Improving Care Transitions and Reducing Readmissions in the COPD/COVID-19 Population

Learning Collaborative Session 3: Using Data as Improvement Strategy

August 16, 2023
Welcome!

Please introduce yourself in the chat box with your name, your role in your organization, and the name of your organization.
Meet the Team

Rebecca Hancock, PhD, RN, CNS

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Bruce Spurlock, MD

Madeline Wilson, MSN, RN, CLSSBB
Collaborative Webinar Series

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<tr>
<th>Webinar Date</th>
<th>Planned Topic</th>
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<tr>
<td>6/21/2023</td>
<td>Overview/Goals – Recording &amp; Slides</td>
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<tr>
<td>7/19/2023</td>
<td>Self-assessment &amp; Addressing Gaps in Transitions – Recording &amp; Slides</td>
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<td>8/16/2023</td>
<td>Using Data as Improvement Strategy</td>
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<td>9/20/2023</td>
<td>Strengthening Partnerships Across the continuum</td>
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<tr>
<td>10/18/2023</td>
<td>Specific practices to improve care transitions</td>
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<tr>
<td>11/15/2023</td>
<td>Refinement of specific practices to improve care transitions</td>
</tr>
<tr>
<td>12/6/2023</td>
<td>Sustainability Plan</td>
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Once you register for the series you can attend any of the monthly webinars.

Register in advance for the meetings: 
https://ihaconnect-org.zoom.us/meeting/register/tZMscu6trzMoGNCzBtr4yG47jZb5xOKKVGXt

After registering, you will receive a confirmation email containing information about joining the meetings.
Roadmap for the Collaborative

Live Event: Kickoff
- June 21

Live Event: Addressing Overall Gaps in Care Transitions
- July 19

Hospital Team Activity: Complete Discovery Tool, Identify Pt Population, Inventory of Partners

Live Event: The Use of Data as an Improvement Strategy
- Aug 16

Hospital Team Activity: Patient Interviews and Deep Dives Into Drivers of Readmission

Live Event: Strengthening Partnerships Across the Continuum
- Sept 20

Hospital Team Activity: Meet With One High Priority Partner

Coaching Calls

Live Event: Implementing Specific Practices to Improve Care Transitions in the COVID/COPD Population
- Oct 18

Hospital Team Activity: Develop One New Practice to Test

Coaching Calls

Live Event: Refining Specific Practices to Improve Care Transitions in the COVID/COPD Population
- Nov 15

Hospital Team Activity: Test the New Practice

Coaching Calls

Live Event: Wrap Up
- Dec 6
A Review of the Collaborative Focus Areas

- Reliability testing for routine care transitions practices
- Addressing staffing challenges for staff engaged in care transitions
- Identifying gaps in different discharge dispositions

Specific Practices for the COPD/COVID-19 Population
- Co-designing practices with physicians to support pulmonary rehab
- Simulation strategies as teach back for COPD patients
- Pharmacy interventions

Addressing Gaps in Care Transitions Processes for All
- Use of Data as an Improvement Strategy
  - Deep dive at the individual hospital level
  - Identification of high utilizers and their specific drivers
  - Optimizing other data sources like d/c phone calls, SNF f/u, readmission interviews, HCAHPS results

Strengthening Partnerships Across the Continuum
- Co-designing practices with patient family partners
- Co-designing practices with post acute care providers
- Co-designing practices with shelters, housing insecurity, other social needs organizations
Addressing Gaps in Care Transitions Processes for All

- Reliability testing for routine care transitions practices
- Addressing staffing challenges for staff engaged in care transitions
- Identifying gaps in different discharge dispositions
Homework After Our Last Meeting

• Review your readmissions data if you have not yet had an opportunity to do so

• Complete a Discovery Tool for 5 to 10 patient records if you have not yet had an opportunity to do so

• Interview 1 or 2 currently or recently readmitted patients with a diagnosis of COPD / COVID / Respiratory Disease to learn more about the specific challenges that bring them back to the hospital

• Get your improvement team together to talk about the contributing factors to readmissions and create a list of 3-5 ideas about “enhanced care transitions needs” for the team to test
Have received completed Discovery Tools from:

- Marion General
- Greene County
- Harrison
- Memorial Jasper
- Schneck
- St. Elizabeth Dearborn

What did you learn from the Discovery Tool process? What do you still need to learn in order to design a small test of change?
What are the Discovery Tools telling us?

Top Findings:

- Transportation challenges
- Referral to Pulmonary Rehab
Use of Data as an Improvement Strategy

• Deep dive at the individual hospital level

• Identification of high utilizers and their specific drivers

• Optimizing other data sources like d/c phone calls, SNF f/u, readmission interviews, HCAHPS results
What are you learning from the data? What priorities are emerging?
Stories from the Field: Data Insights

Harrison County
Corydon, IN

April Shewmaker
Care Coordination Mgr

Use of Covid-19 codes and COPD primary/secondary diagnosis codes

Z-codes
## COVID-19 Codes

<table>
<thead>
<tr>
<th>COVID-Category</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of COVID-19</td>
<td>J12.82</td>
<td>Pneumonia due to coronavirus disease 2019</td>
</tr>
<tr>
<td>History of COVID-19</td>
<td>U07.1</td>
<td>COVID-19</td>
</tr>
<tr>
<td>History of COVID-19</td>
<td>U09.9</td>
<td>Post COVID-19 condition, unspecified</td>
</tr>
<tr>
<td>History of COVID-19</td>
<td>Z86.16</td>
<td>Personal history of COVID-19</td>
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</tbody>
</table>

## COPD Codes

<table>
<thead>
<tr>
<th>ICD-10-CM Code (index claim, principal diagnosis code)</th>
<th>Description</th>
<th>Principal Diagnosis Code - No Additional Coding Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>J41.0</td>
<td>Simple chronic bronchitis</td>
<td>Y</td>
</tr>
<tr>
<td>J41.1</td>
<td>Mucopurulent chronic bronchitis</td>
<td>Y</td>
</tr>
<tr>
<td>J41.8</td>
<td>Mixed simple and mucopurulent chronic bronchitis</td>
<td>Y</td>
</tr>
<tr>
<td>J42</td>
<td>Unspecified chronic bronchitis</td>
<td>Y</td>
</tr>
<tr>
<td>J43.0</td>
<td>Unilateral pulmonary emphysema [MacLeod’s syndrome]</td>
<td>Y</td>
</tr>
<tr>
<td>J43.1</td>
<td>Panlobular emphysema</td>
<td>Y</td>
</tr>
<tr>
<td>J43.2</td>
<td>Centrilobular emphysema</td>
<td>Y</td>
</tr>
<tr>
<td>J43.8</td>
<td>Other emphysema</td>
<td>Y</td>
</tr>
<tr>
<td>J43.9</td>
<td>Emphysema, unspecified</td>
<td>Y</td>
</tr>
<tr>
<td>J44.0</td>
<td>Chronic obstructive pulmonary disease with (acute) lower respiratory infection</td>
<td>Y</td>
</tr>
<tr>
<td>J44.1</td>
<td>Chronic obstructive pulmonary disease with (acute) exacerbitation</td>
<td>Y</td>
</tr>
<tr>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
<td>Y</td>
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</tbody>
</table>
What is the Indiana data telling us?

All IN Hosps: 17% of top 10 readmissions respiratory in nature
COPD #7 in top 10

Most readmits from home/self care
I-HOPE Indiana Hospitals 2021 to Q1 2023

**COPD Patients**
- Patient Volume: 64,590
- Patient Rate: 19.55%
- Average Length of Stay: 6.568 days
- Mortality Rate: 4.11%

**COVID-19 Patients**
- Patient Volume: 28,603
- Patient Rate: 8.66%
- Average Length of Stay: 10.216 days
- Mortality Rate: 7.30%
Why were the COPD patients readmitted?

Sepsis, COVID-19 and CHF most common with pneumonia
Why were the COVID-19 patients readmitted?

**Top 10 Readmission Record Primary Diagnosis**

Codes from COVID-19 Patients Index Admissions

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2022 Q1</th>
<th>2022 Q2</th>
<th>2022 Q3</th>
<th>2022 Q4</th>
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<tbody>
<tr>
<td>COVID-19</td>
<td>277</td>
<td></td>
<td>142</td>
<td></td>
</tr>
<tr>
<td>Other specified sepsis</td>
<td>32</td>
<td>3</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Sepsis, unspecified organism</td>
<td>9</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Acute kidney failure, unspecified</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonitis due to inhalation of food and vomit</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Hypo-osmolality and hyponatremia</td>
<td>3</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Paroxysmal atrial fibrillation</td>
<td>3</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Hepatic failure, unspecified without coma</td>
<td></td>
<td></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Type 1 diabetes mellitus with ketoacidosis</td>
<td>4</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension, chronic kidney disease</td>
<td>2</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

When patients were readmitted, what was their primary diagnosis?

COVID-19 and Sepsis most common
What SDOH’s are associated with COPD patients?

Top Z-codes for COPD

- Problems living alone
- Unemployment
- Homelessness
- Disappearance and death of family member
What SDOH’s are associated with COVID-19 patients?

Top Z codes for COVID-19

- Problems r/t living alone
- Unemployment
- Disappearance and death of family member
Discussion Question

What are the biggest challenges your patients and staff experience in trying to get patients both referred to AND participating in pulmonary rehabilitation following hospitalization for patients with COVID / COPD/ Respiratory Disease?
Planning Small Test of Change

Experiences

- Discovery Tools
- Patient Interviews
- IHA Datalink

Improvement Strategy
Strategy Planning Sessions with Physician Expert

One or two 30-minute meetings with your team to strategize:

• How to address care transitions challenges
• How to engage clinical staff
• How to increase referrals to pulmonary rehab
• Sign Up Link: [IHOPE Strategy Sessions with Dr. Jessica Goldstein (office.com)]
Next Steps: Find Out More

✓ Review your readmissions data if you have not yet had an opportunity to do so

✓ Complete a Discovery Tool for 5 to 10 patient records if you have not yet had an opportunity to do so

• Interview 1 or 2 currently or recently readmitted patients with a diagnosis of COPD / COVID / Respiratory Disease to learn more about the specific challenges that bring them back to the hospital

• Interview 1 or 2 providers to find out what challenges they face in referring patients to pulmonary rehab

• Get your improvement team together to talk about the contributing factors to readmissions and create a list of 3-5 ideas about “enhanced care transitions needs” for the team to test

• Set up a strategy session for your team with our Physician Advisor
IHA Webpage Resources Available

• Focus on COPD/SDOH z-code Training
• Tools: Oximeters, Oral Hygiene
• Asthma/COPD/COVID-19 Therapies
• Pulmonary Rehab Education
• Smoking Cessation Education
• Datalink SDOH/Readmission Dashboard
• COPD Educator Courses
• Asthma Certification Courses
• Culture of Patient Safety Implications—community / family resources
Questions?

We’ve got answers!
See You Next Month!

September 16, 2023
3:00 – 4:00 pm ET

Questions before we meet next month?

Reach out to Rebecca Hancock at rhancock@ihaconnect.org at any time!

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