

Reducing Readmission by Optimizing Transition

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Hospital Quality Improvement Project (HQIP)

- HQIP Partnership (aka HQIC):
 - Primary Contractor: Alliant Quality
 - Subcontractor: Comagine Health
- Funded by Centers for Medicare and Medicaid Services (CMS)
- A four-year program designed to improve the efficiency, economy and quality of services
- Focus on rural, critical access hospitals and hospitals serving vulnerable populations

Three Key Focus Areas

- Behavioral health, opioid use
- Patient harm
- Care transitions

Readmission

- **Avoidable admission:** Unplanned readmission for any cause within thirty days of discharge date from index admission (all causes)
- **Exceptions:** Planned admission (e.g., surgery)
- **Opportunity:**
 - HCAHPS survey
 - Teach back method
 - Discharge summary - use PFAC member

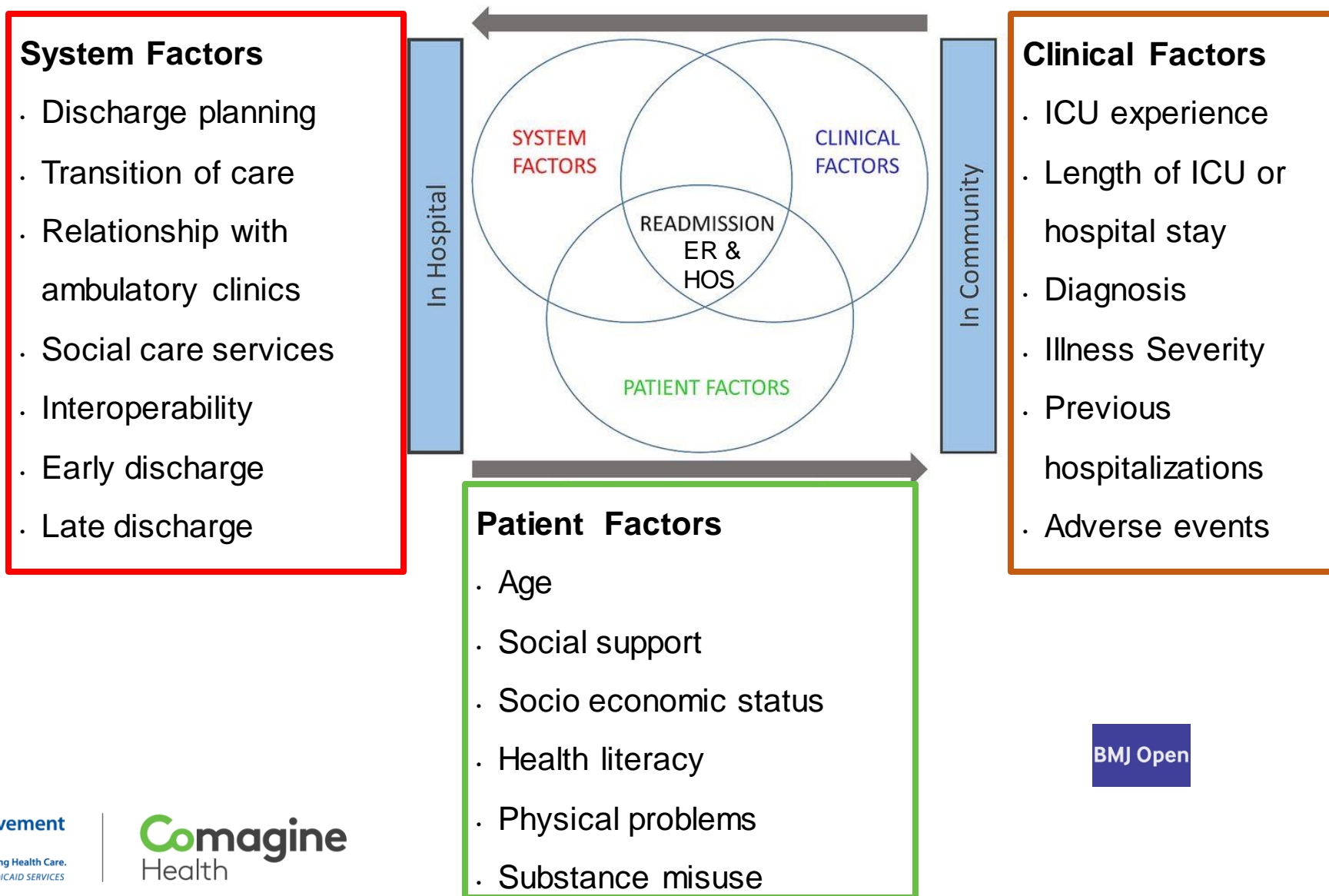
Why is there focus on reducing avoidable readmission?

- Indicator of lower quality of care
- Result of ineffective discharge processes
- Costly for the health care system and for patients
- Impacts hospital ratings
- Hospital can suffer Medicare penalties

Readmission – Goal Setting

- Establish the goal
- Define how many fewer readmissions are needed to achieve the goal
- Team building:
 - Case management, physician, CNO, ER, Pharmacist, PFAC member (start small, try an idea to make sure it works before making policies)
- Expand collaborating within the community – opportunity

Factors Impacting Readmission, ER and Hospitalization



Four Drivers to Address Avoidable Admissions

- Use data to make informed decision
- Continuous improvements needed in transition of care
- Enhanced service
- Collaboration outside the hospital

Use of Data for Informed Decisions

- Data enables strategic planning and targeted approach
- Macro data – Administrative claims, EMR (codes, age, d/g, timeline)
 - Patients come back home from nursing home etc.
 - High diagnosis – sepsis, HF
 - Race, ethnicity, payers
 - Trends, specific reasons within diagnosis etc.
- Micro data from interviews and post-discharge calls

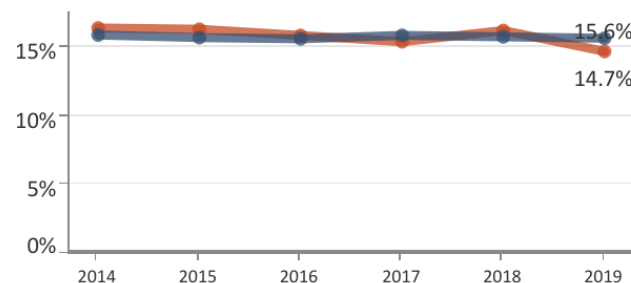


Care Transitions Community Report: Southwestern Washington



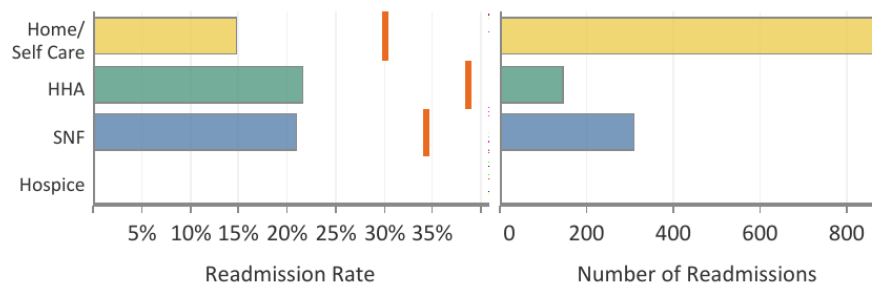
Hospital Readmissions

Trends in Readmission Rates



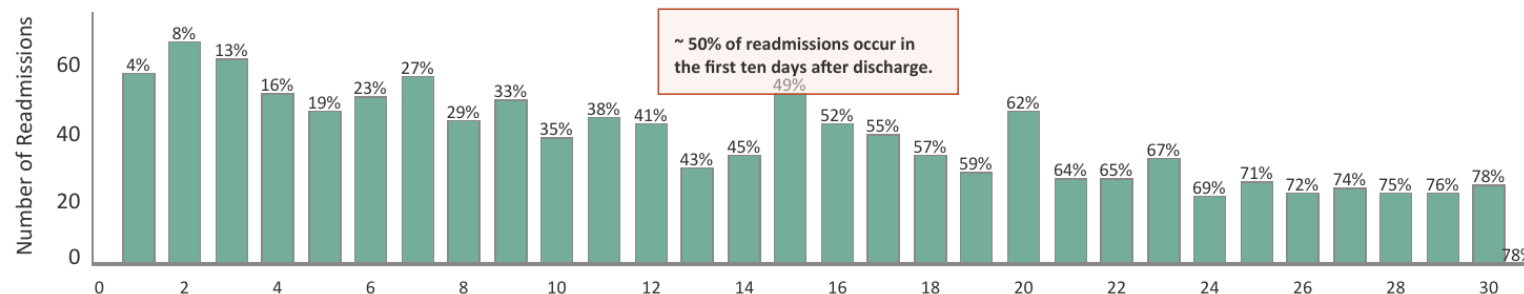
This graph shows the 30 day readmission rates over time for the **Southwestern Washington** community (blue line) compared to the rate for the other **Washington** communities combined (orange line). The readmission rate is defined as the number of readmissions within 30 days of discharge/number of live discharges.

Readmission Rates and Number of Readmission by Discharge Destination



These graphs show readmission rates (left) and number of readmissions (right) for the **Southwestern Washington** community, by discharge destination (colored bars). Statewide readmission rates are also shown (orange lines). Note that patients discharged to home/self care account for the largest number of readmissions, even though they do not have the highest readmission rate. **NOTE: data is suppressed when the number of readmissions is less than 11.**

30 Day Readmissions By Days Since Discharge



This graph shows the number of readmissions (blue-green bars), by days since discharge, for the **Southwestern Washington** community, along with the cumulative percentage of 30 day readmissions. Note that approximately 50% of readmissions occur within ten days of discharge.

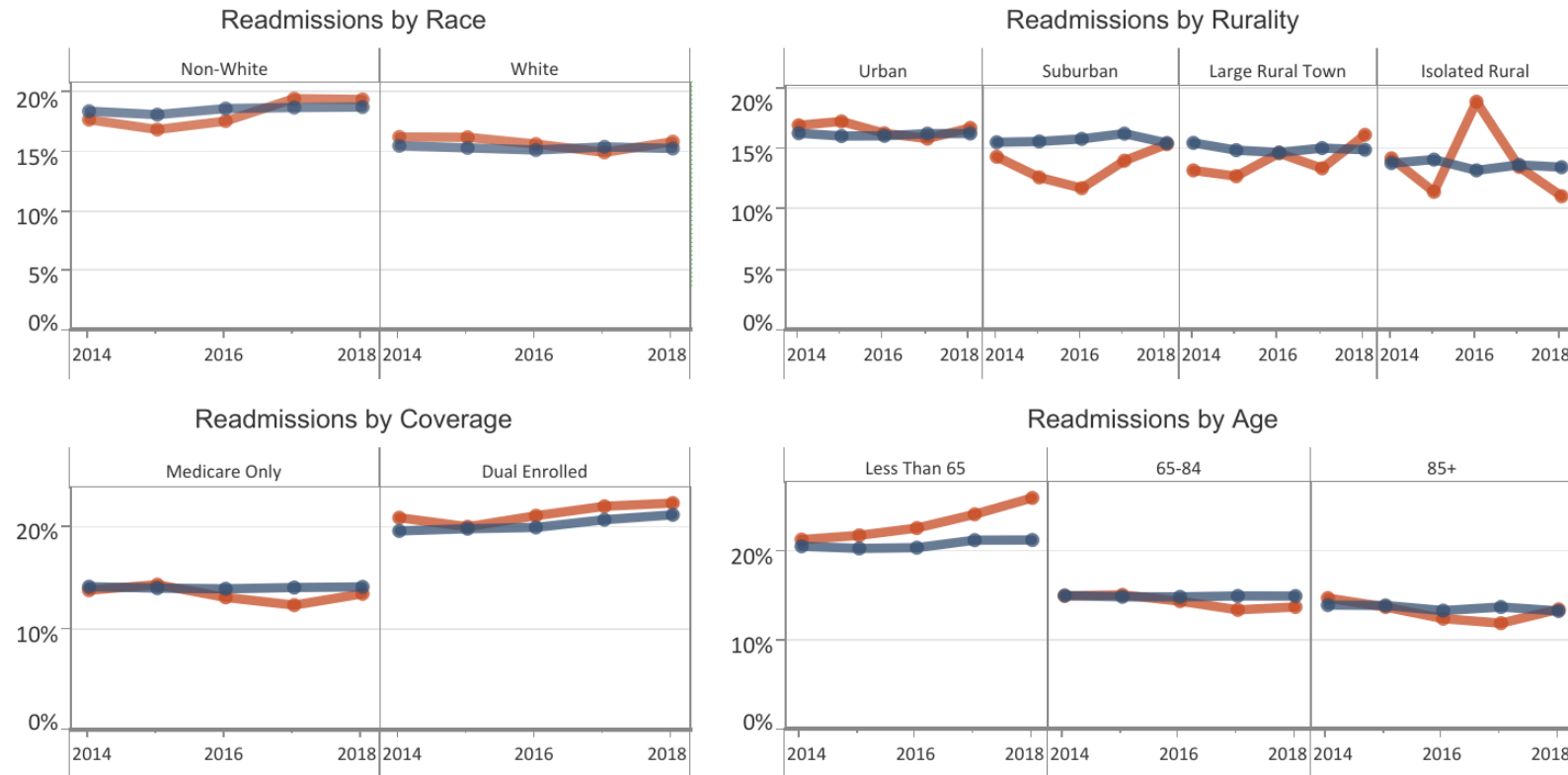
Start:	Community Admits & Readmits:	Hospital Readmissions - Disparities:	State Readmission Rates:	User's Guide:
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Care Transitions Community Report: Southwestern Washington



Potentially Underserved Populations



These graphs show the 30 day readmission rates for the Southwestern Washington community (**blue line**) compared to the rates for the other Washington communities combined (**orange line**), for potentially underserved populations. **NOTE: community rates are suppressed when the number of readmissions is less than 11.**

Start • Community Admits & Readmits • Hospital Readmissions • State Readmission Rates • User's Guide •

Use of Data for Informed Decisions – Cont.

- Learning from individual patients
 - Why come back, food insecurity, housing, transportation, information not be present in chart
- **Who can interview:** the case manager, social workers, PFAC members (where was the breakdown)
- Understanding the reason for your hospital is important
- Start small – don't become bogged down about creating policies see if an idea is working first

Use of Data for Informed Decisions – Cont.

- **Coaching package (interview skills):** Nonjudgmental, curiosity, open-ended e.g. Headache due to lack of meds- understand root cause, patient loneliness, PC after hours -call
- The discharge plan maybe not be the right plan
- PRAPARE tool, Aspire readmission review tool

Continuous Improvement in Transition of Care

- Do not use the same plan – keep evaluating
- Team building – Case management, physician, CNO, ER, Pharmacist, PFAC member (start small, try an idea to make sure it works before making policies)
- Infection control
- Customize discharge planning
- Timely post-discharge follow up phone call
- Family members know whom to contact
- Teach back method to validate patient understanding of discharge summary – staff requires training
- Develop follow-up plan with the patient

Advanced Services for High Utilizers

- Advanced services for a specific group
- Two types of patients: Complex health issues and high utilizers
- Complex health issues – Medication management with help of pharmacy, meds to beds, cardiac rehab, health literacy, palliative care
- Consider developing a program to help with a specific diagnosis like diabetes
- Telehealth, remote patient monitoring
- High utilizers – are they non-compliant, frequent flyers?
- Small team approach – knowing them well, relating, peer-to-peer help

Collaboration Outside of the Hospital

- Comagine Health has a project to reduce readmission with focus on community
- Network with a team that shares the care of high-risk patients
- Improve the referral process – Unite us, EDIE
- Collaborate with nursing home, home health and faith-based organizations
- Work with primary care providers

Lake Health District – Readmission

- Started as a quality improvement coordinator in Mid 2021
- Work experience in Eastern Europe
- Used power BI tool for better understanding of current data
- First investigating – hospital data from EMR
- Moved data from EMR to Power BI (pivot table)
- Training on Power BI– official training on the Microsoft website
- Timeline – Over a month
- Leadership – Supportive in addressing readmission
- Findings were presented to leadership in the quality meeting

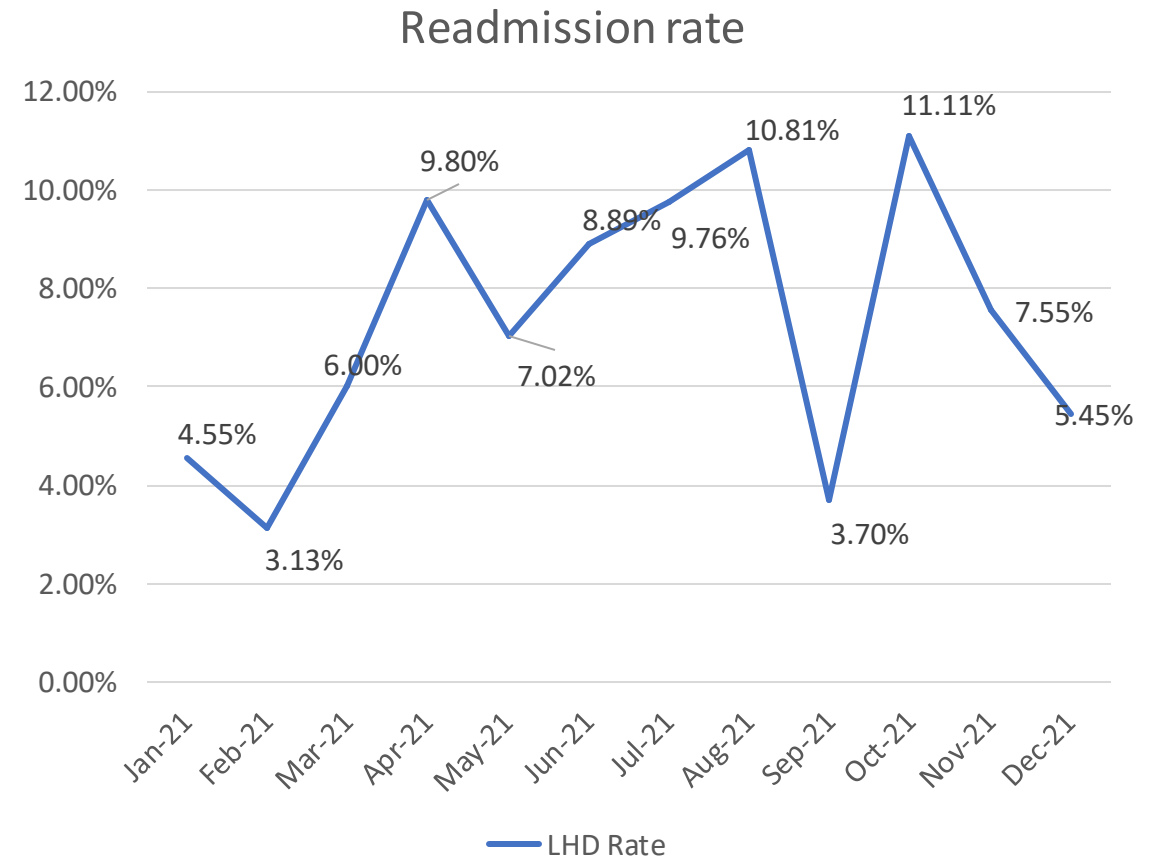
Lake Health District – Readmission

- Lake Health District is a Critical Access Hospital, an attached 24-bed skilled long term care facility, a home health and hospice service, outpatient clinic services.
- Our facility is located more than 50 miles from the next closest critical access hospital and 90 miles from the next higher level of care center at Sky Lakes in Klamath Falls OR.



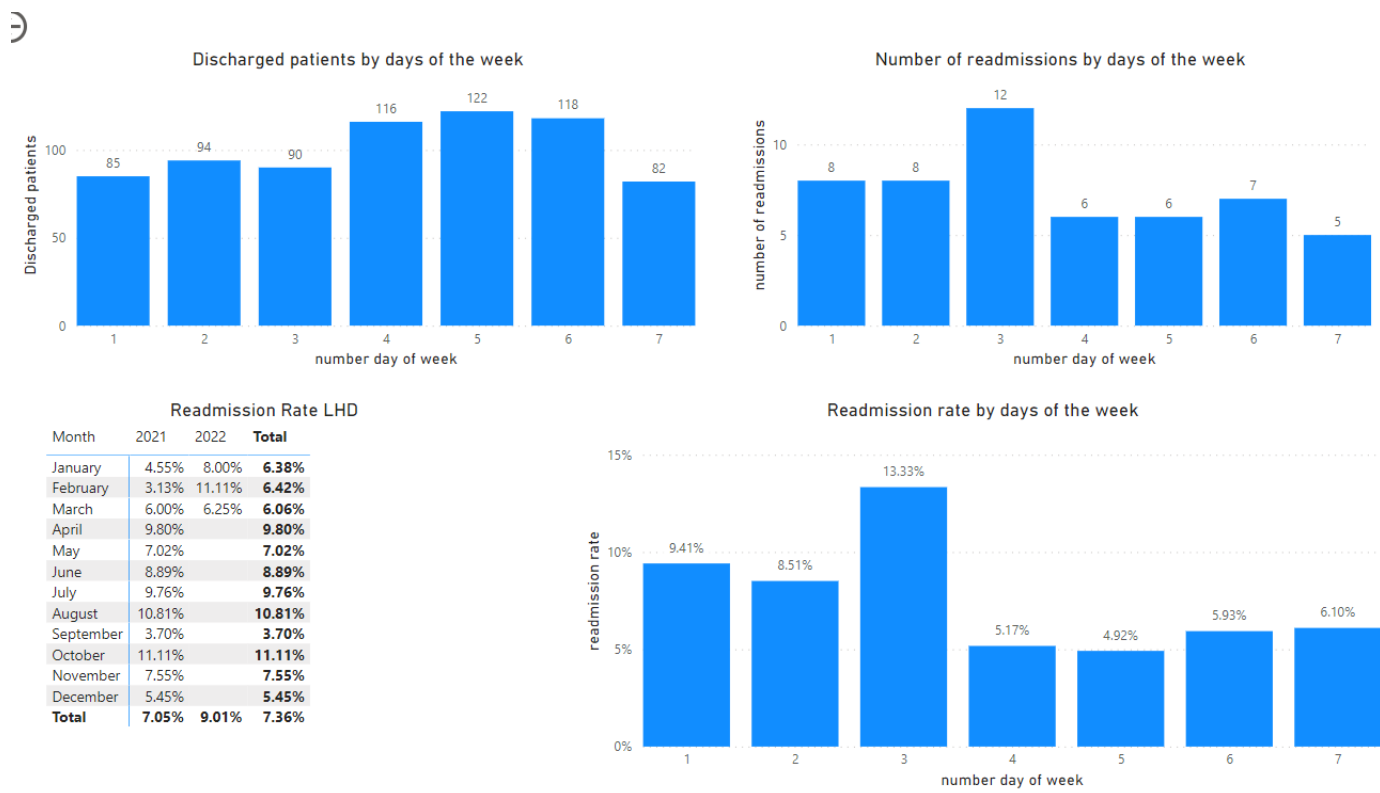
Readmission Rate

- Our readmission rates are between 4-11%
- We were looking for various ways to improve the readmission rates
- Work with Comagine Health to implement a readmission reduction program
- Personal challenge to operate in new environment



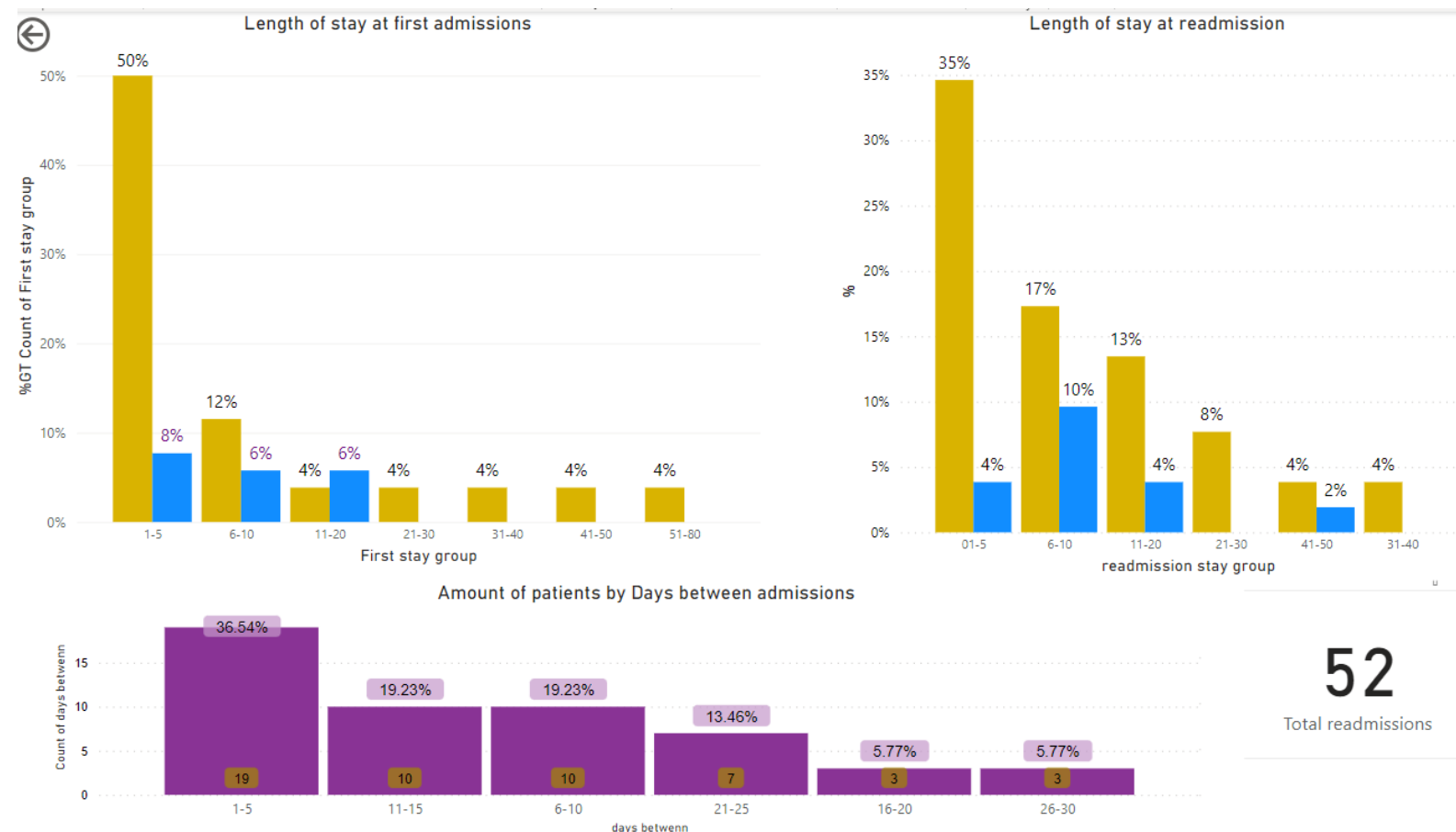
Reasons for Readmissions

- Analysis performed by using Power BI
- Comagine Health guided us in analyzing the data
- Higher amount of readmission happens on Sunday, Monday and Tuesday, with a higher number of discharges on Thursday Friday and Saturday



Outcome of Analysis

- Analyze existing patterns to make changes
- Up to 37% readmission happens at 1-5 days after discharge.

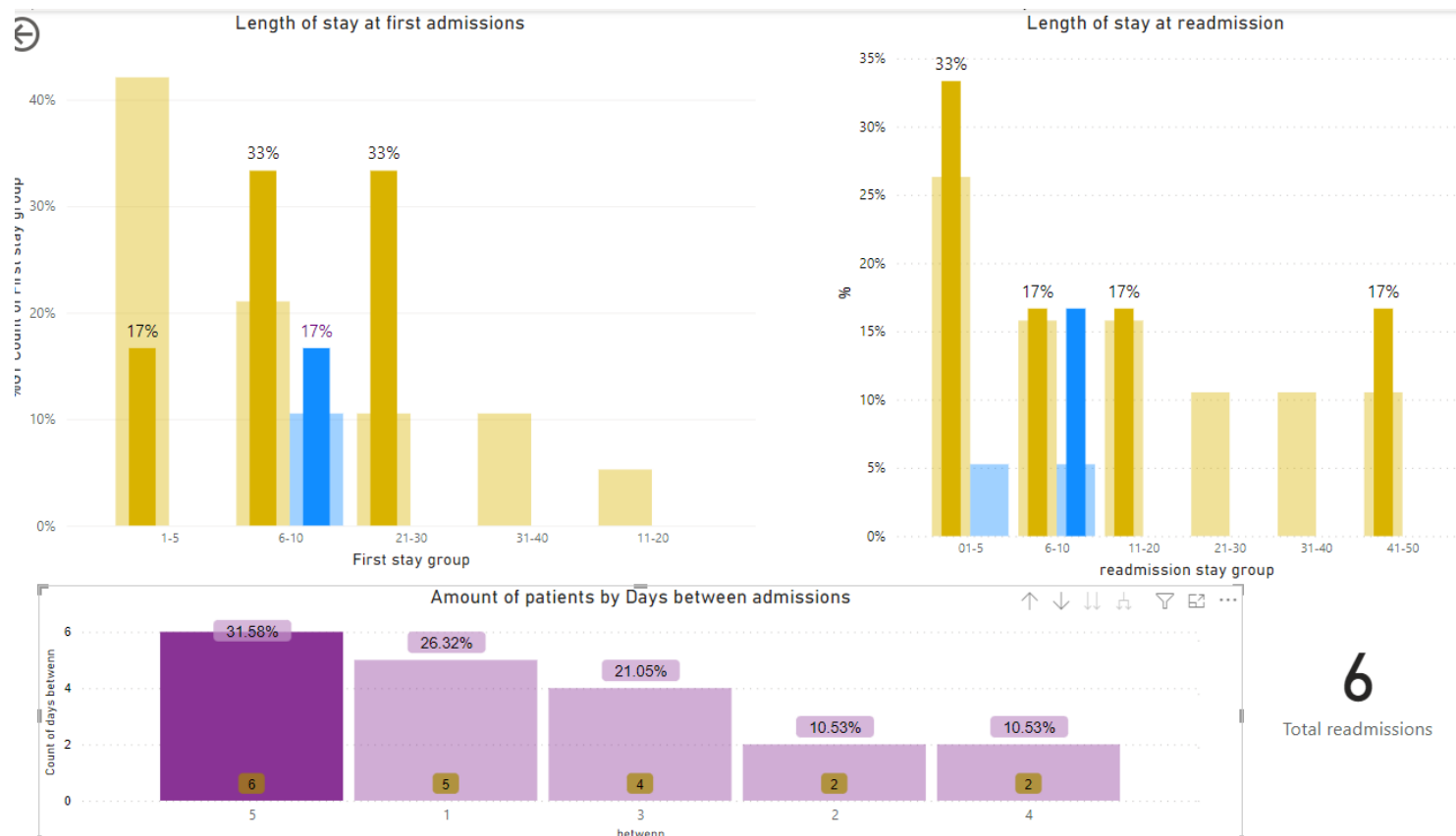


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Total readmissions

Outcome of Analysis

- Analyze existing patterns to make changes.
- Focus of action is discharged patients over the weekends, helping the patient to adapt to new environment, understand discharge instructions



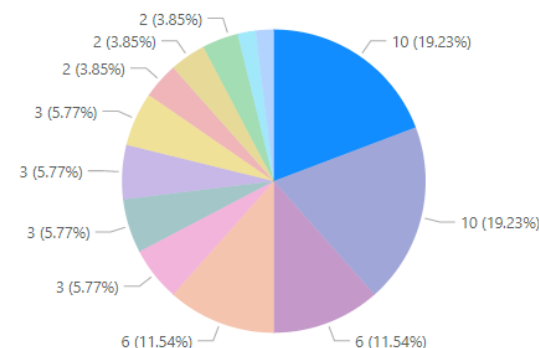
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Total readmissions

Outcome of Analysis

- Analyze existing patterns to make changes.
- Also analyzing diagnosis, about 40% coming with the same diagnosis and focus for improving process

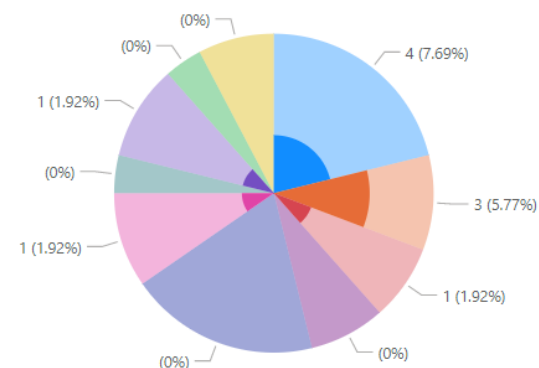
ICD-10 codes by Diagnosis at first admission



Diagnosis at first admission

- Diseases of the circulatory system
- Diseases of the digestive system
- Injury, poisoning and certain other consequences of ex...
- Other
- Covid
- Diseases of the respiratory system
- Diseases of the skin and subcutaneous tissue
- Mental, Behavioral and Neurodevelopmental disorders
- Diseases of the genitourinary system
- Diseases of the musculoskeletal system and connective...

Count of ICD-10 diagnosis readmission (groups) by ICD-10 diagnosis readmission

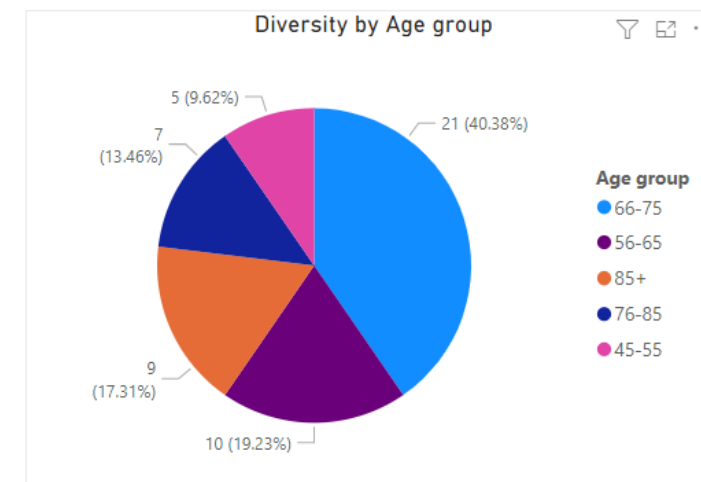
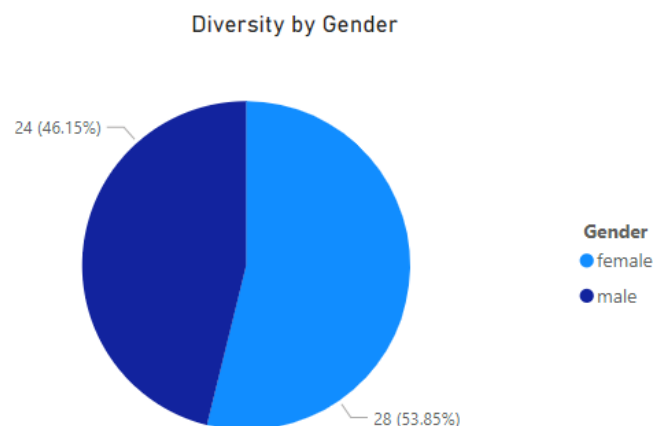
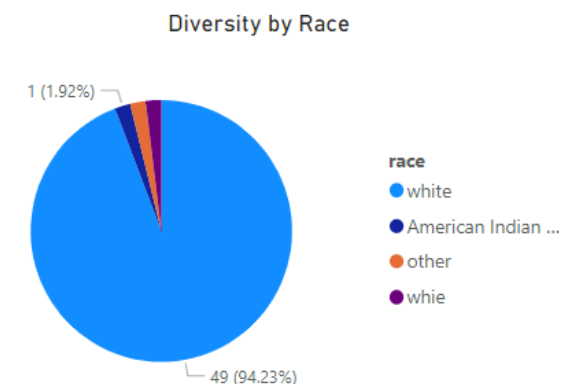
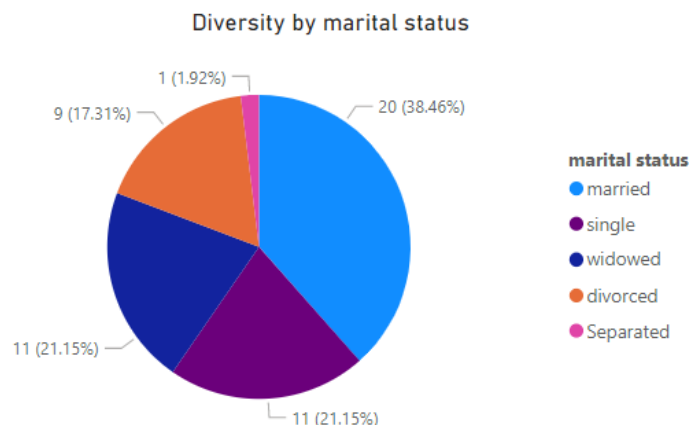


ICD-10 diagnosis readmission

- Diseases of the circulatory system
- Diseases of the digestive system
- Diseases of the respiratory system
- Diseases of the skin and subcutaneous tissue
- Injury, poisoning and certain other consequences of ex...
- Mental, Behavioral and Neurodevelopmental disorders
- Metabolic disorders
- Other
- Sepsis
- Symptoms, signs and abnormal clinical and laboratory f...

Outcome of Analysis

- Analyze existing patterns to make changes.
- 60% of readmission is the patient between 56-75, mostly living alone



Future Plans

- Collaborate with Fire Department-dispatch paramedics to check on patients within 1 or 2 days of discharge
- Basic training on the transition of care—grocery, medication refills, install shower handrail, safety toilet sheet, check blood pressure, blood glucose
- Dedicated nurse for reporting back

Toolkits/Resources

- [AHRQ teachback](#)
- [ARHQ Re-engineered Discharge \(Red\) Toolkit](#)
- [ASPIRE Toolkit: Designing and Delivering Whole-Person Transitional Care](#)
- [CMS Guide for Reducing Disparities in Readmission](#)
- [Mobile Integrated Healthcare Community Paramedicine](#)
- [CMS Discharge planning checklist for patients](#)
- [Whole Person Transitional Care Planning Tool](#)
- Review chronic conditions, high risk medications, health literacy, social support and resources. [Perfect 10 Flyer](#)

Comagine Health Resources

- Community level report
- Readmission report – small hospitals do not have all data points
- Resource for primary care setting
- Resources for SNF
- Community resources
- SBDOH-Resources on 211, Unite Us, EDIE

Thank you!