Indiana Hospital Association

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

Lynn Seaver-Forsey, PhD, RN, CPPS, CPHQ

Jessica Goldstein, MD, FACEP

Kim Werkmeister, MS, RN, CPHQ, CPPS

Bruce Spurlock, MD

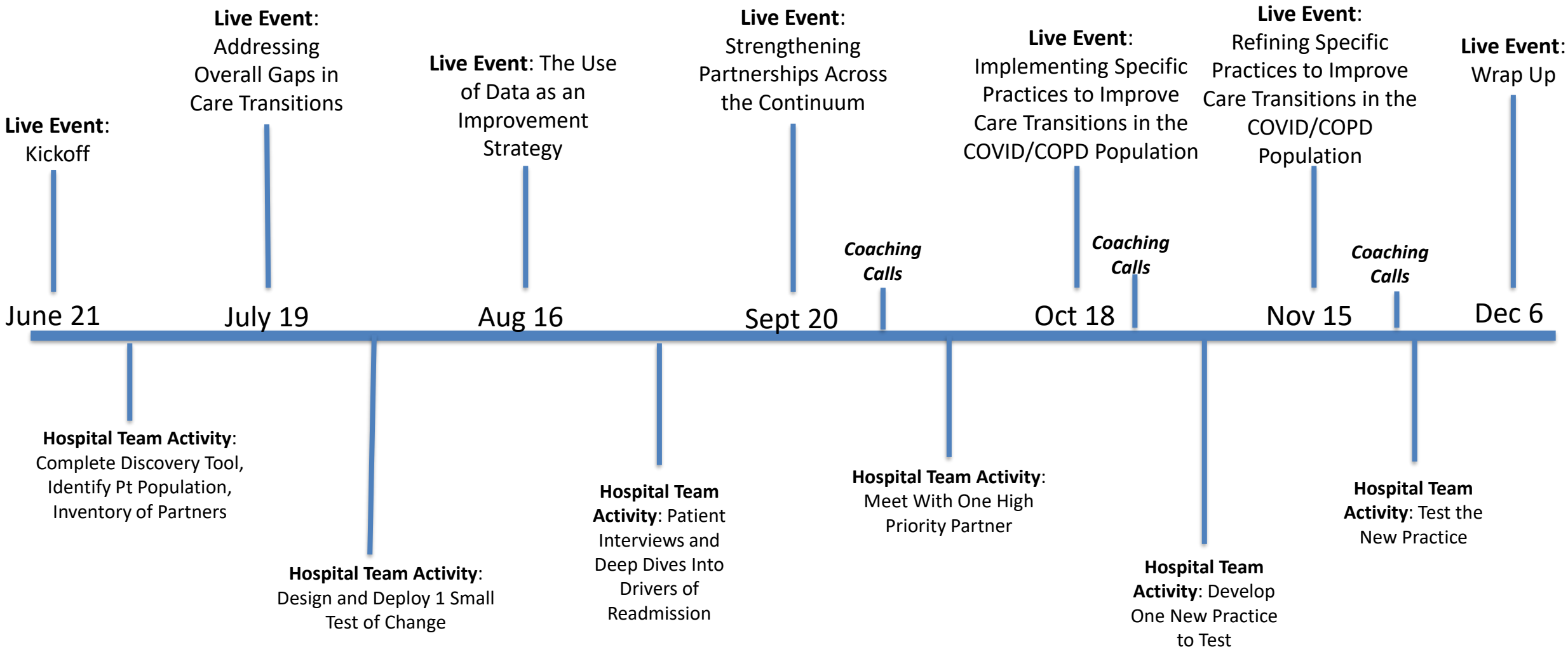
Madeline Wilson, MSN, RN, CLSSBB

Collaborative Webinar Series

Webinar Date	*Planned* Topic
6/21/2023	Overview/Goals – Recording & Slides
7/19/2023	Self-assessment & Addressing Gaps in Transitions – Recording & Slides
8/16/2023	Using Data as Improvement Strategy
9/20/2023	Strengthening Partnerships Across the continuum
10/18/2023	Specific practices to improve care transitions
11/15/2023	Refinement of specific practices to improve care transitions
12/6/2023	Sustainability Plan

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



A Review of the Collaborative Focus Areas

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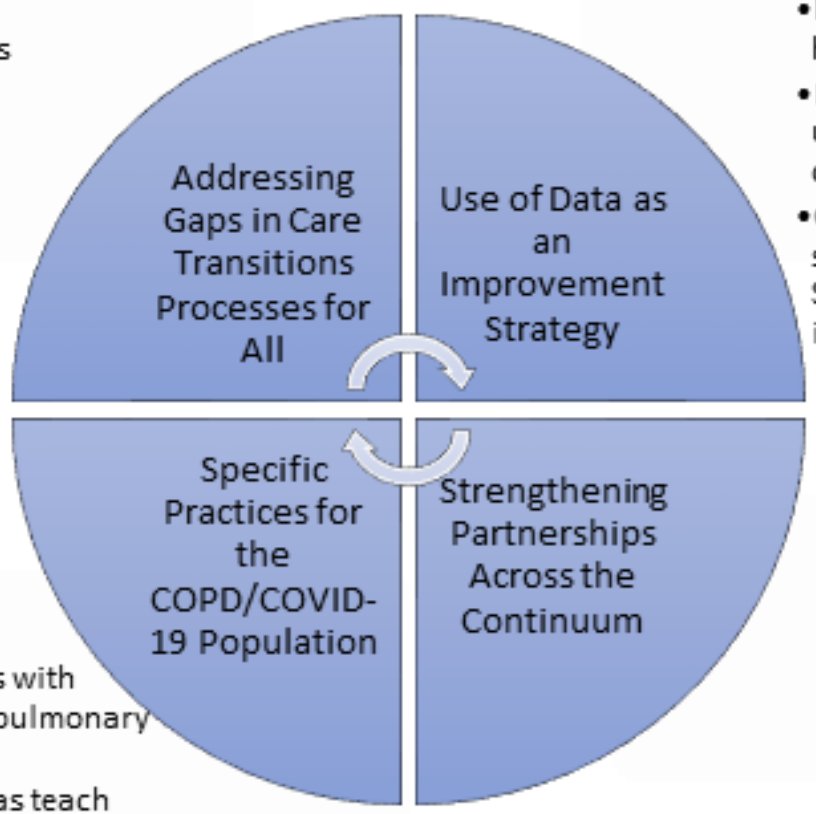
- Reliability testing for routine care transitions practices
- Addressing staffing challenges for staff engaged in care transitions
- Identifying gaps in different discharge dispositions



- 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

- Co-designing practices with physicians to support pulmonary rehab
- Simulation strategies as teach back for COPD patients
- Pharmacy interventions

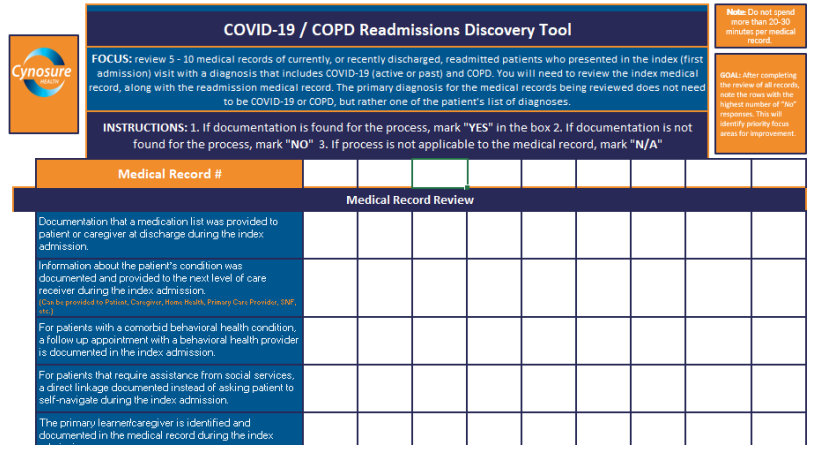
- Co-designing practices with patient family partners
- Co-designing practices with post acute care providers
- Co-designing practices with shelters, housing insecurity, other social needs organizations

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



COVID-19 / COPD Readmissions Discovery Tool

FOCUS: review 5 - 10 medical records of currently, or recently discharged, readmitted patients who presented in the index (first admission) visit with a diagnosis that includes COVID-19 (active or past) and COPD. You will need to review the index medical record, along with the readmission medical record. The primary diagnosis for the medical records being reviewed does not need to be COVID-19 or COPD, but rather one of the patient's list of diagnoses.

INSTRUCTIONS: 1. If documentation is found for the process, mark "YES" in the box 2. If documentation is not found for the process, mark "NO" 3. If process is not applicable to the medical record, mark "N/A"

Note: Do not spend more than 20-30 minutes per medical record.

GOAL: After completing the review of all records, note the rows with the highest number of "No" responses. This will identify priority focus areas for improvement.

Medical Record #									
Medical Record Review									
Documentation that a medication list was provided to patient or caregiver at discharge during the index admission.									
Information about the patient's condition was documented and provided to the next level of care receiver during the index admission. (Can be provided to Patient, Caregiver, Home Health, Primary Care Provider, SNF, etc.)									
For patients with a comorbid behavioral health condition, a follow up appointment with a behavioral health provider is documented in the index admission.									
For patients that require assistance from social services, a direct linkage documented instead of asking patient to self-navigate during the index admission.									
The primary learner/caregiver is identified and documented in the medical record during the index									

READMISSIONS INTERVIEW GUIDELINES

OBJECTIVE OF THE INTERVIEW

To facilitate the development of effective strategies that minimize hospital readmissions for patients. By gathering qualitative insights on the factors that contributed to a readmission, these interviews provide valuable insights to validate or challenge assumptions derived from aggregated readmissions data. This comprehensive understanding of the underlying causes enables hospitals to create targeted approaches for preventing future hospital visits.

GOLD STANDARD

Patients and Families are engaged in ALL quality improvement projects!

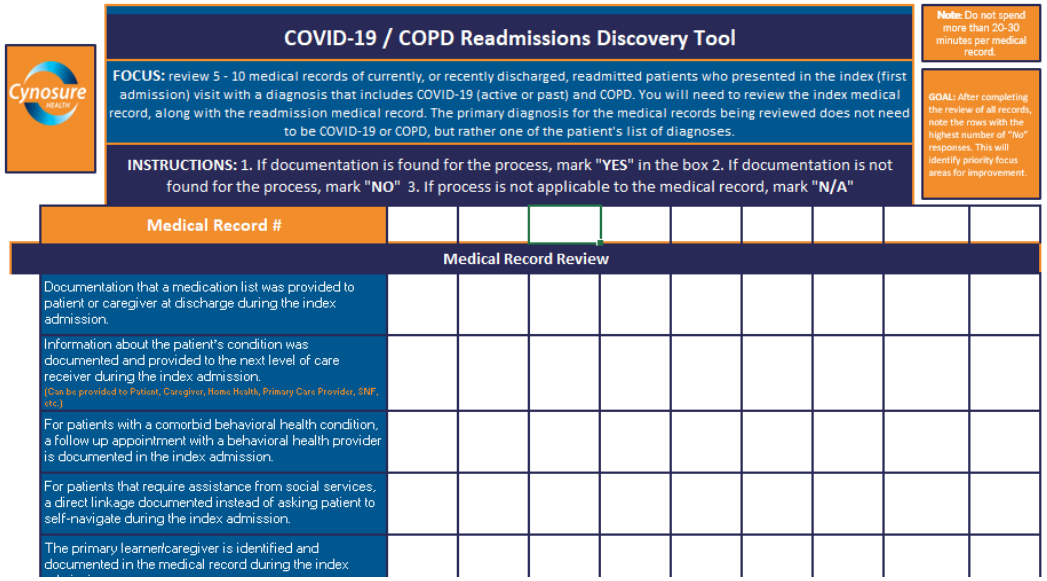
TIPS FOR IDENTIFYING PEOPLE TO INTERVIEW

Anyone with lived experience being readmitted to your hospital will have critical insights for your quality improvement efforts!

Stories from the Field: Discovery Tools

Have received completed Discovery Tools from:

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



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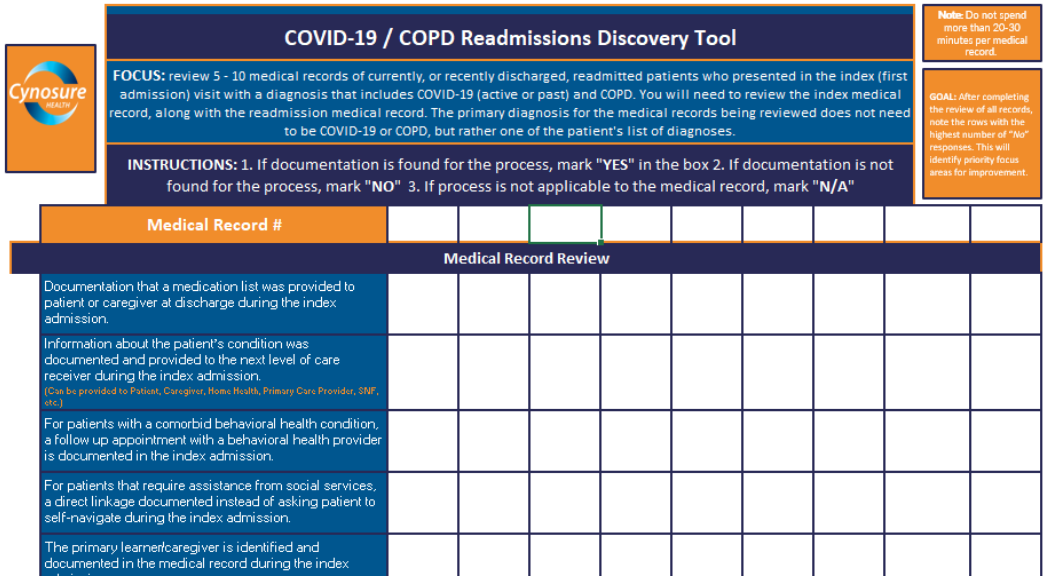
What did you learn from the Discovery Tool process? What do you still need to learn in order to design a small test of change?

What are the Discovery Tools telling us?



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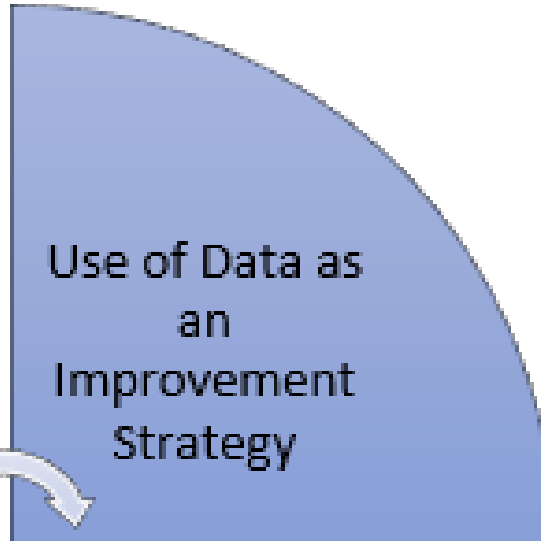
Top Findings:

- 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



Stories from the Field: Data Insights

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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

Data Diagnostic Codes

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COVID-19 Codes

COVID-Category	Code	Description
History of COVID-19	J12.82	Pneumonia due to coronavirus disease 2019
History of COVID-19	U07.1	COVID-19
History of COVID-19	U09.9	Post COVID-19 condition, unspecified
History of COVID-19	Z86.16	Personal history of COVID-19

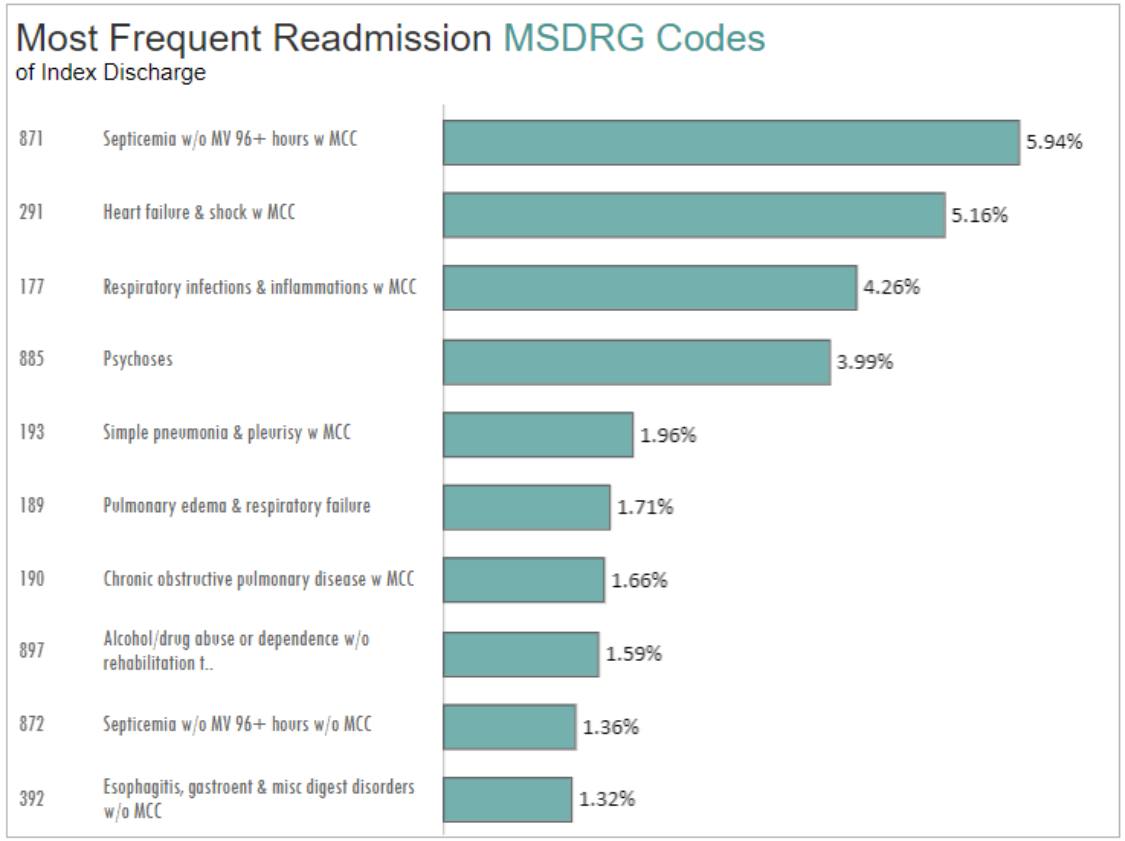
Datalink I-HOPE

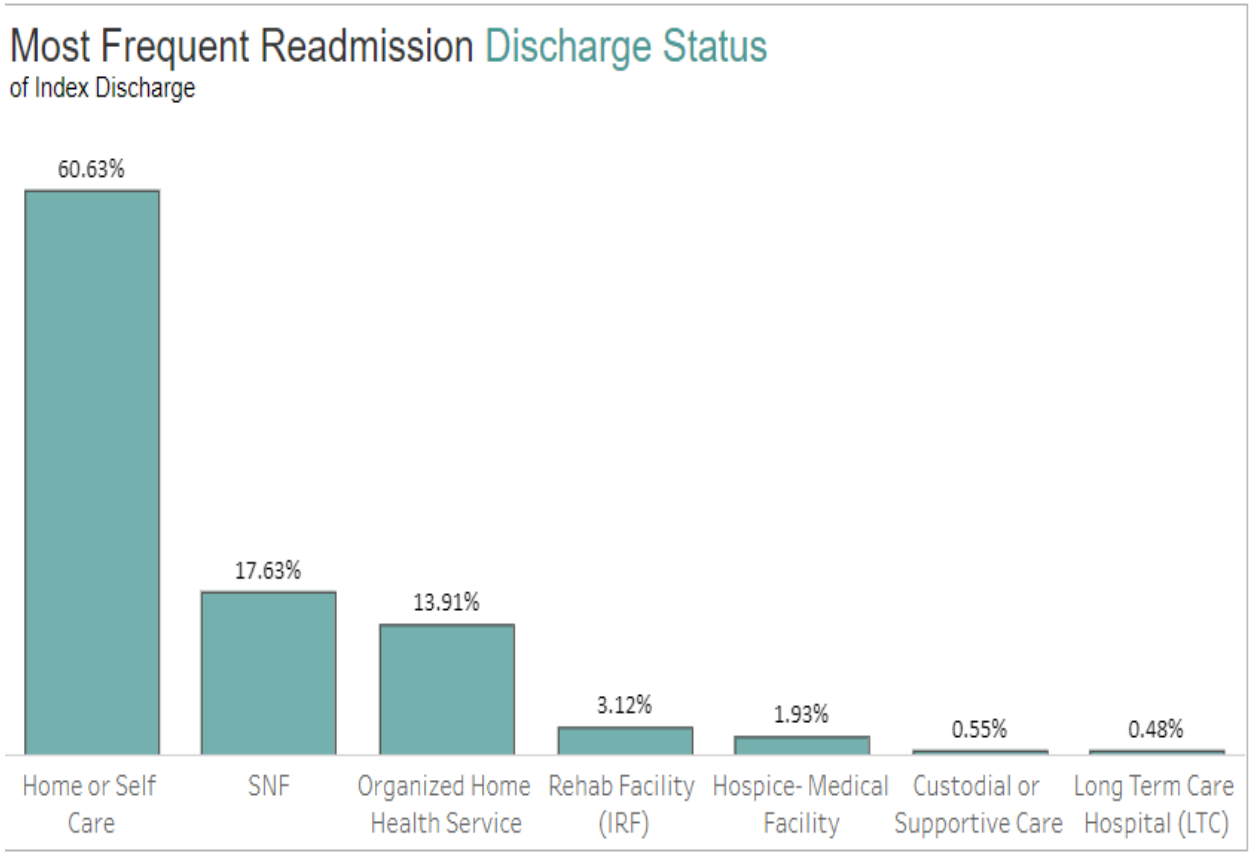
COPD Codes

Datalink I-HOPE

ICD-10-CM Code (index claim, principal diagnosis code)	Description	Principal Diagnosis Code - No Additional Coding Requirements
J41.0	Simple chronic bronchitis	Y
J41.1	Mucopurulent chronic bronchitis	Y
J41.8	Mixed simple and mucopurulent chronic bronchitis	Y
J42	Unspecified chronic bronchitis	Y
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]	Y
J43.1	Panlobular emphysema	Y
J43.2	Centrilobular emphysema	Y
J43.8	Other emphysema	Y
J43.9	Emphysema, unspecified	Y
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection	Y
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	Y
J44.9	Chronic obstructive pulmonary disease, unspecified	Y

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

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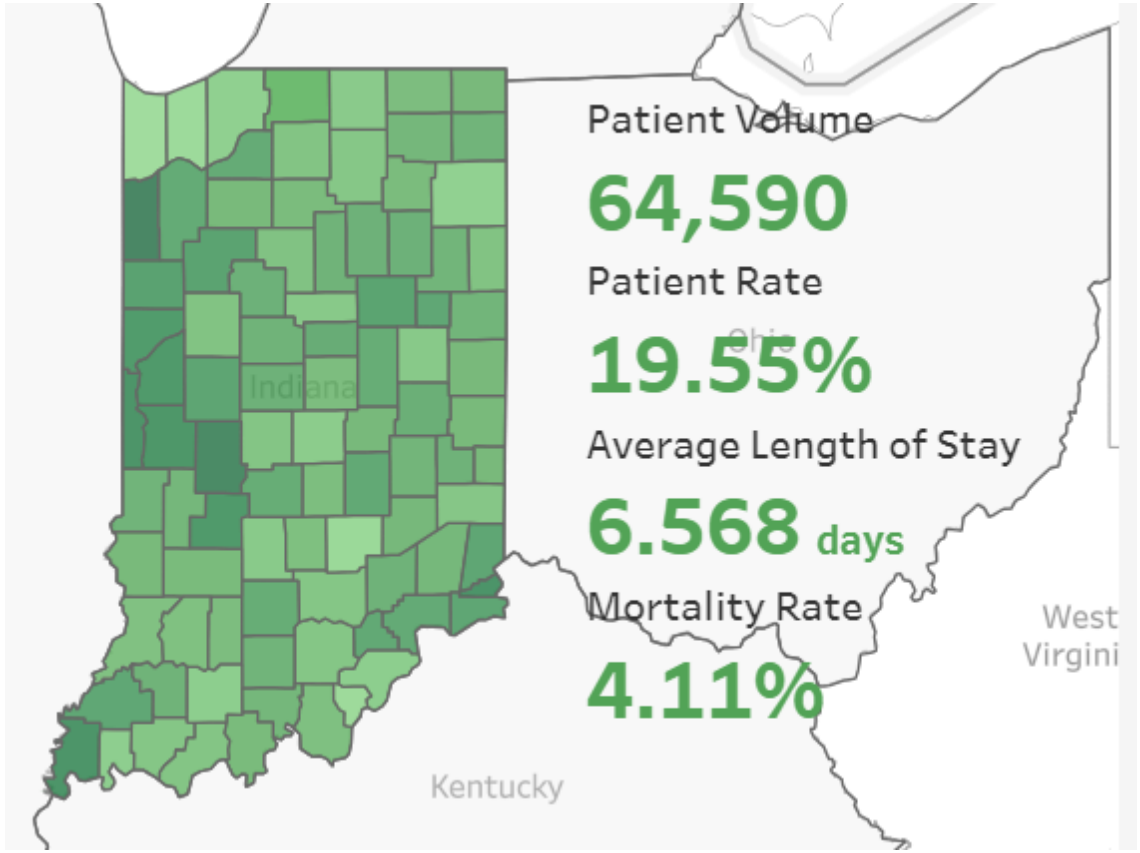
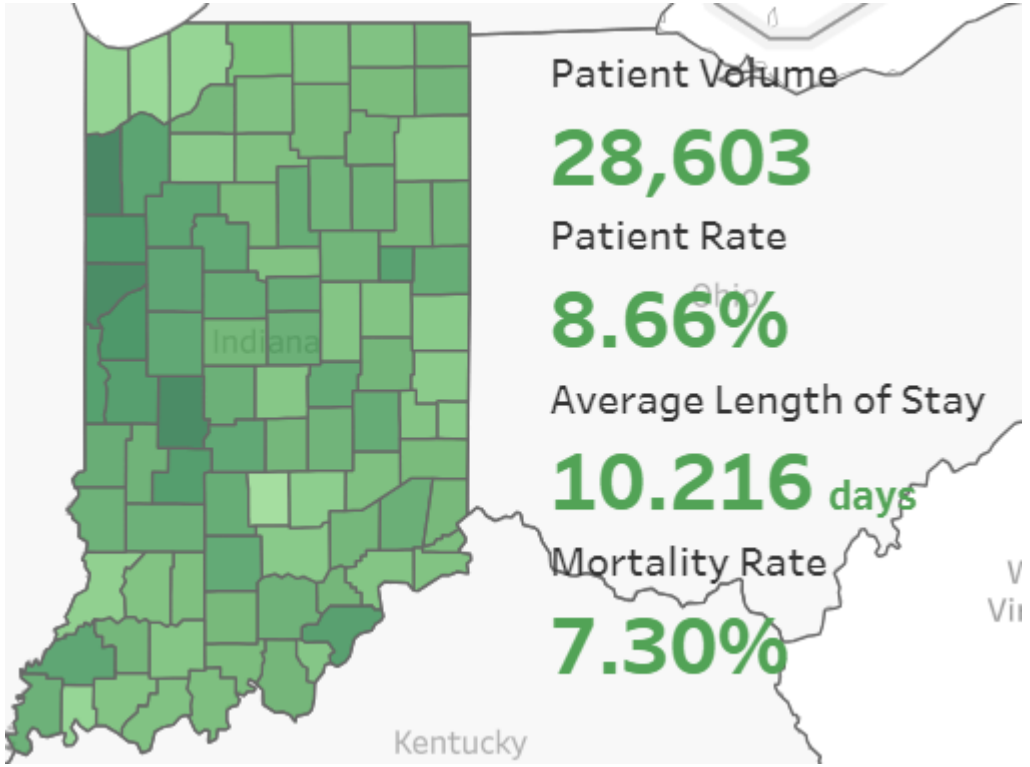
COPD Patients



COVID-19 Patients



Why were the COPD patients readmitted?

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Top 10 Readmission Record Primary Diagnosis Codes from **COPD Patients** Index Admissions

When patients were readmitted, what was their primary diagnosis?

		2022 Q1	2022 Q2	2022 Q3	2022 Q4
	Total Readmissions (including outside top 10)	794	700	793	763
A419	Sepsis, unspecified organism	51	65	56	67
U071	COVID-19	99	16	56	27
J441	Chronic obstructive pulmonary disease w (acute) exac..	50	38	45	55
I130	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr k..	54	36	43	33
J189	Pneumonia, unspecified organism	35	40	34	42
I110	Hypertensive heart disease with heart failure	16	41	33	29
J9621	Acute and chronic respiratory failure with hypoxia	19	24	27	24
N179	Acute kidney failure, unspecified	12	23	16	23
J9601	Acute respiratory failure with hypoxia	6	7	10	18
J690	Pneumonitis due to inhalation of food and vomit	7	11	13	10

Sepsis, COVID-19 and CHF most common with pneumonia

Why were the COVID-19 patients readmitted?

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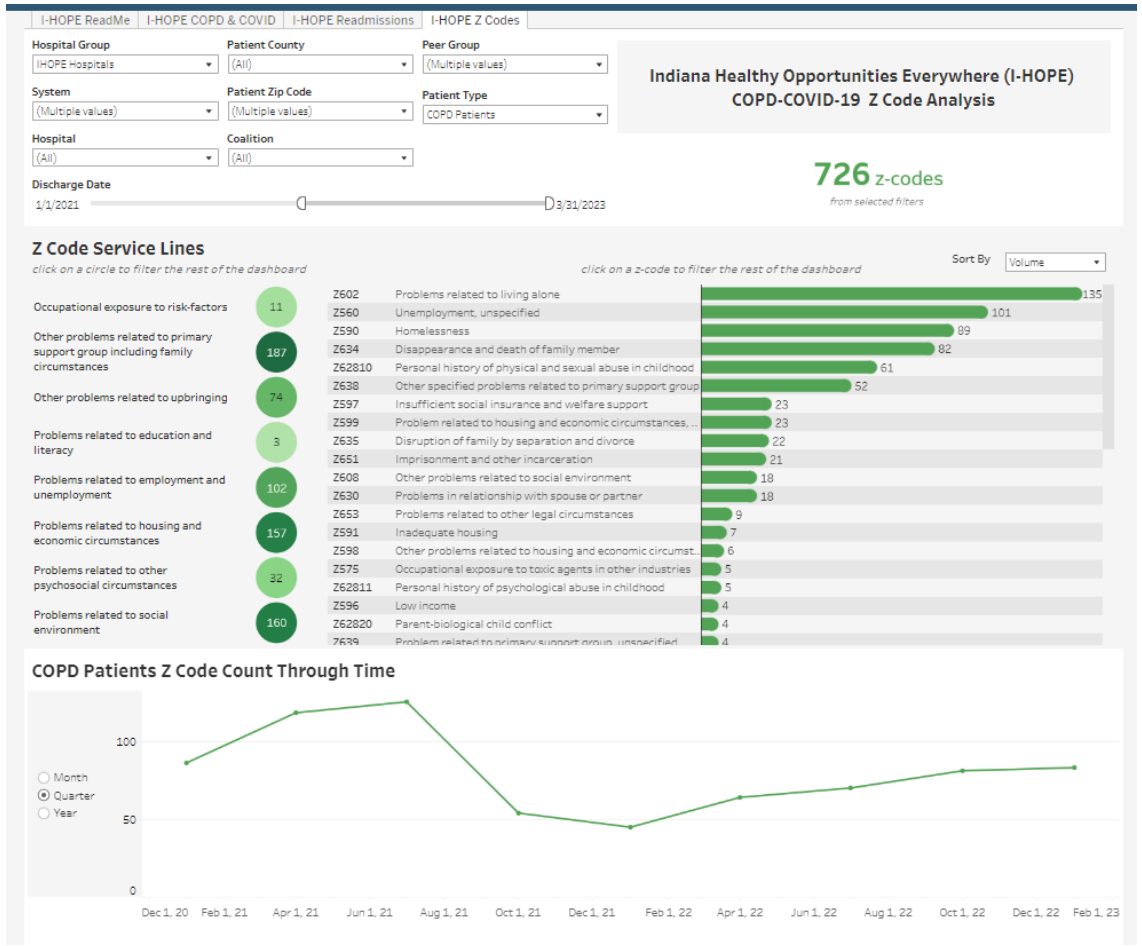
Top 10 Readmission Record Primary Diagnosis Codes from **COVID-19 Patients** Index Admissions

When patients were readmitted, what was their primary diagnosis?

		2022 Q1	2022 Q2	2022 Q3	2022 Q4
Total Readmissions (including outside top 10)		439	64	233	131
U071	COVID-19	277	42	142	79
A4189	Other specified sepsis	32	3	11	8
A419	Sepsis, unspecified organism	9	1	5	4
N179	Acute kidney failure, unspecified	6		3	2
J690	Pneumonitis due to inhalation of food and vomit	1	1	1	4
E871	Hypo-osmolality and hyponatremia	3		2	1
I480	Paroxysmal atrial fibrillation	3		2	1
K7290	Hepatic failure, unspecified without coma			6	
E1010	Type 1 diabetes mellitus with ketoacidosis without ..	4			1
I130	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp ch..	2			3

COVID-19 and Sepsis most common

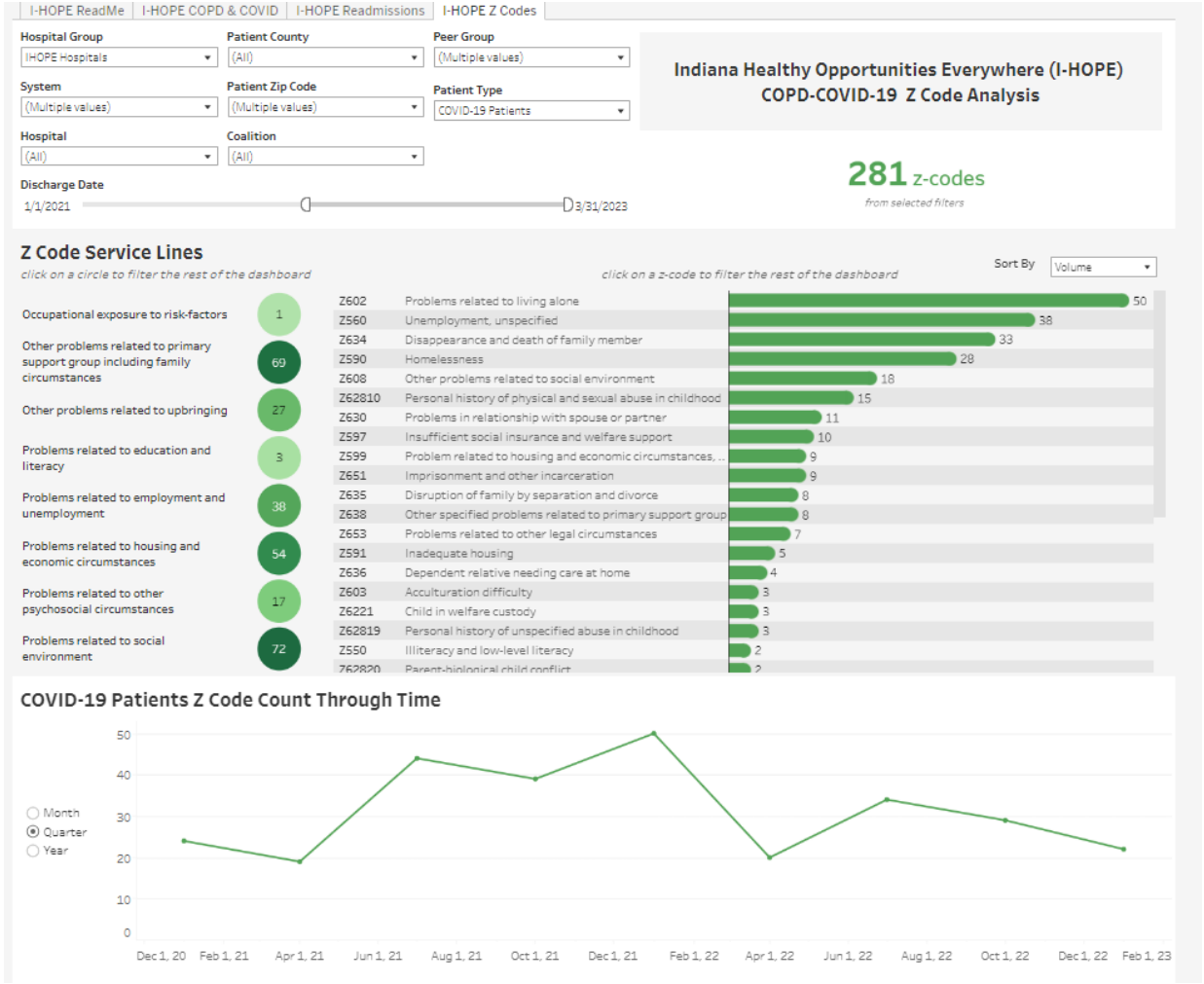
What SDOH's are associated with COPD patients?



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?



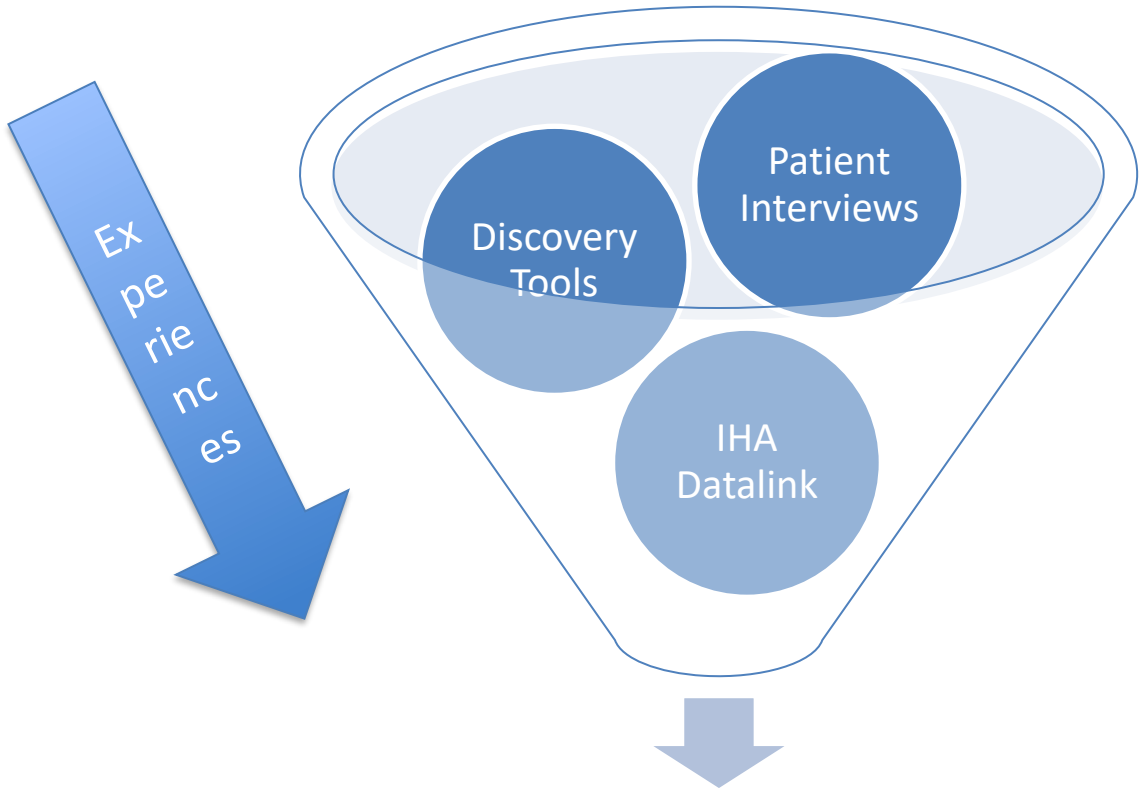
Top Z codes for COVID-19

- 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

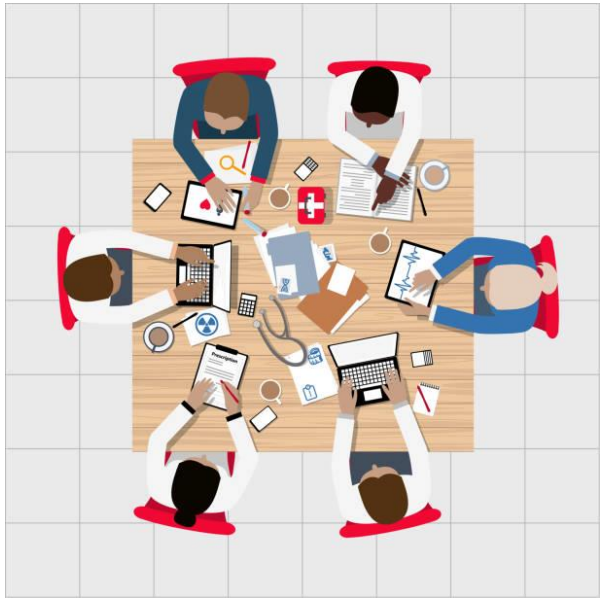


Improvement Strategy

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

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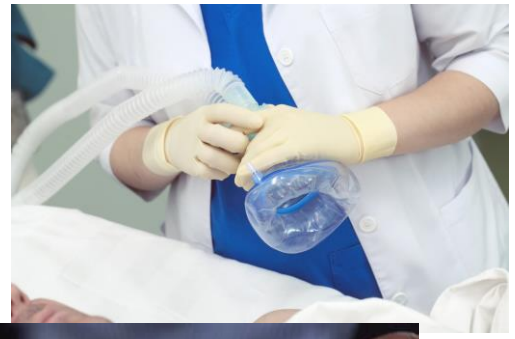
I-HOPE



- 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

COPD/COVID-19 Readmissions Reduction

Questions?

We’ve got answers!

See You Next Month!

Indiana Hospital Association

September 16, 2023

3:00 – 4:00 pm ET

Questions before we meet next month?

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