHS on Initial vist	**40.00%**	**Discharge Disposition of HHS on 2nd Visit**	**40.00%**
# Discharges to HHS	2	# Discharges to HHS	2
# Readmissions	5	# Readmissions	5

Readmission Tool	**80.00%**
Tool Complete	4
# Readmissions	5
MD Appt. prior to readmission	**40.00%**
MD Appt.	2
# Readmissions	5
Follow Up appt. scheduled 1st visit	**40.00%**
F/U Appt. Initial Visit	2
# Readmissions	5
Take Medication as Prescribed	**100.00%**
No issues with Meds	5
# Readmissions	5

1 of 5 poss preventable readmit
2 of 5 poss related medical stability with CMO review
2 of 5 TC2 patients

1 of 5 SNF

2 of 5 HHNs
3 of 5 unpreventable valid medical needs

Patient's Story: 71 yr old female with history of insulin-dependent diabetes and diabetic ketoacidosis; non-English speaking; cared for by two sons who speak English

Frequent hospital re/admissions (20 + visits) for elevated blood sugar

→

Found insulin administered intramuscularly rather than subcutaneously

→

Home Health agency noted non-compliance as reason for readmissions

↓

Care Conference held with clinical providers and patient's family

←

Determined two sons could speak English but did not fully comprehend

←

Family education regarding insulin administration plus other health education

↓

Referred to Population Health for follow up and 24/7 access

↔

Primary caregivers (two sons) given instructions

→

Patient cared for with Home Health and primary caregivers at home for 6 months

Less re/admissions

Key Takeaways

- Identify high risk patients and establish post acute services on initial discharge
- Conduct discharge post acute call backs within 24 – 48 hours
- Consistent collaboration and communication with post acute provider of services.
- Review real-time at risk for readmission
- Facilitate appropriate level of care in the emergency department
- Review real-time readmission data for process improvement

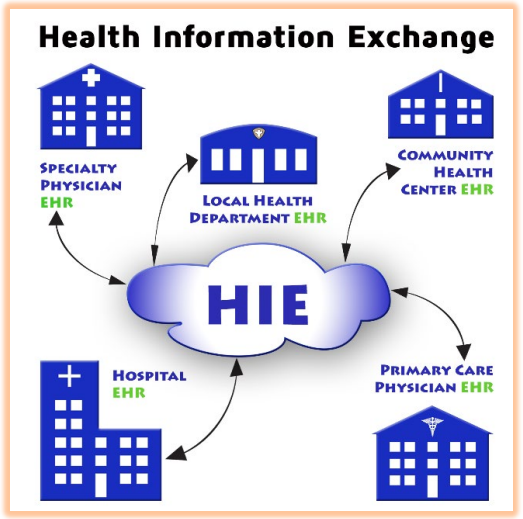
Utilizing Health Information Exchange to Guide Quality Interventions

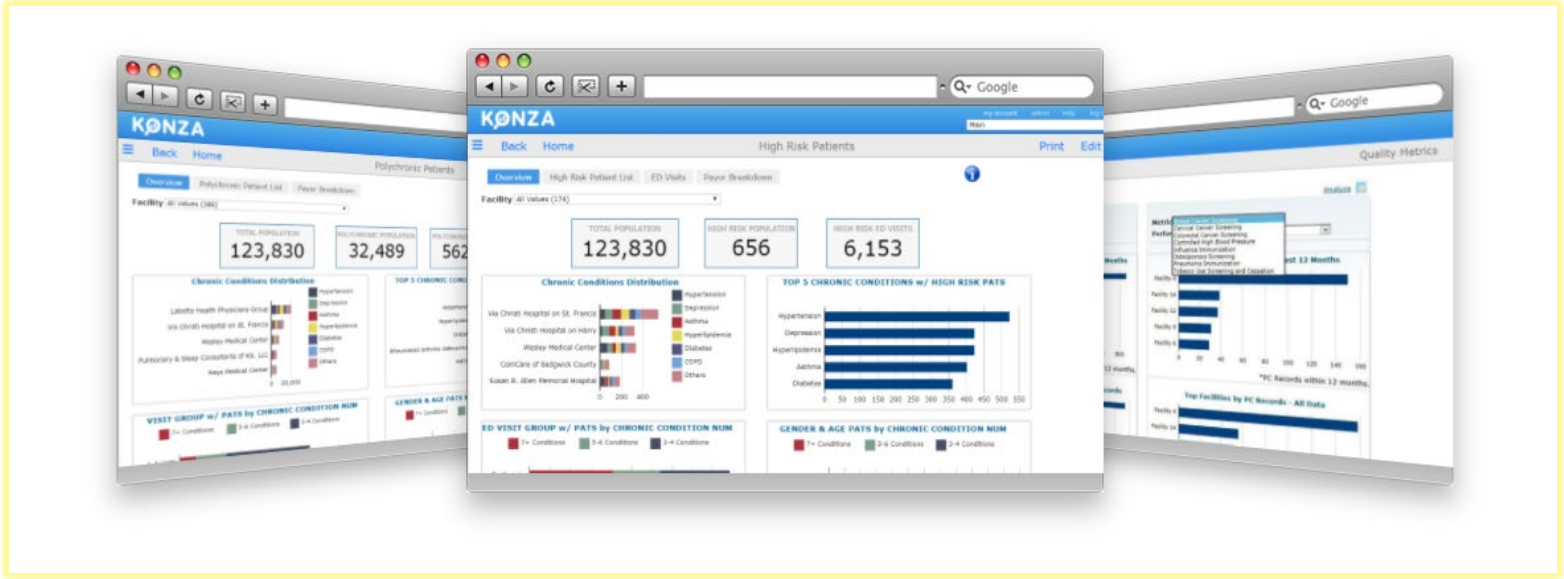
Rhonda Spellmeier MBA BSN RN

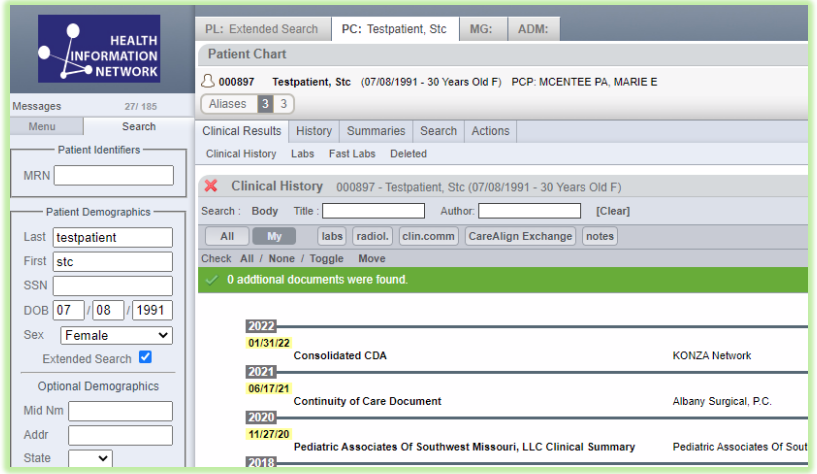
HIE Workflow and Informatics Specialist KHIN

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

KONZA/KHIN Technology Tools







HIE can be used at the point of care to view individual patient records. This information can then be aggregated, analyzed, and presented in a way that helps guide action.

Using our technology tools to support your HQIC initiatives

Site Review of Data

- Determined vulnerability period for admits was 1-5 days after discharge
- Determined majority of readmissions occurred within the same facility
- Determined Heart Failure as #1 dx for readmission
- Determined certain patients had multiple readmission episodes for the same or similar diagnosis sequela

Suggested Interventions

- Consider f/u phone calls within 48 hours
- Consider review of Heart Failure continuum of care (order sets, discharge instructions, f/u appts completed, medication availability)
- Consider CCM for patients with multiple readmissions
- Utilize readmission risk assessment to identify high risk patients during inpatient stays
- Review Dashboard data regularly
  - Acute Alerts, to ID patients who need f/u from ER and Inpatient Visits
  - Utilization tile to review compliance with f/u visits
  - High Risk and Polychronic tiles to ID High Risk patients for CCM
  - Disease Registry for A1C and other CCM management interventions

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

Readmission Series

Session 1: Deep Dive into Data Access

√ November 3, 2021

Session 2: Identify/Validate Local Readmission Data Sources

√ December 1, 2021

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

√ January 5, 2022

Session 4: Intervention Exploration

Session 5: Re-measurement and Next Steps

Key Takeaways

- Learn Today:
  - Identify how to use the RCA results to identify a target root cause and/or contributing factor to be addressed.
  - Understand how to develop an action plan to address the targeted root cause and/or contributing factor.
- Use Tomorrow:
  - Evaluate and select an intervention for implementation to address your identified root causes of unplanned readmissions.

Questions?

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

Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has appeared in the lower right-hand side of your screen.
- Completion of this survey will help us ensure our topics cater to your needs.

HQIC Goals

Behavioral Health Outcomes & Opioid Misuse

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

Patient Safety

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

Quality of Care Transitions

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

Upcoming Events

March 2, 2022
2PM EST
(Occurring the first Wednesday of each month)

HQIC Patient Safety Network
Intervention Exploration (Part 2)

https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=e6a636d55792825404c8b8ba0ab0fd527

Melody Brown and Sarah Irsik-Good

www.quality.allianthealth.org

ALLIANT HEALTH SOLUTIONS | 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

@alliantqio

Alliant Health Solutions

Thank you for joining us!

@AlliantQIO

AlliantQIO

This material was prepared by Alliant Health Solutions (AHS), the Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHSQIN-QIOTO3 - HQIC--1442-02/01/22

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