HQIC Community of Practice Call

Reducing Readmissions - Successful Rural Hospital Strategies

November 18, 2021

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

Introduction

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Welcome!

Who's in the Room?

Overview

- North Baldwin Infirmary Hospital:
  - Jo Ann Nix, RN, BSN, CMSRN and Lisa Bush, RN, CEN, CFRN
    - High Reliability
    - Culture of Safety
- Marshall Medical Center:
  - Hollie Powell, LBSW, MPH
    - Quality Focus
    - Readmissions Success
- Coffee Regional Hospital:
  - Wendy Griffis, BSN, RN and Shan Fields, BSN, RN
    - Readmissions Success
    - Person-centered
- Q & A

Speakers

Jo Ann Nix, RN BSN CMSRN
Chief Nursing Officer,
North Baldwin Infirmary

Lisa Bush MSN, RN, CEN, CFRN
Manager of Emergency Department, North Baldwin Infirmary

Hollie Powell LBSW, MPH
Director of Case Management,
Marshall Medical Center

Wendy Griffis BSN, RN
Administrative Director of Quality and Risk Management,
Coffee Regional Medical Center

Shan Fields BSN, RN
Director of Care Management,
Coffee Regional Medical Center

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As You Listen, Consider…

- How can you leverage the dynamic environment to foster success?
- Where can you begin with your facility to continue to ensure safety, and a patient-centered approach as you engage care partners?
- Which activities underway can you expand and push forward?
- What actions can you take in the next 30 days? 90 days?

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NORTH BALDWIN INFIRMARY

COMMITMENT TO A HEALTHY CULTURE HAS CONTRIBUTED TO CONSISTENCY AND SUSTAINABILITY OF PATIENT OUTCOMES

ALLIANT HEALTH SOLUTIONS

North Baldwin Infirmary
INFIRMARY HEALTH

North Baldwin Infirmary
INFIRMARY HEALTH

YTD FY 2022 Overview Statistics

234 Current Employees at NBI

6,033 Inpatient Patient Days

1,177 Surgical Cases

7,603 Emergency Department Visits

244 births

13,574 Radiology Procedures

83,874 Laboratory Procedures

Programs and Services

Hospitalist Program

Surgical Services: General, GI, and Limited Vascular

Cardiology Services

Orthopedic Services

Tele-Nephrology and Dialysis

Geriatric Inpatient Psychiatric Services

Tele-Pulmonary Services

Radiology Services: Ultrasound, Nuclear, MRI, Echo, CT, Mammography

Respiratory Services: Pulmonary Function Test

Cancer Center and Outpatient Chemo Infusion Center

Diabetic Education Program

Nursing/Clinical Departments

7 Bed OB Department with OR Suites

Nursery (Level 3)

5 Bed Intensive Care Unit

25 Bed Medical Surgical Unit

15 Bed Emergency Department

Surgery/Recovery Areas (3 OR Suites, 2 GI Labs)

23 Bed Senior Behavior Unit

Radiology

Respiratory

Laboratory

Pharmacy

Dietary

North Baldwin Infirmary
INFIRMARY HEALTH

Proud to be
Baby-Friendly
DESIGNATED

Alabama Breastfeeding Committee

Mission Statement

High Reliability at Infirmary Health

We have developed an entire program that will lead us to high reliability and a culture of safety.

Our program consists of:

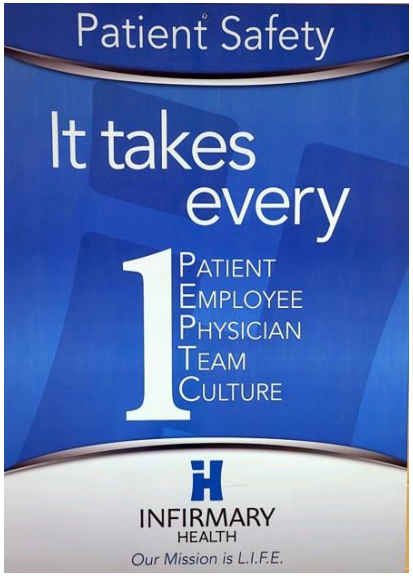
- Error Prevention Toolkit
- Hospital Huddles
- Unit Based Daily huddles
- Patient Safety Coaches
- Rounding to influence safety behaviors
- Serious Safety Event Committee
- Serious Safety Event Graphs
- Root Cause Analysis
- Safety LINKS
- Recognition Program

INFIRMARY HEALTH

House Divided?

It Takes *Everyone ….*

- Executive team
- Medical Staff
- Frontline Leaders
- Clinical staff
- Non-Clinical Staff



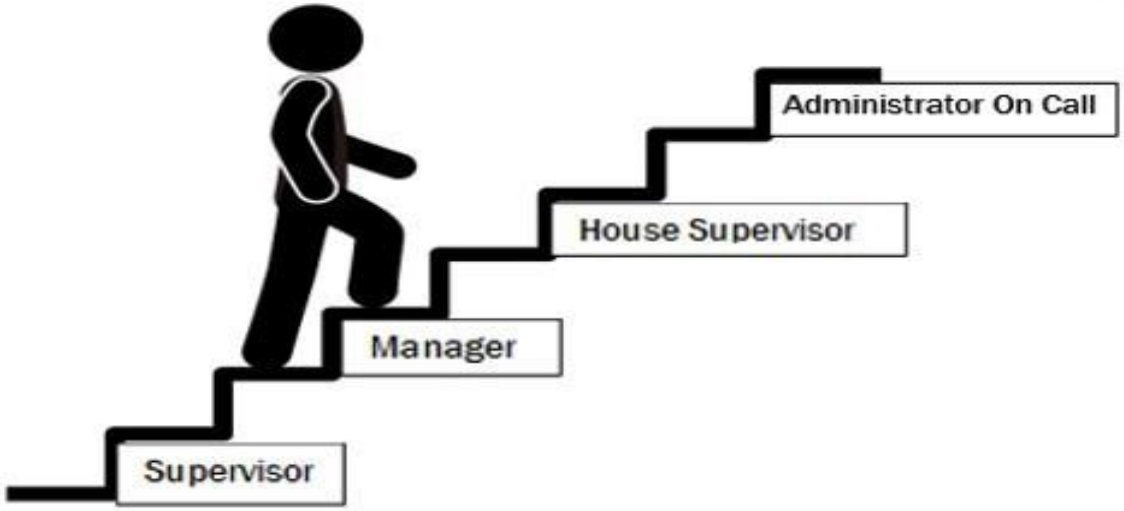
Safety Error Prevention Toolkit

Our Error Prevention Toolkit

I commit to the following . . . **Safety Behavior Expectations**	*By practicing the following . . .* **Error Prevention Tools**
Communicate Clearly	• 3-Way Repeat Back and Read Back • Phonetic and Numeric Clarifications • Ask Clarifying Questions
Handoff Effectively	• Use **SBAR** to handoff: **S**ituation **B**ackground **A**ssessment **R**ecommendation
I Got Your Back	• Cross Check • Coach Each Other
Pay Attention to Detail	• Self-Checking Using STAR: **S**top **T**hink **A**ct **R**eview
Speak up for Safety	• Question and confirm • Escalate Safety Concerns when necessary by saying "Before we go any further, I need some clarity..."

Speaking Up For Safety

- Anyone at Infirmary Health has the authority to STOP THE LINE any time that an immediate threat (real or perceived) to patient or staff safety is identified.



Safety Huddles

Great Catch Recognition, Safety Coach Program Lifeguards, and Safety Hero's Recognition

SINCE 2017 NBI HAS …

26 CURRENT POSITIONS AS PATIENT SAFETY COACHES

AWARDED …

 # 220 AVERAGE/YEAR OF GREAT CATCHES

 # 26 LIFE GUARD AWARDS

 # 17 SAFETY HERO AWARDS

Quality and Safety

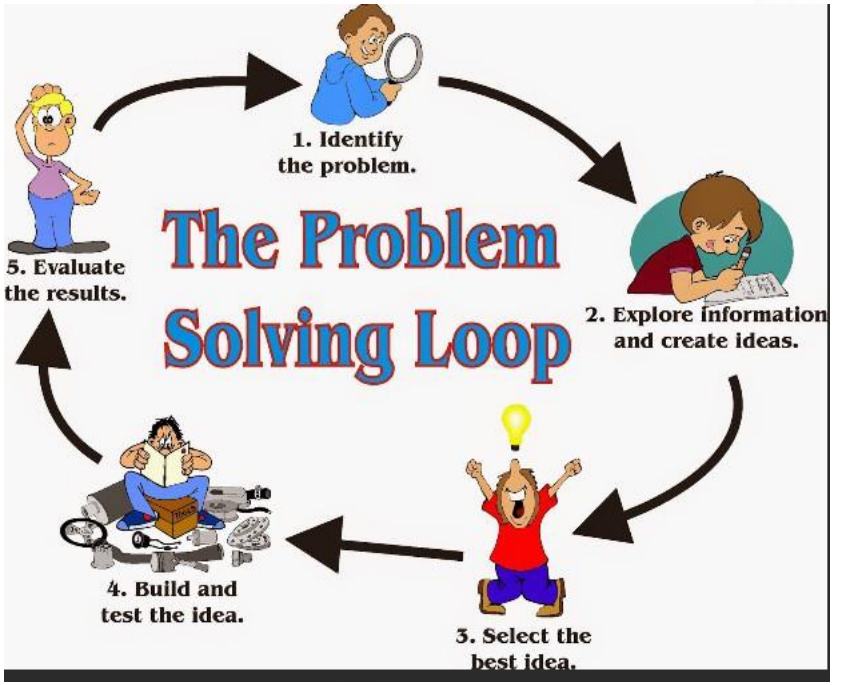
How does this translate into improving and sustaining quality ?

- ZERO CLABSI since 2017
- ZERO CAUTI since January 2019

- Safety Toolkit
- Daily safety Huddles
- Interdisciplinary Meetings

Building on the Culture of Safety
NBI Emergency Department Team

- Reducing CAUTI ….
- Where did we start?
- Identification of the problem?
- How did we succeed?
  - Use your best resources! Staff!



Building on the Culture of Safety Communication and Transparency

- How do we connect and create change through communication?
  - Morning Huddles/Mid Shift Huddles
  - Open Door
  - Great Catches/Recognition: Beyond the standard Safety Catches
  - Absence of Hierarchy
- Transparency
  - People cannot fix what they do not know about!

Building on the Culture of Safety
Just Culture

- Just Culture
  - Every question is a chance to teach or learn.
  - Every mistake is an opportunity.
- Serious safety event reduction starts with honest reporting

. . . creates an atmosphere of trust in which people are encouraged to provide, and even rewarded for providing, essential safety-related information but in which they are clear about where the line must be drawn between acceptable and unacceptable behavior.

James Reason

Managing the Risks of Organizational Accidents (1997)

Maintaining Forward Motion

- Keeping Safety on the Forefront
- Leadership Driven
  - Lead by example. Safety is not an exception.
- Employee Engagement
  - Education
  - Building Relationships
  - Building Team Dynamics/Culture
  - Empowering Staff

Retention and Safety

- Education Opportunities
  - Education promotes Safety through Knowledge
  - Job Satisfaction
- Development Opportunities
  - Strong Leadership Development Program in the System
  - Departmental Leadership supports growth and development
- Retention
  - Engagement
  - Retaining strong employees = Better Culture of Safety

Using the Frontline to Find Solutions

Let's Talk Readmissions!

Situation: Increasing readmission rates

Background: Largest Inpatient Admission driven from the ED

Assessment: No indicator for staff

Recommendation: Staff generated solution: Track board Indicator (Sep 2021)

Improvement To Date: Internal reporting system for tracking and trending

Readmission Reduction

November 18, 2021

Hollie Powell, LBSW, MPH

Director of Case Management

Marshall Medical Centers

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Marshall Medical Centers

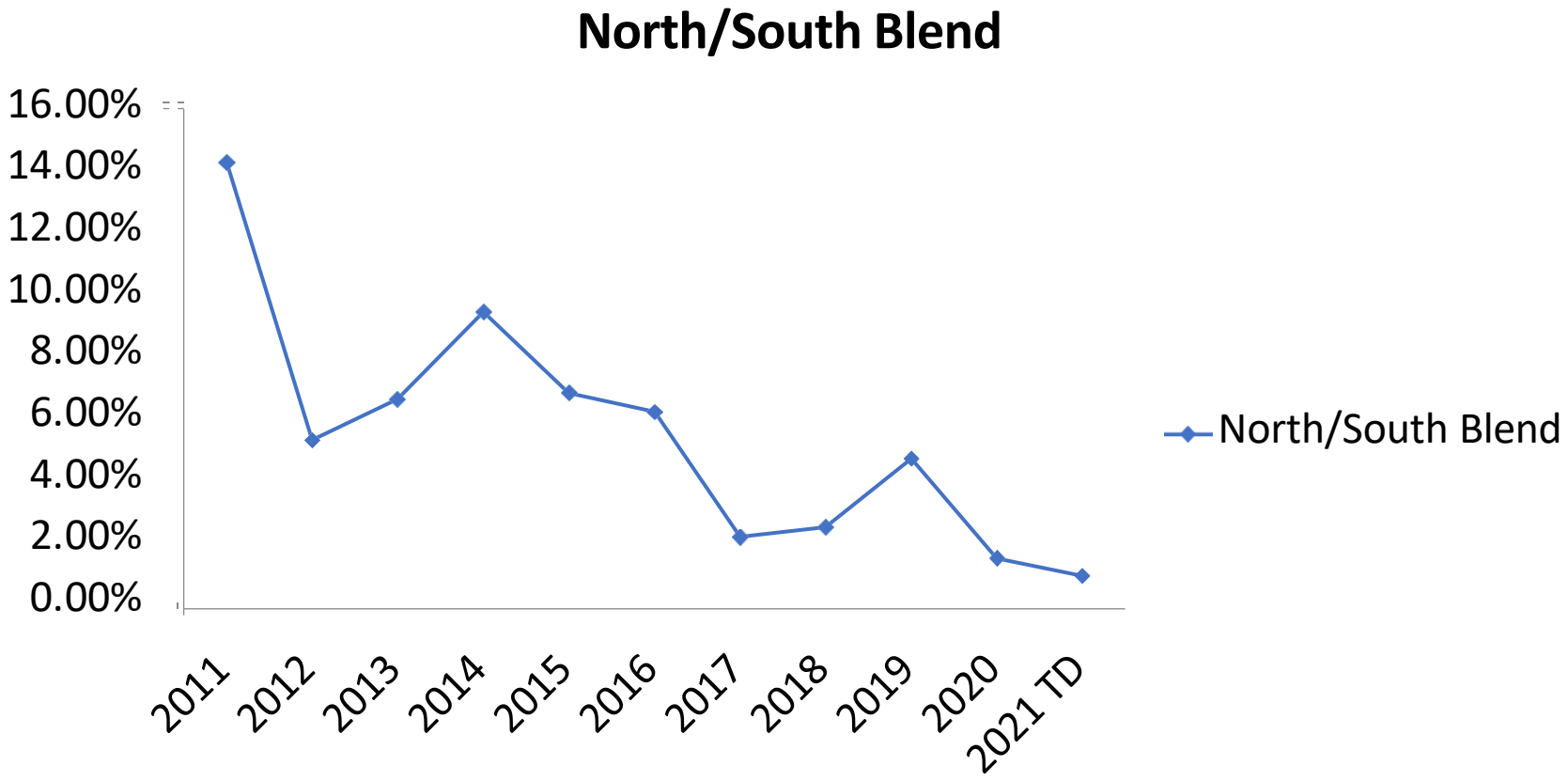
Marshall Medical Centers provides comprehensive inpatient and outpatient healthcare services serving the residents of Marshall County and the surrounding area (population about 125,000) with two hospitals: North, a 90-bed hospital located in Guntersville, AL and South, a 150-bed hospital located in Boaz, AL

Named by the Joint Commission as a "Top Quality Performer" among America's hospitals

Marshall Medical North
Guntersville, AL

Marshall Medical South
Boaz, AL

THA/TKA Readmission Rates



Readmission Risk Reduction for THA/TKA

In order to keep readmission rates low for THA/TKA patients, we utilize the following preventative measures:

- Joint Academy
  - This 45-minute class goes over everything our joint patients can expect going into their surgery and how to take care of themselves once they go home.
- In-house Education
  - Prior to discharging, all of our joint patients are visited by one of our case managers to go through what they need to be aware of once they get home. Our case managers also ensure that the patient is aware of the time and date of their follow up appointments.
- Follow Up Calls
  - We follow up with joint patients 3-5 day post discharge and two weeks post discharge. We ensure they are following all discharge instructions and check to ensure they aren't having any issues.

Joint Academy

Marshall Joint Academy

We encourage our patients to try everything possible to avoid joint replacement. Non-surgical treatment options include oral medications; exercises/physical therapy; and injections into the joint. If, however, you have exhausted all efforts of conservative management and are considering joint replacement, it can offer a lasting resolution of symptoms and return to normal activities.

You will be asked to attend a JOINT ACADEMY preoperative education class. We invite you to bring a "coach," who can be a friend, spouse, relative or neighbor to attend the class with you. Together with other patients and your coaches, you will hear from a nurse, physical therapist, and care coordinator (discharge planner). They will provide you with information about how you should prepare for the surgery (suggestions of things to help you at home), what you need at PAT (pread-mission testing), what to expect the day of surgery until you discharge home or to rehab—everything we think you'll need to be prepared.

Our goal is to help restore you to optimal comfort (decrease pain), increase mobility (independence), and improve quality of life (health).

- This 45-minute class prepares all of our knee and hip patients to take care of themselves when they discharge home.
- Patients who attend Joint Academy have less anxiety, they've completed their pre-surgery exercises, have few if any infections, go home sooner, use less pain medication, and usually, their rehab goes smoother.
- These patients and their coaches are educated in advance and prepared for what to expect coming out of the surgery.
- A key part of the pre-hospital work is assessing patient for and addressing any comorbidities.

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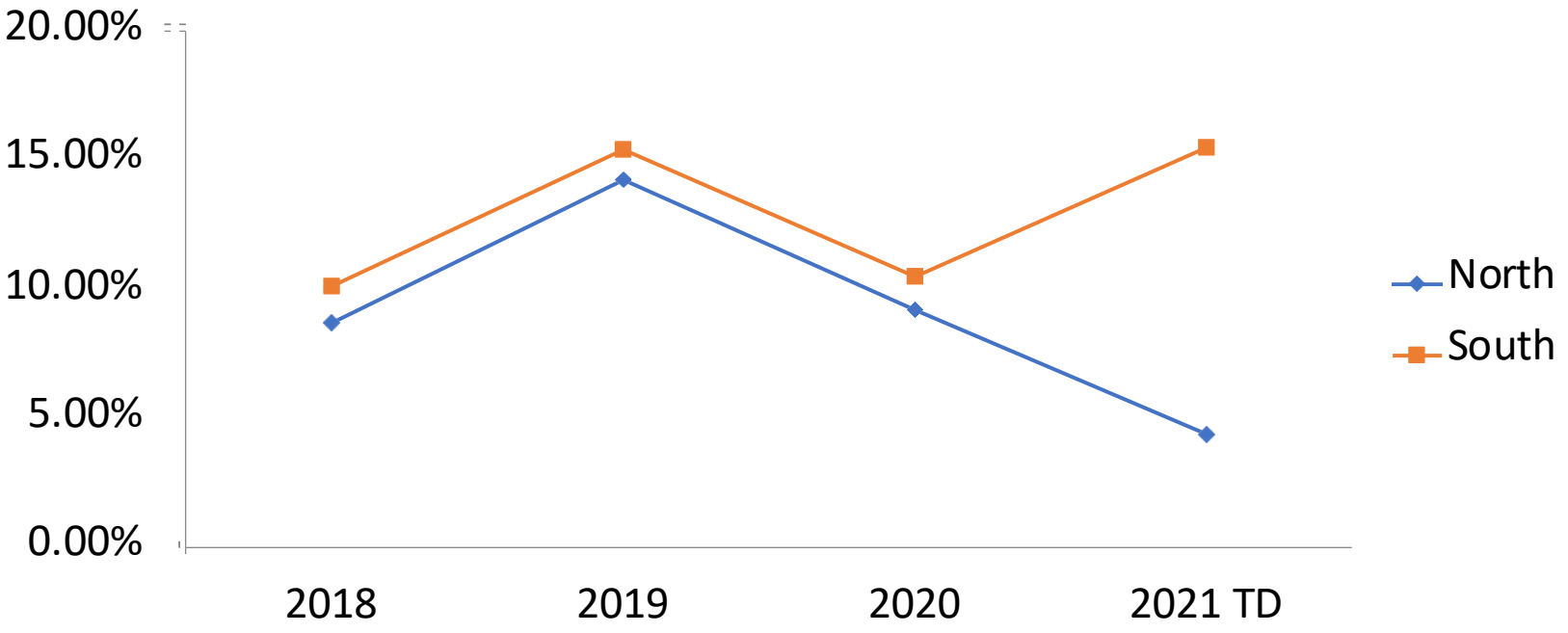
COPD Readmission Rates



Readmission Risk Reduction for COPD

All patients with a primary diagnosis of COPD receive a visit from one of our RN Case Managers prior to discharging and receive the following resources:

- Zone Magnets
  - Each COPD patient receives a folder at discharge with 3 color coded magnets that are used to indicate how they are feeling.
  - Patients then follow the directions on the magnet that corresponds to the zone they put themselves in for the day.
- Educational Literature
  - COPD patients will also receive educational brochures prior to their discharge to help educate themselves on their disease and how to take care of themselves.

Zone Magnets

Green Zone

- Feel Good
  - My sputum is white or clear
  - My breathing is no harder than usual
  - I can do my usual activities
  - I am able to think clearly

Action: Take your normal medications, including oxygen, as instructed by your doctor.

Yellow Zone

- Feel Worse
  - My sputum has changed
  - I am more short of breath
  - I cough or wheeze more
  - I cannot do my usual activities
  - I weigh more and my feet & legs swell

Action: Call your doctor or home health nurse immediately. You may be instructed to begin taking additional medications. Have your pharmacy phone number available.

Red Zone

- Emergency: Feel in danger
  - I cannot cough out my sputum
  - I am much more short of breath
  - I have to sit up to breathe
  - I cannot do my usual activities
  - I am unable to speak more than one or two words at a time
- I feel confused Action: Call your doctor immediately or home health nurse immediately. You may be asked to come in to be seen, be told to go to the emergency room, or call 9-1-1.

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Summary

- Key factors that aided in reducing readmission rates throughout Marshall Medical Centers facilities:
  - Patient Education
    - Joint Academy
    - Educational Literature
  - Patient Aides
    - COPD Zone Magnets
  - Post Discharge Follow Up
    - Tracking knee/hip patients for two weeks post discharge to catch potential readmission risk factors early and provide solutions that keep the patient from having to come back to the hospital.

Readmission Reduction Plan

November 18, 2021

Wendy Griffis, BSN,RN

Shan Fields, BSN, RN, CCM

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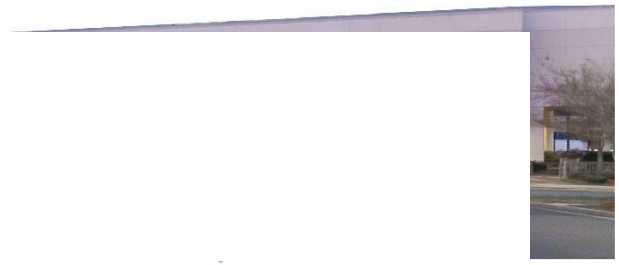
COFFEE REGIONAL MEDICAL CENTER

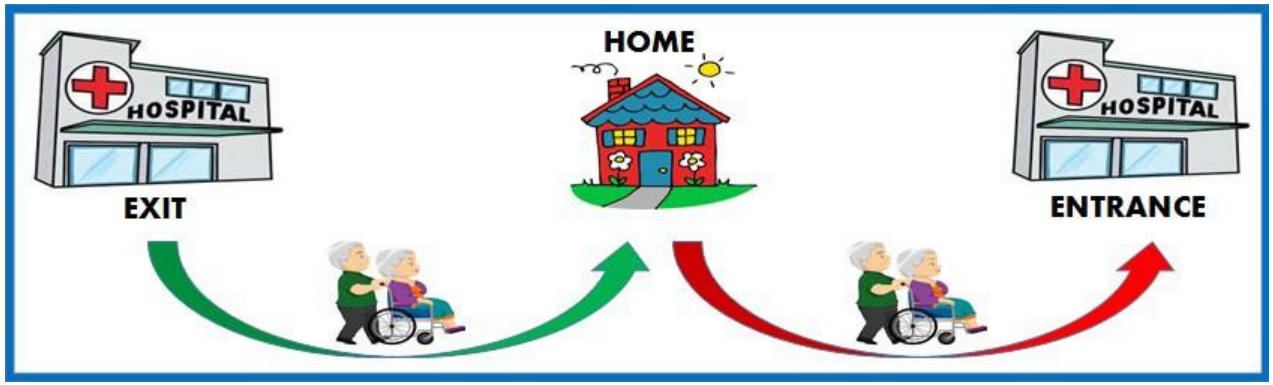
Douglas, GA

Purpose:
To Serve. To Heal. To Save.
Vision:
Healthy Lifestyles. Better Lives.
Mission:
To Provide Exceptional Care and Wellness Close to Home.
Values:

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

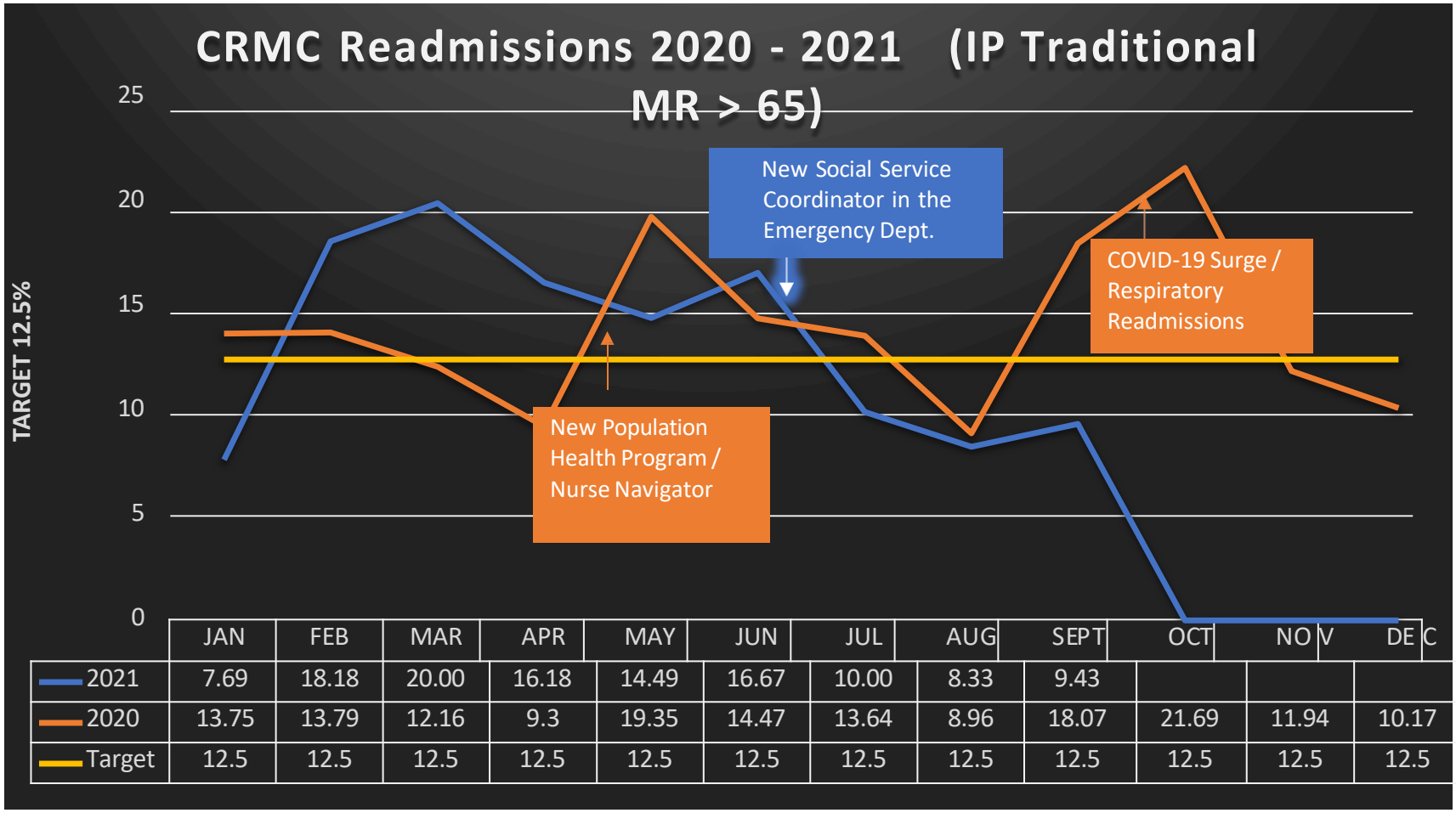
- Inefficient Discharge Process
- Inadequate coordination with clinicians and providers
- Insufficient follow-up appointments
- Medication Management after discharge from hospital
- Patient lack of knowledge with new diagnosis or new medication
- Socioeconomic barriers / Cultural barriers
- Care Management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



	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			
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	1 of 5 poss preventable readmit
# Readmissions	5	2 of 5 poss related medical stability with CMO review
		2 of 5 TC2 patients
MD Appt. prior to readmission	**40.00%**	1 of 5 SNF
MD Appt.	2	2 of 5 HHNs
# Readmissions	5	3 of 5 unpreventable valid medical needs
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	

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Patient's Story: 71-year-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

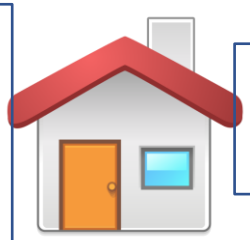
Determined two sons could speak English but did not fully comprehend

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

Discussion

- How can you leverage the dynamic environment to foster success?
- Where can you begin with your facility to continue to ensure safety, and a patient-centered approach as you engage care partners?
- Which activities underway can you expand and push forward?
- What actions can you take in the next 30 days? 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on December 9, 2021
from 1:00 – 2:00 PM ET

We invite you to register at the following link:

https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post event assessment here: post assessment_11.18.21

We will use the information you provide to improve future events.