OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

2023 ORH

Hospital Quality Workshop

May 15-17, 2023

Seaside Civic and Convention Center | Seaside, OR

Strengthening the Relationship Between Hospital and Communities to Reduce Hospitalization Utilization

Seema Rathor, Senior Improvement Advisor, Comagine Health

Strengthening the relationship between hospital and communities to reduce hospitalization utilization

Wednesday, May 17, 2023

Seema Rathor – Senior Improvement Advisor, Comagine Health

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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 efficiency, economy and quality of services.
- Focus on rural, critical access hospitals and hospitals serving vulnerable populations.

Focus Areas

- Patient Safety
  - Opioid stewardship
  - Adverse drug events (opioids, anti-coag, glycemic)
  - CLABSI
  - Cauti
  - D. diff/MRSA
  - Sepsis
  - Pressure injuries
  - Readmissions
- Other
  - COVID-19 and/or public health emergencies
  - Health disparities and health equity
  - Patient and family engagement (PFE)
  - Leadership engagement

HQIC Evaluation Metrics and Goals by 2024*

Behavioral health decreased opioid misuse

- Decrease opioid-related ADEs by 7%, including deaths
- Decrease opioid prescribing (>90MME) by 12%

Patient safety reduction of harm

- Reduce ADEs by 13%
- Reduce all-cause harm by 9%
- Reduce Clostridioides *difficile* rates

Care transitions focus on high utilizers

- Reduce readmissions by 5%

*For the nine hospital quality improvement contractors (HQICs)

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Technical Assistance

Educational Events	1:1 Coaching	Cohorts	Communications
• Learning and action networks (LANs) • QI Boot Camp • Community of Practice calls hosted by CMS • On-demand webinar recordings	• Quality advisors • Subject mater experts • Office hours – IP chats (quarterly) • Coaching packages • Data analysis (portal)	• Patient safety topic areas • Coaching calls with action periods • QI tools such as fishbone diagram and PDSA worksheet	• Monthly newsletter • HQIC website • Resources, articles and success stories

Comagine Hospital Utilization Project Goals

- Decrease emergency department (ED) visits
- Decrease hospital utilization
- Decrease readmissions within 30 days of discharge
- Have a ready Public Health Emergency Preparedness Plan

Definition of Readmission

The most commonly asked questions:

- Planned readmission
- If the patient is readmitting multiple times in the same 30-day period
- If the patient is readmitted to another hospital within 30 days

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 collaboration within the community (Opportunity: HCAHPS survey)

Four drivers to address avoidable admissions

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

Use of data for informed decision

- 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
  - Is there any trend, specific reason within the diagnosis etc.
- **Micro data** from interviews and post-discharge calls

Use of data for informed decisions (continued)

- Learning from individual patients
  - Reasons for admits, food insecurity, housing, transportation, information not present in the chart
- Who can interview:
  - The case manager, social workers, nursing leadership, or quality leadership staff (participate)
- Understanding the reason for your hospital is important
- Start small: Don’t become bogged down with creating policies, first see if an idea is working

Use of data for informed decisions (continued)

- Coaching package (interview skills):
  - Nonjudgmental, curios, 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

Continuous improvement in transition of care

- Do not use the same plan: Keep evaluating
- Infection control
- Customize discharge planning (YouTube)
- 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 a follow-up plan with the patient

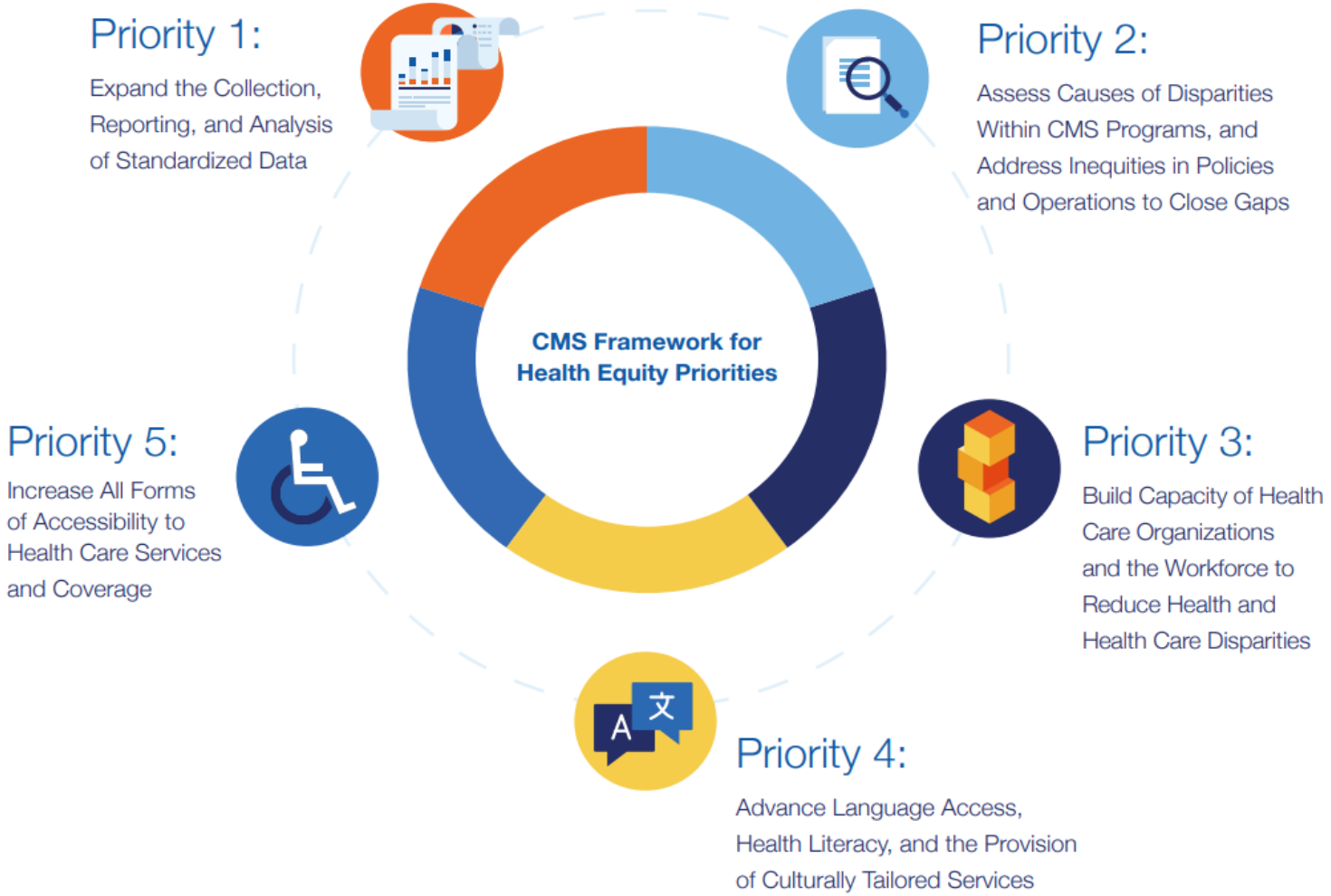
Advanced services for high utilizers

- 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, cardi 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 really non-compliant, frequent flyers?
- Small team approach – knowing them well, relating, peer-to-peer help

Peer-to-Peer support group

- Peer support workers are people who have been successful during their own recovery process and help others experiencing a similar situation
- Through shared understanding, respect and mutual empowerment, peer support workers:
  - Help people become and stay engaged in the recovery process
  - Reduce the likelihood of relapse
  - Peer support services can extend the reach of treatment beyond the clinical setting
- Myth-meet for coffee, help with groceries, hang out, etc.
- Comagine is hosting ECHO (how to use peer-to-peer support group)

CMS Framework for Health Equity 2022-23



CMS Framework for Health Equity 2022-23

- Screening for social drivers of health
  - Race, ethnicity, language, age, income etc.
- Screen positive rate for social drivers of health
  - Food insecurity, access to transportation

Collecting Health Equity Data

- Are you currently collecting data?
  - At the time of registration or during interview
- If not, why?
- How are you using this data?
- Have you had success using this data and providing care?

Collecting Health Equity Data

- What data can you use to identify health disparities and/or your priority population(s)?
- What population(s) will you prioritize?
- What health disparities do you want to address?

Resources

Race, Ethnicity, and Language (REaL) Sexual Orientation and Gender Identity (SOGI) Data Collection Conversation

PURPOSE:

Collecting verbal self-reported REaL SOGI data from patients ensures your hospital has accurate information that can be used to improve care for all patients.

REMINDERS:

1. Everyone comes to interactions with a set of ideas based on their own experiences over time, this is called implicit bias. Understanding your own bias helps you to connect more authentically with the person in front of you. Consider identifying any implicit bias that you may have by taking the Harvard Implicit Association Tests.
2. It is recommended that you ask the SOGI questions first. This will ensure you are referring to the person by the correct pronoun.
3. It is recommended that you ask for ethnicity before race.
4. Language changes constantly. Consider reviewing and revising your script annually.

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Source:

What Comagine Health is Doing Outside Hospitals

- Promoting CHW and EMS services
- Promoting patient-facing education material at senior centers and barber shops
- Listening sessions with Medicare beneficiaries
- Learning sessions
- Collaborative meetings

What we have learned so far

- Patient financial burden
- Telehealth is widely used but broadband is limited
  - Telehealth and public libraries
- Limited community resources
- Need to improve electronic communication and data with hospital and physician offices, skilled nursing facilities, and rehab
- Timely insurance authorization for home health agencies
- Education regarding usage of ER/urgent care
- CHW cost-effective way to address readmissions
- Health literacy
- Provider availability
- Lack of consistency due to urgent care usage
- Lack of BH provider, lack of resources

Your Observations

What factors have you identified in your communities that contribute to 30-day hospital readmission?

Community Collaborative

- How would you use a collaborative to reduce readmissions, hospital utilization and emergency department visits in your community?

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

Toolkits and Other 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
- ASPIRE Tool 9: Whole-Person Transitional Care Planning Tool
- Review chronic conditions, high risk medications, health literacy, social support and resources: Perfect 10 Flyer

Thank you!

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Thank you!

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