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: Remeasurement & Next Steps

Melody Brown, MSM

Sarah Irsik-Good, MHA

March 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

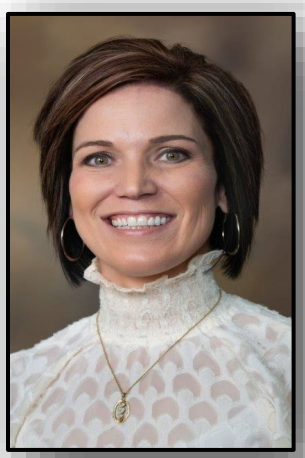
kfmc HEALTH IMPROVEMENT PARTNERS

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:
  - Understand how QI Methodologies and “Lessons Learned” can be leveraged to identify potential readmissions prior to index discharge
  - Understand how to set up quality improvement efforts for sustainable success
- Use Tomorrow:
  - Leverage the tools and successes in reducing readmissions to tackle any quality improvement priority

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 1-4

- 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.
- Heard from peers about the process of using data to evaluate readmission reduction interventions for implementation

Bringing it Home

- Taking lessons learned, incorporating them into existing workflows, developing/implementing permanent tools/process changes
- No matter the payer, these types of activities will be required
- Should be a permanent part of your culture; how you do business
- Continuous quality improvement

What Next?

Most Readmitted Population(s)= Population(s) ***most likely*** to be readmitted

1. Risk Identification can be formal (i.e. Predictive Modeling using EHR Data) or informal (i.e. screening and flagging patients with specific conditions or other risk factors upon admission)

Readmission Risk Assessment Tools

- HOSPITAL Score
- 8P Screening Tool
- Modified LACE Tool
- Transitional Care Model (TCM)

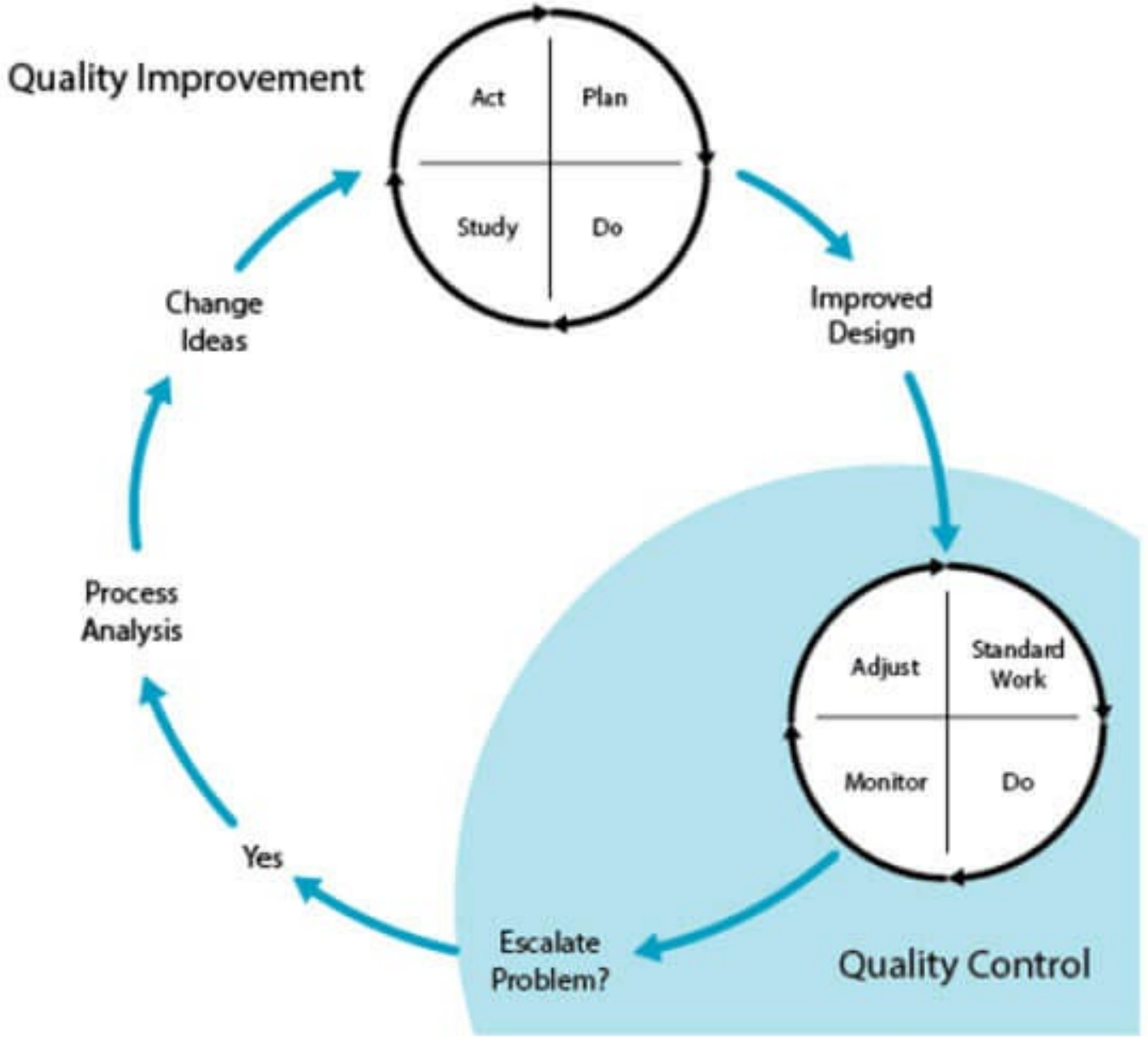
What Next?

Most Readmitted Population(s)= Population(s) ***most likely*** to be readmitted

1. Risk Identification can be formal (i.e. Predictive Modeling using EHR Data) or informal (i.e. screening and flagging patients with specific conditions or other risk factors upon admission)

2. Connect at-risk patients to resources

3. As effectiveness is proven, incorporate new processes into daily workflows to reduce barriers to sustainability



http://www.ihi.org/communities/blogs/six-essential-practices-for-sustainable-improvement

Sustainability

6 Essential Practices for Sustainable Improvement:

1. Standardization
2. Accountability
3. Visual Management
4. Problem Solving
5. Escalation
6. Integration

‘Quality’ is not a department and ‘Improvement’ is not a project. It “….is everyone’s responsibility”!

-W. Edwards Deming

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

√February 2, 2022

Session 5: Remeasurement & Next Steps

COMPLETED!

Key Takeaways

- Learn Today:
  - Understand how QI Methodologies and “Lessons Learned” can be leveraged to identify potential readmissions prior to index discharge
  - Understand how to set up quality improvement efforts for sustainable success
- Use Tomorrow:
  - Leverage the tools and successes in reducing readmissions to tackle any quality improvement priority

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

Thank You!

Thank you for your time over the past four months.

We look forward to seeing your progress while utilizing the tools and resources shared.

Melody Brown and Sarah Irsik-Good

www.quality.allianthealth.org

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Thank you for joining us!

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