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HEALTH QUALITY INNOVATORS

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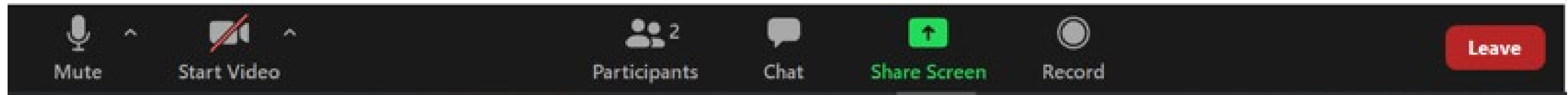
HQIC Summer Spread and Sustainment Series

August 8, 2024

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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Readmissions

Health Quality Innovation Network

Today's Faculty

Kendra Cooper, MSN-HCQ, RN, CPHQ, SSGB
Consulting Manager, HQI

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Disclosure of Relevant Financial Relationships

The faculty: Loribelle Kim, RN, Melissa Cawley-Chambers, MHA, BSN, RN, CV-BC, Rosie Hubbard, RN, BSN, Joshua Williams, MD, and Kendra Cooper, MSN-HCQ, RN, CPHQ, SSGB, reported no relevant financial relationships or relationships with ineligible companies of any amount during the past 24 months.

The directors, planners, managers, peer reviewers, and relevant staff for this activity reported no financial relationships they have with any ineligible company of any amount during the past 24 months.

Series Learning Objectives

1. Examine new options for reducing health care associated infections, sepsis, and readmissions
2. Develop strategies to improve outcomes for health care associated infections, sepsis, and readmissions
3. Outline operationalizing new interventions to improve outcomes for health care associated infections, sepsis, and readmissions
4. Apply new strategies to strengthen your improvement efforts
5. Identify approaches to integrate health equity and engage patients and their families with the support of leadership

National Priorities

Behavioral Health & Opioids

Patient Safety

Care Transitions

Public Health Emergencies

Health Equity

Person & Family Engagement, Rural Health, Vulnerable Populations

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Increase Quality of Care Transitions

Care Transitions

1. Reduce readmissions through coordination of care with post acute providers and community clinicians
2. Address social determinants of health and contributing factors such as poor transportation, poor access to care, and multiple comorbidities to improve care transitions

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HQIC Readmission Reduction Progress

Successful Strategies

QI Process	Toolbox
Data analysis (including patient interviews)	HQIC reports Interview Template
Team formation	ASPIRE+ Guide
Inventory current services & resources (hospital & community)	
Understand discharge /care transition processes	Zone Tools Chronic Care Management
SMART goal	HQIN SMART Goal Worksheet
Sustainment	HQIN Sustainment Guide

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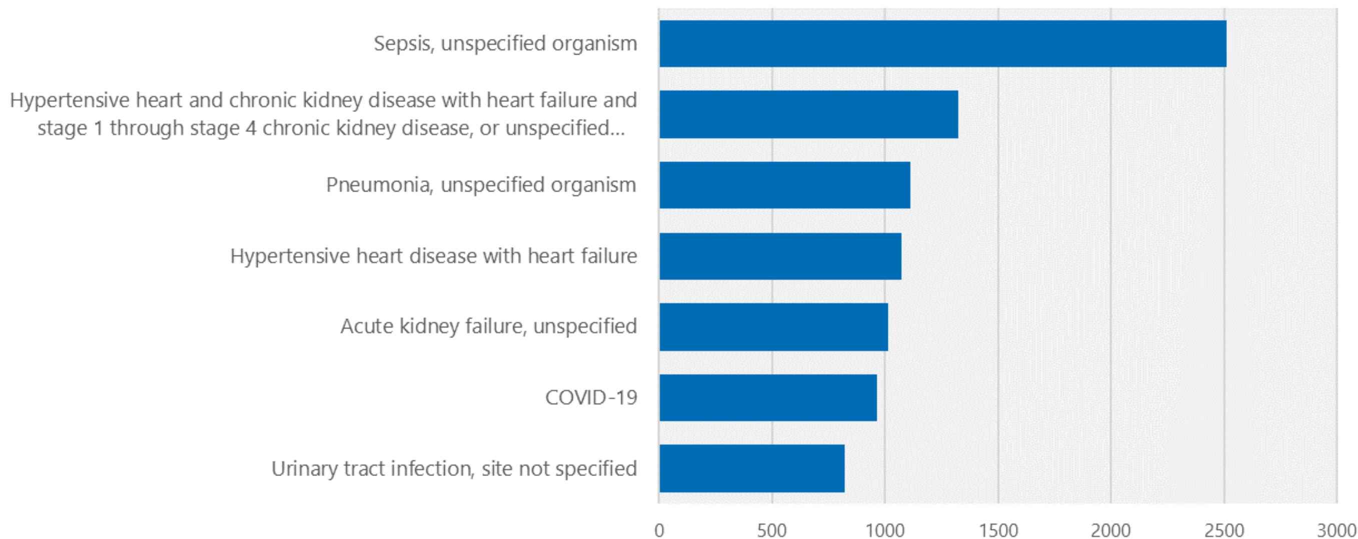
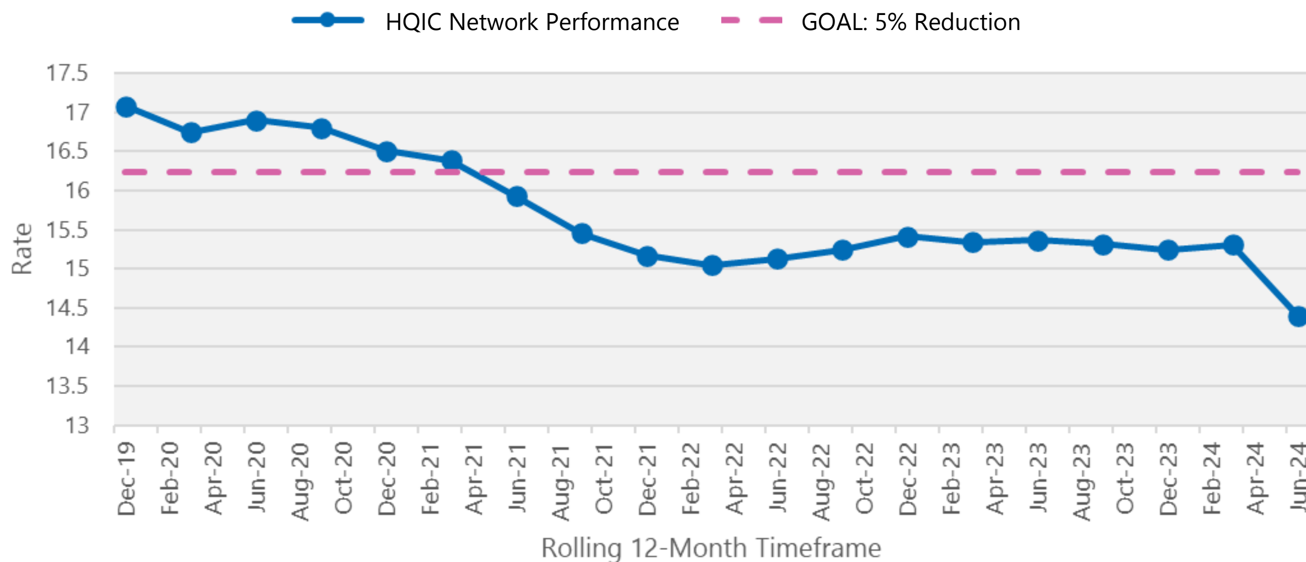
HQIC Network Top Diagnosis Codes



Hospital Quality Improvement Contractor (HQIC)

Results



15.7%

Relative Improvement Rate (RIR)

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HQIC Network Readmission Disparities

Baseline Timeframe: Jan-19 - Dec-20
Remeasurement Timeframe: Apr-22 - Mar-24

	HQIC Network							
	Baseline			Remeasurement			Improvement	
Demographic Category	Num	Den	**Rate**	Num	Den	**Rate**	**RIR**	Disparity Reduction*
All Medicare FFS	33,604	194,337	17.29	25,707	167,370	15.36	11.2%	-
Gender								
Male	15,522	86,007	18.05	11,611	73,680	15.76	12.7%	47.4%
Female	18,082	108,330	16.69	14,096	93,690	15.05	9.9%	
Race/Ethnicity								
White	27,874	166,135	16.78	22,162	147,243	15.05	10.3%	20.1%
Black	4,074	19,263	21.15	2,225	11,912	18.68	11.7%	
Asian	273	1,504	18.15	298	1,587	18.78	-3.4%	
Hispanic	175	955	18.32	115	751	15.31	16.4%	
Native American	753	3,512	21.44	410	2,558	16.03	25.2%	
Enrollment								
Dually Eligible for Medicaid	10,771	51,202	21.04	6,379	34,798	18.33	12.9%	26.2%
Not Dually Eligible	22,833	143,135	15.95	19,328	132,572	14.58	8.6%	

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Today's Presenters

GUAM MEMORIAL HOSPITAL AUTHORITY
ATURIDÅT ESPETÅT MIMURIÅT GUÅHÅN

Loribelle Kim, RN
Clinical Case Manager
Guam Memorial Hospital Authority

CENTRA

Melissa Cawley-Chambers, MHA, BSN, RN, CV-BC
Nurse Navigator
Centra Southside Community Hospital

COXHEALTH

Rosie Hubbard, RN, BSN
Administrative Director of Nursing
Cox Health

Joshua Williams, MD
Hospitalist/Family Medicine
Cox Health

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Reducing Readmission Rates
Guam Memorial Hospital Authority

Background

Location:
Tamuning, GUAM

Hospital Type:
Acute Care, Government-owned

Bed size: 161

Contact info: Loribelle Kim, RN
Clinical Case Manager
671-922-0762

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Reducing Readmission Rates
Guam Memorial Hospital Authority

Interventions	Results
Description: • Identify Contributing Factors **Resource(s) required:** • Nurse/physician • DC Planning QAPI Team (CCM, SW, and UR) **Key Implementation Tip:** • Data-driven • Appropriate consultations are done in a timely manner. • Identify & assist patients who are in need of additional financial assistance • Identify & refer patients to appropriate outpatient services	• Early identification of needs (eg. housing, caregiver assistance, medications, home care, primary physician, etc) • Appropriate consultation (e.g. Case management, Social work, dietary, rehab, utilization review, etc) • Referrals to appropriate outpatient services (eg. HHA, SNU, specialists, etc) • Outpatient services are scheduled prior to patient's discharge.

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Reducing Readmission Rates

Guam Memorial Hospital Authority

Interventions	Results
Description: • **Financial Assistance** **Resource(s) required:** • **Social Workers** • **Program Coordinators (and Americorp. Members)** • **Eligibility specialists** **Key Implementation Tip:** • **Assist patients who are in need for additional financial assistance.** • **Identifying other underlying contributing factors** • **Ensure discharge medications are secured for certain high risk populations**	• **An established routine process to assist patients who do not have medication coverage. (Medicare part D, private or Medicaid)** • **An established follow-up process for SW to follow up with the Eligibility Specialists regarding Medicaid application status.**

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Reducing Readmission Rates

Guam Memorial Hospital Authority

Interventions	Results
Description: • **Communication** **Resource(s) required:** • **Staff participation (physicians, nursing administration, Discharge Planning Committee, Performance Improvement Committee and Quality & Safety)** • **Ward clerks (Data collection)** **Key Implementation Tip:** • **Report QAPI findings** • **"Discharge Planning Process Algorithm"** • **Inform, educate, recommend, and reinforce** • **Emphasize placing Discharge Planning Evaluations/Consultations when indicated, especially when patient meets high risk criteria**	• **Decreasing readmission rates becomes a hospital-wide effort** • **Appropriate consultation guides the Discharge Planning Process** • **"Safe discharge" culture**

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Reducing 30-day Readmissions
Centra Southside Community Hospital

Background

Location: Farmville, Virginia

Hospital Type: Acute Care

Bed size: Licensed 116-bed

Contact info: Melissa Cawley-Chambers, MHA, BSN, RN, CV-BC, CCRN
Clinical Nurse Navigator

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Reducing 30-day Readmissions

Risk Screening on Admission

Interventions	Results
Description: Decreasing 30-day readmission rates using a risk screening tool on index admission. **Resource(s) Required:** Interdisciplinary Teamwork ☺ **Key Implementation Tip:** 1. Readmission Risk Screening is completed with hospital admission documentation. 2. Follow-up appointments are scheduled with PCP or specialty clinic based on the Readmission Risk identified at admission.	Using a readmission risk screening tool at index admission helps identify patients considered frequent hospital utilizers. It allows the case management team and nurse navigator to identify patients who are at high risk for readmission. At discharge, a follow-up appointment with the patient's PCP or specialty provider is made based on the Readmission Risk identified.

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Reducing 30-day Readmissions

Readmission Risk Screening

Guidelines

High Risk:
Pt has had one Mental Health admission OR two or more previous hospital admissions within the last 12 months.

Moderate Risk:
Pt has had one previous hospital admission within the last 12 months.

Low Risk:
Pt has had no previous admission in the last 12 months.

Excluded Populations:
-Pt discharged under hospice care.
-Pt discharged to long-term care or PACE facility where a follow-up provider visit will occur after admission to the facility.

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Reducing 30-day Readmissions
Follow-Up Appointments

Guidelines Based on Readmission Risk Screening

High Risk:
48 hours. If with home health, 5 days to see MD.

Moderate Risk:
5-7 days.

Low Risk:
7-14 days.

If an appointment in the appropriate time frame is unavailable, obtain the soonest appointment and make a note in the chart in the box to the right of the appointment.

On the weekends or off hours, fax the MD office with a request for the appropriate time frame.

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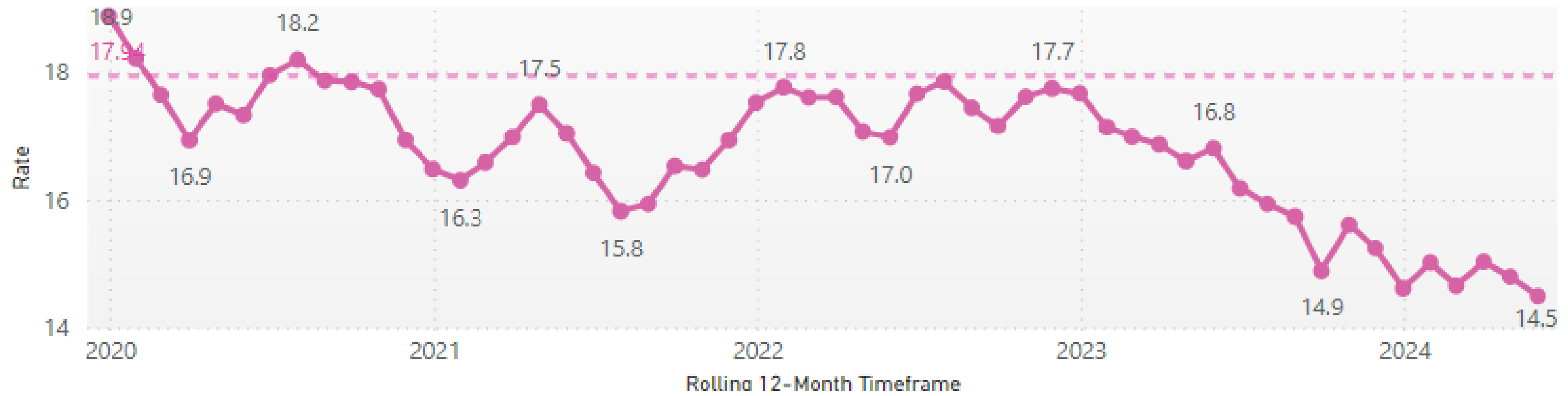
Reducing 30-day Readmissions

Results



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Building a Readmissions Team
Cox Barton County Hospital

Background

Location: Lamar, MO

Hospital Type: Critical Access Hospital

Bed size: 25

Contact info:

Rosie Hubbard, RN, Admin. Dir. of Nursing
Rosie.hubbard@coxhealth.com
417-681-5111

Dr. Joshua Williams, Hospitalist
Joshua.Williams@coxhealth.com
417-681-5102

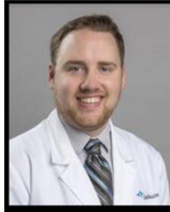
Building a Readmissions Team

Cox Barton Team

Plan

- Establish interdisciplinary, focused, readmission team
  - Monthly meetings starting in November 2023

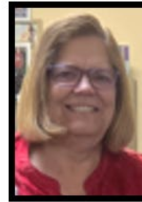
Dr. Joshua Williams
Hospitalist



Rosie Hubbard, RN
Administrative Director of Nursing

Sean Guiheen
Nurse Manager

Mary Lyn Hunter-Collier
Nurse Case Manager



Amanda Baker
Quality Management Coordinator

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Building a Readmissions Team

Overview

Plan

- Review and evaluated available readmission data sources
  - HQIC
  - Vizient
  - Supplemental

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Building a Readmissions Team

Data Analysis

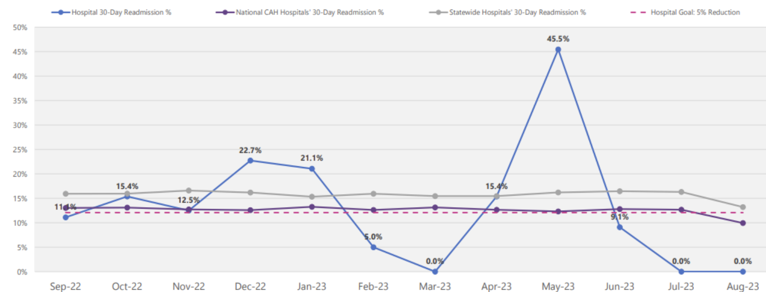
UNADJUSTED HOSPITAL-WIDE, ALL-CAUSE 30-DAY READMISSION %

Timeframe: Sep-22 - Aug-23

ALL-CAUSE READMISSION %	Jan-19 - Dec-19	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
# of Live discharges	173	9	13	8	22	19	20	20	13	11	11	5	12
# of 30-Day Readmissions following discharge from your hospital	22	1	2	1	5	4	1	0	2	5	1	0	0
Hospital 30-Day Readmission %	**12.7%**	**11.1%**	**15.4%**	**12.5%**	**22.7%**	**21.1%**	**5.0%**	**0.0%**	**15.4%**	**45.5%**	**9.1%**	**0.0%**	**0.0%**
National CAH Hospitals' 30-Day Readmission %	14.4%	13.0%	13.1%	12.7%	12.6%	13.3%	12.6%	13.1%	12.7%	12.3%	12.8%	12.7%	9.9%
Statewide Hospitals' 30-Day Readmission %	16.8%	15.9%	16.0%	16.6%	16.2%	15.3%	15.9%	15.5%	15.5%	16.2%	16.5%	16.3%	13.2%
Hospital Goal: 5% Reduction	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%

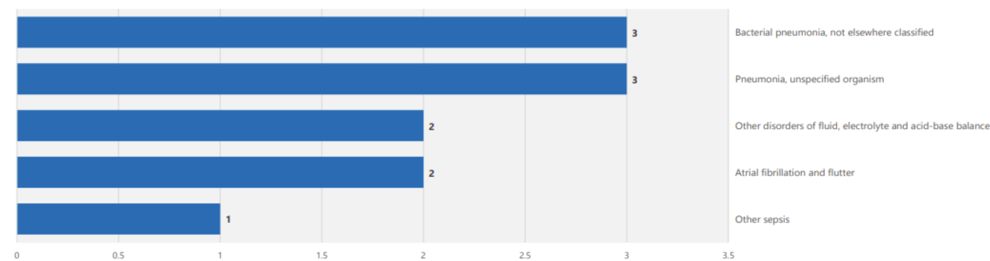
UNADJUSTED HOSPITAL-WIDE, ALL-CAUSE 30-DAY READMISSION %

LOWER IS BETTER



NOTE: Data represents inpatient discharges pulled from Medicare FFS Part A claims only.

TOP 5 PRINCIPAL DIAGNOSES LEADING TO A 30-DAY READMISSION AMONG ALL PATIENTS

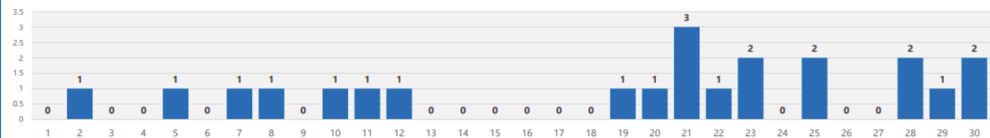


SUPPLEMENTAL DATA REPORT

HISTOGRAM OF DAYS UNTIL EVENT BY DAY OF DISCHARGE FROM INDEX ADMISSION

Timeframe: Sep-22 - Aug-23

DAYS UNTIL READMISSION FROM ALL DISCHARGE DESTINATIONS



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Building a Readmissions Team

Goal and Objectives

Do

SMART goal:

Reduce Unadjusted Hospital-Wide, All Cause 30-Day Readmission rolling 12-month rate from 12.99 to below HQIC program goal of 12.08% by March 2024 and sustain through September 30, 2024.

Objectives:

1) Identify processes to optimize discharge and follow up for pneumonia patients by 2/29/2024
2) Clarify workflow, data analysis, and related actions for SDoH screening.

- Monthly readmission committee meetings
- Conduct hospital-based inventory of current practices to reduce readmissions using ASPIRE + Guide
- Create and deploy "High-Risk for Readmission Checklist"
- Screen for Social Determinants of Health (SDoH) and utilize SDoH data to inform needed services for high-risk patients
- Create a Barton specific community services resource list

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High Risk for Readmission Checklist

1. Patient flagged on nursing board (in orange) and in SBAR handoff
2. Patient's "learner/care plan partner" identified by nursing at admission and placed on SBAR handoff
3. Case Management Consult (Mary Lyn)
4. Home Health Ordered (circle the appropriate action)
   Not eligible   Patient Declined   Home Health Co: ______________
5. Pharmacist Consult
6. If respiratory patient: evaluate if patient qualifies for pulmonary rehab. (circle one)
   Not eligible   Patient Declined   Schedule date/time:
7. Discharge instructions meeting with provider and nurse with use of teach-back.
8. Discharge summary sent to PCP and confirmed received with follow up appointment scheduled

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Social Determinants of Health Assessment

1. Included in ED and Admission Inpatient assessments
2. Assessments will prompt the nurse to consult Case Management/Social Services
3. A resource document is also available to print and give to patient/family
4. Questions about:
    - Being able to afford Food, Housing, Medical care, or Heating
    - Does the patient accept or decline social needs screening questions
    - Specific concerns regarding safety- pets, mold, water leaks, bugs, mice, lead, fear of falls at home, human trafficking, living situation/home safety, oven or stove not working, losing the place that I live in the future
    - Lack of transportation to medical appointments, meetings, work, or from getting things that you need for daily living
    - Utilities
    - Food Insecurities
    - Difficult Relationships- "Because difficult relationships can cause health problems, does anyone physically hurt you, threaten, or scream at you?"

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Cox Barton County Hospital Community Resources

Resources

Essential Community Services
Call 211
www.211.org
Get help paying bills, finding food and locating resources near you

Suicide and Crisis Lifeline
Call 988
www.988lifeline.org

Domestic Violence Hotline
417-864-7233

Burrell Behavioral Health
1-800-494-7355 417-761-5555
www.burrellcenter.com

One Door Community Partnership
417-225-7499
www.cpozarks.org

County Health Departments	
Greene County	417-864-1658
Christian County	417-581-7285
Taney County	417-334-4544
Stone County—Galena Reeds Spring	417-357-6134 417-272-0500
Lawrence County	417-466-2201
Barry County	417-847-2114
Barton County	417-682-3363
Dade County	417-637-2345
Webster County	417-859-2532
Polk County	417-326-7250
Douglas County	417-683-4174
Laclede County	417-532-2134
Wright County	417-741-7791
Dallas County	417-345-2332
Vernon County	417-667-7418

Substance Abuse Treatment	
Preferred Family Healthcare	417-862-3455
Carol Jones Women's Recovery	417-862-3455
CoxHealth Center for Addictions	417-269-2273
Mercy Chemical Dependency	417-820-2990
Recovery Outreach	417-823-9691

Recovery Houses	
Harmony House	417-837-7700
Sigma House	417-893-7760
Recovery Chapel	417-887-7228
Heartland Center for Behavioral Change	417-866-3293
Victor Circle Recovery House	417-894-6821
Alpha House	417-831-3033
Synergy Recovery Center	417-812-4440

Shelters	
Samaritan Outreach Center	417-257-7792
COPE	417-533-5201
Salvation Army Harbor House	417-831-3371
Community Partnership of the Ozarks	417-888-2020
The Kitchen, Inc.	417-837-1500
Victory Mission	417-864-2200
Christian County Family Crisis Center	417-582-0344

Employment	
Missouri Career Center	417-887-4343
Vocational Rehabilitation North	417-895-5863
Vocational Rehabilitation South	417-895-5720

Health Care	
Department of Mental Health	417-895-7400
Family Medical Center	417-269-8817
Jordan Valley Health Center	417-831-0150

12- Step Organizations	
Alcoholics Anonymous	417-823-7125
Alcohol and Substance Abuse	417-865-5200

Domestic Violence organizations

Nevada, Missouri Moss house 417-667-7171

Joplin, Missouri Lafayette House 1-800-416-1772

Carthage, Missouri Carthage Crisis Center 417-358-3533

Housing Assistance

Economic Security Council Lamar 417-682-5591

Joplin 417-781-0352

Substance Use and Addiction

Ozark Center Joplin, MO 417-347-7730

Compass Health Network Nevada, MO 844-853-8937

Fast Comprehensive Care, Nevada, MO 417-667-8352

Homeless Shelters

Watered Gardens, Joplin, MO 417-623-6030

Souls Harbor, Joplin, MO 417-623-7927 or 417-623-4358

Employment

Missouri Job Center – Nevada, MO 417-448-1177

Building a Readmissions Team
Findings

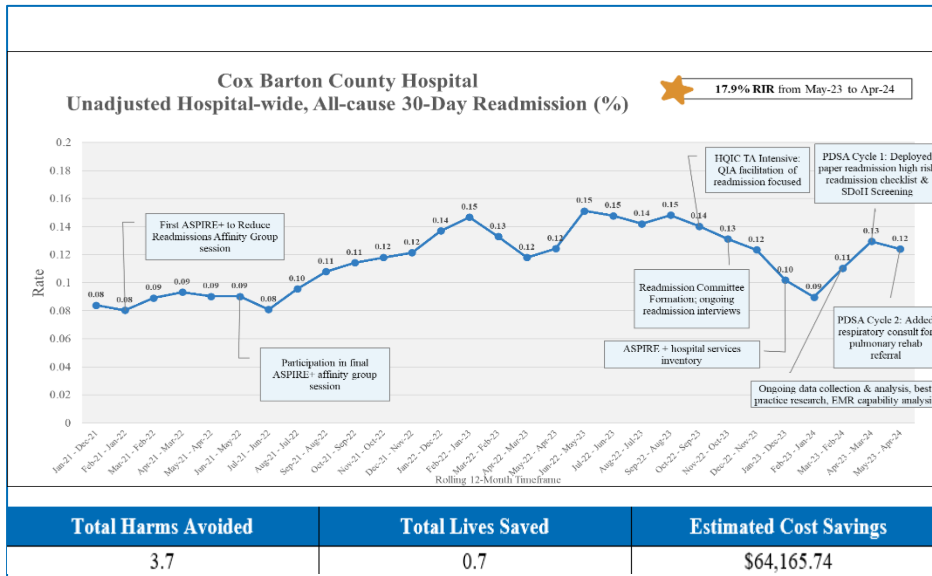
Study

Findings:

- **Reduction in high risk readmissions**
- March – May 2024 11 patients identified as high risk for readmission
- One out of the 11 readmitted : 9% readmission rate

- **Overall reduction in readmissions hospital wide**
- 17.9% Relative Improvement Rate & $64,175.74 estimate cost savings

- **Improved Teamwork and Culture of Readmission Awareness**

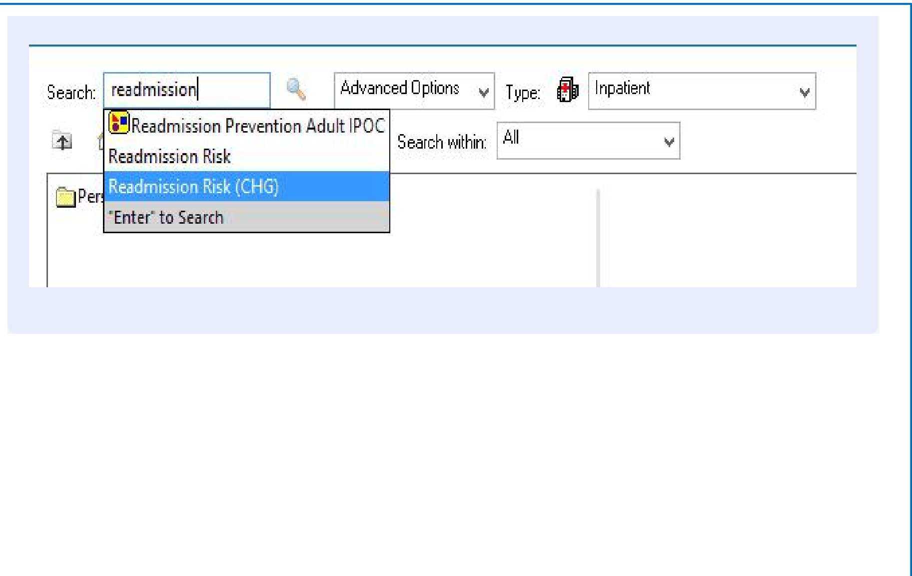


Total Harms Avoided	Total Lives Saved	Estimated Cost Savings
3.7	0.7	$64,165.74

Building a Readmissions Team
Making Improvements

Act

- **Improved Utility of the Readmission Checklist**
  - More formal structure to identify patients
  - Addition of order to EMR
- **Focused reviews of readmission cases**
  - Difficulty appropriately placing patients
  - Admitting extremely sick patients
- **Improved utility of pulmonary rehab**
  - Pulmonary rehab not appropriate for all patients
  - Identified need for an outpatient pulmonary education



Building a Readmissions Team
Final Thoughts

Take Away Points

- **Creating a motivated team and reviewing data**
- **Creating tools to utilize on the floor**
- **Reviewing effectiveness of those tools and ways to implement them better**
- **Questions?**
- **Thank you to Kendra Cooper and Deb Smith with HQI**

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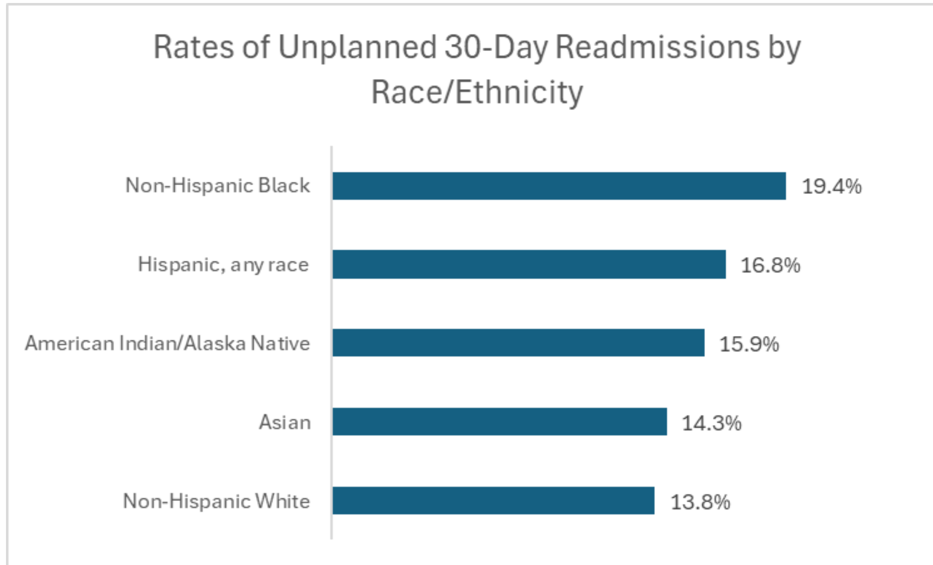
Disparities in Readmissions



- Patients of color experience the highest rates of unplanned 30-day readmissions rates
- Disparities are affected by SDOH and other compounding factors, such as comorbidities

Source: Guide for Reducing Disparities in Readmissions (cms.gov)

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Moving Towards Equity

Secure Buy-In and Develop SDOH Data Infrastructure

- Gain support from leadership
- Collect critical data
- Identify root causes

Build Teams & Partnerships to Support SDOH

- Activate a multidisciplinary team
- Foster external community partnerships

Implement Patient-Centered Systems & Processes

- Identify risk early
- Respond systemically to SDOH
- Provide culturally competent communication

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Key Strategies in Reducing Disparities

ADMISSION & INPATIENT STAY

- Screen for SDOH and provide resources where necessary
- Utilize interpreter services to address language barriers
- Consider presence of comorbidities
- Remain attentive to cultural beliefs & values
- Include behavioral health assessment in care

DISCHARGE

- Refer patients to a primary source of care
- Consider health literacy levels and use plain language
- Ensure discharge and care instructions are easy to understand

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Sustainability

Sustainability Decision Guide

Directions:

This is a resource to help leaders or teams determine if the interventions and changes they are making are sustainable. This guide will help identify why interventions may not be sustainable, and therefore need to be reconsidered. Use this guide at any point during a Performance Improvement Project (PIP), ideally when strategies have been found that appear to be successful and consideration is being given to adopting them broadly within the organization. The more questions that can be answered as "yes," the higher the likelihood of sustainability.

Systems

- ☐ Has the change been defined in terms of how it fits with the overall organizational mission, vision and strategic plan?
- ☐ Are there policies and procedures written in support of the change?
- ☐ Are those who need to carry out the new actions up to date with the information they need to be successful?
- ☐ Have the organization's systems been revised to encourage the new action? How are staff members reminded to carry out the new actions? Are you monitoring that the new actions are being carried out and is staff being supported in their ability to carry out the new actions?
- ☐ Are there system barriers that prevent the new action from occurring? Are there certain identifiable parts of the system that pose a roadblock to doing things in the new way?
- ☐ Are there incentives or rewards for people who do not adopt the new action that need to be addressed or removed?
- ☐ Has the change been integrated into new employee orientation and training?

People

- ☐ Has strong leadership support for the change been established? Has the leadership communicated a clear and convincing message about the change and its purpose? Are multiple levels of leadership engaged (e.g., board of directors, administrator, and department managers)? Is the leadership vocal and visible in its support? How will the leadership continue to promote the change and encourage staff to stick with it over time?

Sustainability Decision Guide

People (continued)

- ☐ Have roles and responsibilities for carrying out new actions been clearly defined and assigned?
- ☐ Are the people responsible for carrying out the change equipped to manage it? Do staff members have the appropriate skills and knowledge to successfully undertake any new actions required? Have training needs been addressed? Is additional or differently trained staff required?
- ☐ Are there champions for the change who are actively modeling the desired actions? Are there informal or natural leaders among the staff who could be encouraged to act as role models? Are there members of your staff exhibiting clear resistance to the change that should be addressed?

Environment

- ☐ Is the organization ready to take on this change? What issues in the workplace culture should be addressed before the change can be expected to become permanent? Is the reason given for the change in line with the values and attitudes of the staff?
- ☐ Has adequate funding (if applicable) been budgeted to support the change?
- ☐ Have resources (equipment, materials, staff time, information) been made available? What additional resources would help to encourage the new actions to take place?
- ☐ Are there things that can be done to the physical environment that make it unavoidable to do things in the new way (e.g., automation of processes; removal of certain objects necessary to do things the previous way)?

Measurement

- ☐ Has ongoing periodic measurement and review been scheduled to ensure the new action has been adopted and is performed consistently?
- ☐ Are indicators/measures chosen that tie directly to the new action? Can the indicator/measure distinguish the performance of different work groups (e.g., by unit, department, shift)? Are some work units carrying out the change more successfully than others?

Thank You!

MEETING Chat DIALOG TALK BUSINESS Answers IDEAS Communicate SOCIAL PROPOSAL IDEAS Discuss

Discussion

Connection Session Group

INPUT

CONVERSATION SHARE OPERATING QUESTIONS Dialog Business Communication

PARTNERSHIP Forum EXPLORATION Community Group TALK Debate

Resources

Office Hours:

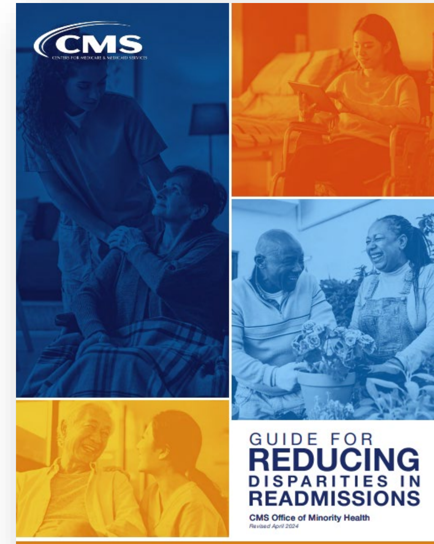
- What Works to Reduce Readmissions-Hear from Your Peers
    - Slides
    - Recording

- Health Equity Now (HEN) Workgroup Sessions 4-6
- CMS Guide for Reducing Disparities (April 2024)

- AHRQ Designing and Delivering Whole Person Transition Care
    - ASPIRE Guide
    - ASPIRE Toolbox
    - HQIN Readmission Interview Template

- Heart Failure Zone Tool
- HQIN Chronic Care Management (CCM) Toolkit
- HQIN Transitional Care Management (TCM) Toolkit

- SMART Goal Worksheet
- Sustainability Decision Guide



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