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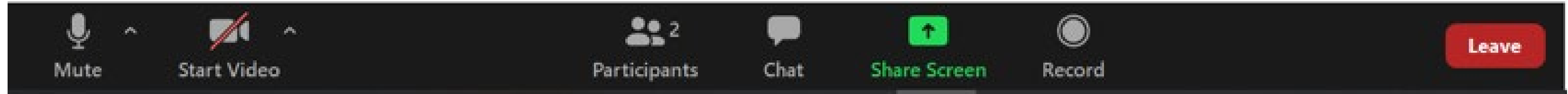
HQIC Office Hours

August 10, 2023

Logistics – Zoom Meeting



To ask questions, click on the **Chat** icon. At the end of the presentation, you will also be able to unmute to ask a question verbally.

You may adjust your audio by clicking the caret next to the **Mute** icon.

Resources from today's session will be shared after the call.

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Hear from your Peers: What Works to Reduce Readmissions

Learning Objectives

1. **Examine new options for reducing readmissions**
2. **Connect with peers for assistance on operationalizing new interventions**
3. **Feel empowered to apply new strategies to strengthen your readmission reduction portfolio**

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Today's Presenters

Susan Randolph, RN, BSN
Carla Barber, RN, BSN
Perry County Memorial Hospital

Nichole Tatum, MSW
Chris Pittsenbarger, RN
Harrison County Community Hospital

Kimberly Williams, MSN, RN, CNL
Phelps Health

What Works to Prevent Readmissions!
Perry County Memorial Hospital

Background

Location: Perryville, Missouri

Hospital Type: Critical Access Hospital

Bed size: 25

Contact info:

Susan Randolph, RN BSN
srandolph@pchmo.org
573-768-3359

Carla Barber, RN BSN
cbarber@pchmo.org
573-768-3209

Problem:

Opportunity identified to coordinate post-discharge care for patients who were identified as high-risk for readmissions with emphasis on respiratory chronic illness.

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What Works to Prevent Readmissions!

Perry County Memorial Hospital

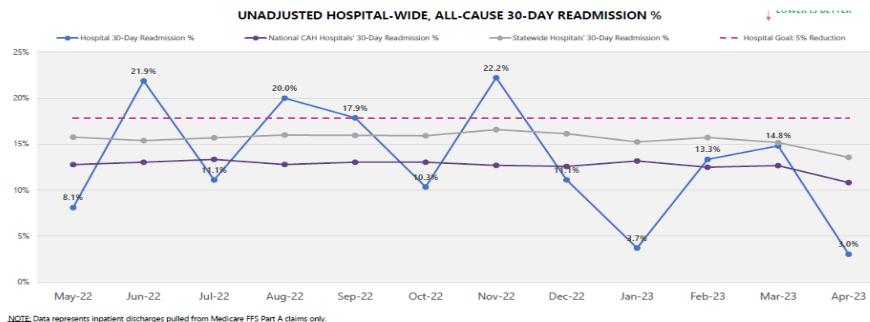
Idea	Results

Description:
Post discharge care for patients with Chronic illness with a high risk for readmission. These patients are identified upon admission and referred to our Chronic care management Program. Primary Care physician referral is required this program. The program provides patients with RN oversight for their healthcare journey along with opportunity for the Nurse to accompany them to appointments and follow up phone calls to ensure all needs are met and addressed.

Resource(s) required:
Staff RN, Medical assistant, Excel spreadsheet to communicate discharges

Key Implementation Tip:
Open communication for hospital staff to communicate a need for primary care physician to refer patients and to educate patients on this benefit.

Through the Nurse Champion program, which started January 1, 2023, we found that we were missing an entire population of patients with respiratory chronic illness that did not qualify for outpatient Cardiopulmonary rehab. Those patients were also in our high risk for readmissions population. Our Nurse Champion Ashley created a process that incorporated the Chronic Care Management program for patients that did not qualify.



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What Works to Prevent Readmissions!

Harrison County Community Hospital

Background

Location: Bethany, Missouri

Hospital Type: Critical Access Hospital offers a wide range of inpatient and outpatient services, a swing bed program, Senior Life Solutions, and primary care medical clinics in Bethany and Eagleville.

Bed size: 19

Contact info:

Nichole Tatum, MSW, Director of Social Services
Chris Pittsenbarger, RN, Transition of Care Nurse
Phone #: 660-425-0215

Problem: Reducing Readmission Rate

- Hospital had a transition of care nurse program in place prior to COVID-19 pandemic.
- Due to pandemic, this program was placed on hold.
- The program was beneficial to patients and hospital wanted to work to re-instate.

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What Works to Prevent Readmissions!

Harrison County Community Hospital

Idea	Results
Description: Transition of Care Nurse Program, the nurse performs education during the hospital stay, performs follow-up phone calls to patients, and can visit the patient in their home post-discharge. **Resource(s) required:** Staff, transition from home health setting due to services ending. **Key Implementation Tip:** Patient reception of program and to encourage them to accept services.	Since January 2023, nurse has followed up with 150 patients. Since starting this program, readmission rates have been at or below HQIC hospital reduction goal. Opportunity to reinforce medication education recognized. Reaching out to skilled-nursing facility patients. Transition of Care meetings began in July 2023.

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What Works to Prevent Readmissions!

Phelps Health

Background

Location: Rolla, MO

Hospital Type: Rural Community

Bed size: 240

Contact info: Kimberly Williams, MSN, RN, CNL (kweaver@phelpshealth.org)

Problem:

- Excess readmission rate for CHF with penalty
- Readmission teams/focus dissipated due to COVID
- Organizational lack of focus on readmissions, staff turnover resulting in lack of awareness/understanding role in prevention

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What Works to Prevent Readmissions!
Phelps Health

Idea	Results

Description:
Utilized ASPIRE + guide to evaluate current state, resources, community resources and a GAP analysis. Root causes were identified.
- CHF education
- Follow- up appointments after discharge
- Lack of resources for supportive/palliative care
- Lack of organizational awareness of readmission prevention

Resource(s) required: Multidisciplinary steering committee formed with 2 sub-teams- CHF Education & Follow-up appointments

Key Implementation Tips:
Don't jump ahead trying to make changes without a thorough evaluation of what resources you have, what your current processes are.

Be Patient, don't expect rapid change, allow culture and process to change and stick or it won't be successful. Involve all stakeholders/settings.

Understand what you can control.

- Launching the process takes time, impact on readmission prevention not realized yet.
- Chart reviews show acute hospital improvement in documentation/delivery of CHF education.
- Several mini projects spawned from this team to include:
  - Social work focus on case management patients admitted with Principal DX of CHF
  - Bedside pharmacy medication educations
  - Provider/Pharmacy education to nursing staff about the basics of CHF and teaching tools
- Social Work and Pharmacy follow up with patient show those who readmitted were more likely to readmit due to presence of major comorbidities.

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Resources

AHRQ Designing and Delivering Whole-Person Transitional Care:

- ASPIRE Guide
- ASPIRE Toolbox

HQIN Readmission Interview-Five Questions

HQIN Chronic Care Management Toolkit

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September Office Hours

Introduction to the Upcoming CDC Core Elements of Hospital Sepsis Programs

Raymund Dantes, MD, MPH

September 14
12:00 PM EST

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