St. Tammany Quality Network

QUARTER 4 STQN NEWSLETTER

Reducing 30-day Readmissions

The Challenge:

- Reduce overall readmissions below the national average for our patients
- Target specific diagnosis to reduce readmissions:
  - CHF: follow up within 7 days of discharge, Use CHF home program, palliative care for patients with end-stage CHF
  - COPD: follow up within 7 days of discharge, palliative care for appropriate patients, advanced care planning for all patients
  - AMI: timely cardiology follow up post discharge, cardiac rehab
  - Elective hips and knees: outpatient physical therapy, home care follow-up for appropriate patients
  - CABG: transitional care visit and patient navigation
  - Simple pneumonia: timely outpatient follow-up, when appropriate transitional care visit, document if “other” type of pneumonia (we have a high rate of simple pneumonia)

Dates to Remember

STQN Performance Management Committee
Jan. 10 | 7:00 a.m.

CME – Precision Medicine with Dr. Marc Matrana
Jan. 18 | 5:30 p.m.

STQN Board Meeting
Feb. 7 | 5:30 p.m.

Fall Medical Staff Meeting
Nov. 3 | 5:30 p.m.

CME – Physician Wellness with Dr. Fred Schouest
Feb. 16 | 5:30 p.m.

STQN Finance and Operations Committee
Mar. 14 | 5:30 p.m.

CME- Multidisciplinary Care of the Breast Cancer Patient
Mar. 29 | 5:30 p.m.

Readmission Effects:

- Patient satisfaction
- Hospital throughput
- CMS Value Based Purchasing: Hospital star ranking, Medicare Spend per Beneficiary (MSBP), Hospital Readmission Reduction Program (HRRP)
- Bundle Payment Programs
- Shared savings in Medicare Advantage, Medicare ACO and Commercial Plans

What Has STHS Done to Reduce Readmissions:

- Outpatient navigation: Continue to follow patients for up to 90 days
- Transitional Care visits in the home for high and moderate risk patients
- Clinical follow up within 7 days of discharge
- Advanced care planning for all hospital medicine patients
- Developed a robust Palliative Care and Hospice program
- Standardized the hospital discharge with focus on accuracy of discharge medications
- Hospital Medicine Structured Interdisciplinary Bedside Rounding (SIBR) at STHS

Other Drivers in Readmissions:

- Social Determinants of Health: (some examples)
  - Adequate healthy food sources
  - Stable housing situation
  - Transportation needs
  - Addiction issues
  - Social isolation
- Mental Health
  - Depression
  - Anxiety
  - Mental health disorders

What Can You Do?

- Discuss advanced care planning with all adult patients
- Follow up all discharged patients timely (within 7-14 days of discharge)
- Screen patients for Social Determinants of Health
- Depression screening on all patients
- Make sure all patients have a primary care physician
- Reach out to STQN for questions or concerns

2022 3rd Quarter Medical Director's Award

MEDICAL DIRECTOR'S QUALITY AWARD

IS AWARDED TO

Dr. Chris Foret

"for his leadership in advancing population health efforts in the tri-parish area encompassing St. Tammany, Washington and Tangipahoa parishes."