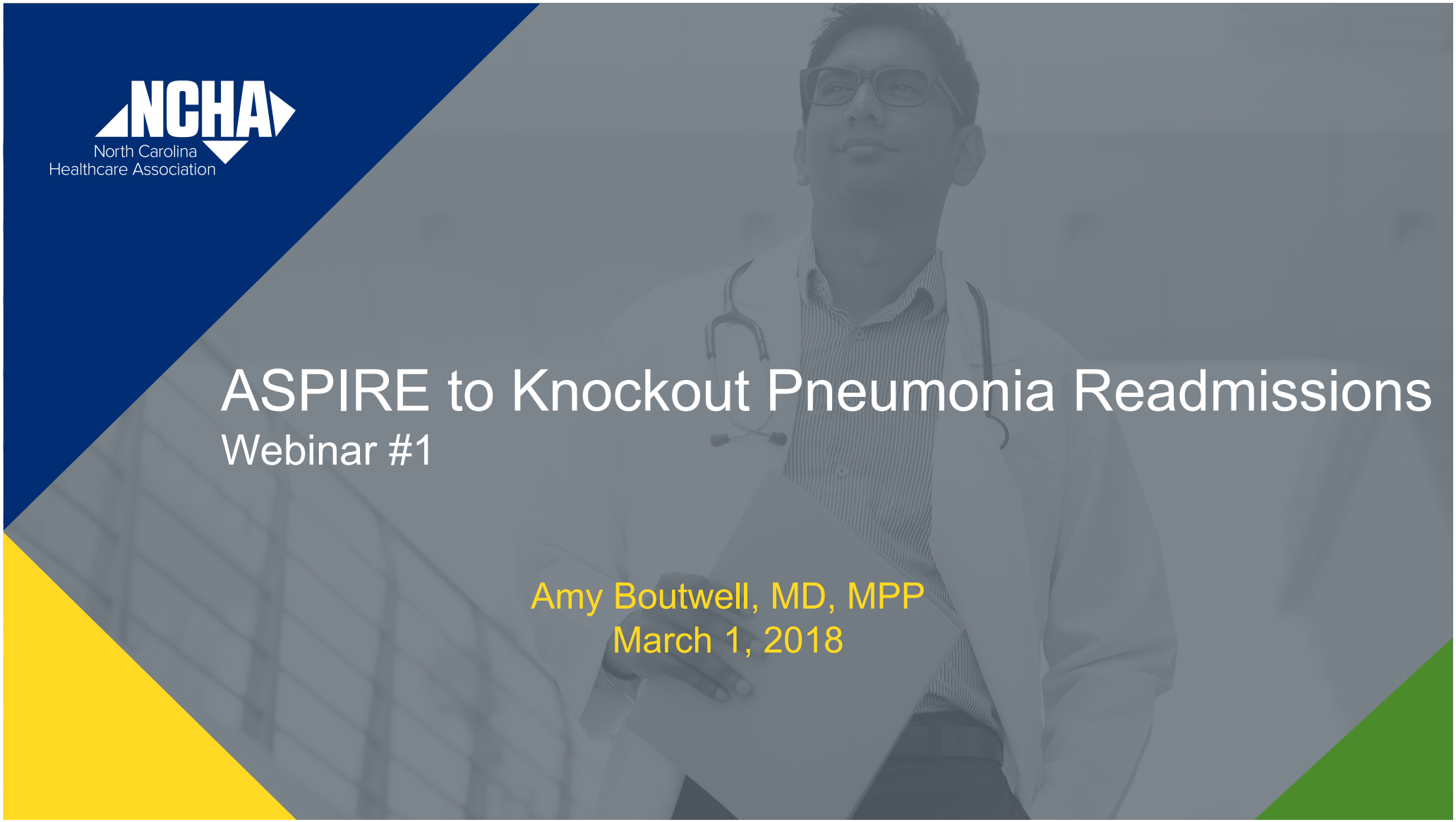


NCHA
North Carolina Healthcare Association

ASPIRE to Knockout Pneumonia Readmissions

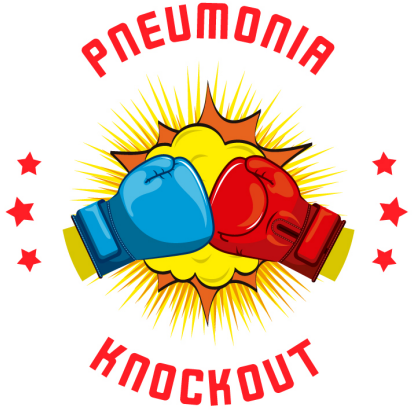
Webinar #1

Amy Boutwell, MD, MPP

March 1, 2018


PNEUMONIA
KNOCKOUT

NCHA Pneumonia Knockout Team



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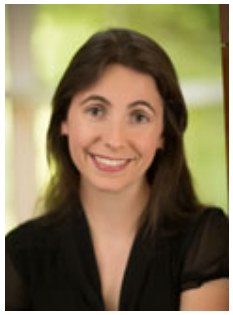

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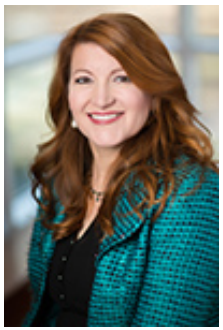

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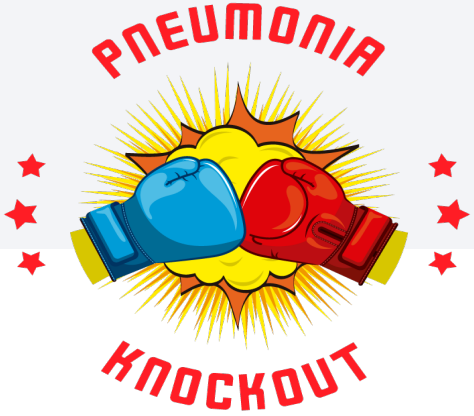


ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

Amy E. Boutwell, MD, MPP

NCHA Knockout Pneumonia Campaign - Webinar 1

March 1 2018

Knockout Pneumonia Readmissions Series

Monthly Webinars; all are 2-3 pm
March 1
April 5
May 3
June 7
August 2
September 6
October 15-16 in-person learning session
November 1
December 6

Purpose of the Knockout Pneumonia Readmissions Series

This series is to support your work to reduce pneumonia readmissions

- We will focus on connecting concepts to ***action***
- We will focus on high-leverage ***strategies*** to reduce readmissions
- We will focus on ***implementation*** coaching

The best use of your time is to use these hours to actively advance your pneumonia readmission work

- ***Come with*** questions, challenges, cases, data, ideas for improvement
- ***Invite*** your cross-continuum partners to attend
- ***Email us*** with questions or issues to discuss on the next webinar

Objectives for this Session

- ***Know*** your data
- ***Understand*** root causes of pneumonia readmissions

What is your hospital's current all cause readmission rate?*

What is your hospital's current pneumonia readmission rate?

** All cause = adult, non-OB*

Do you know the root causes of pneumonia readmissions?

How do you identify root causes?

What is your hospital's readmission reduction goal?

What is your hospital's pneumonia readmission reduction goal?

What strategies are you testing to reduce PNA readmissions?

Are they targeted strategies? Do they address root causes?

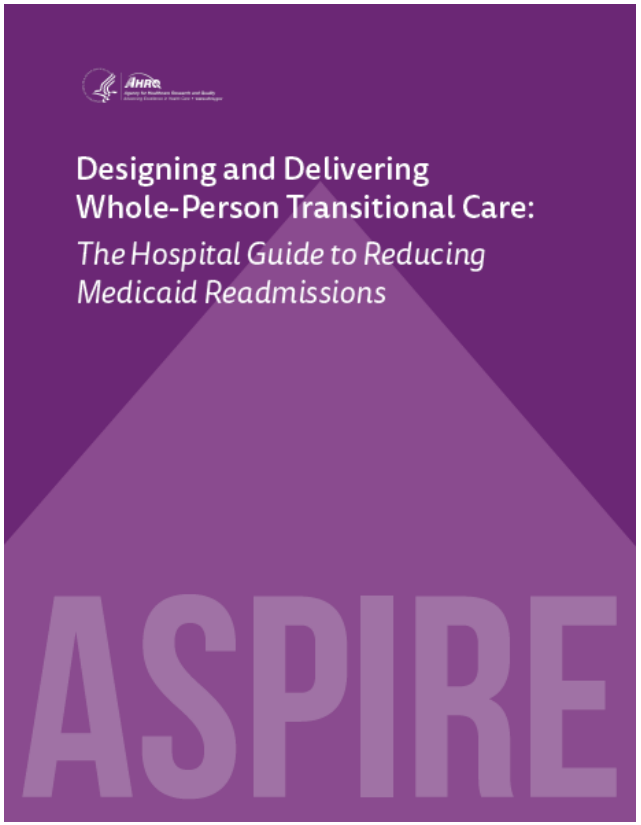
How many pneumonia discharges did you have last month?

How many pneumonia readmissions did you have last month?

How many (what %) pneumonia discharges did you "serve"?*

**"serve" = serve differently because they are high risk of readmission*

Designing and Delivering Whole-Person Transitional Care: *The ASPIRE Guide*

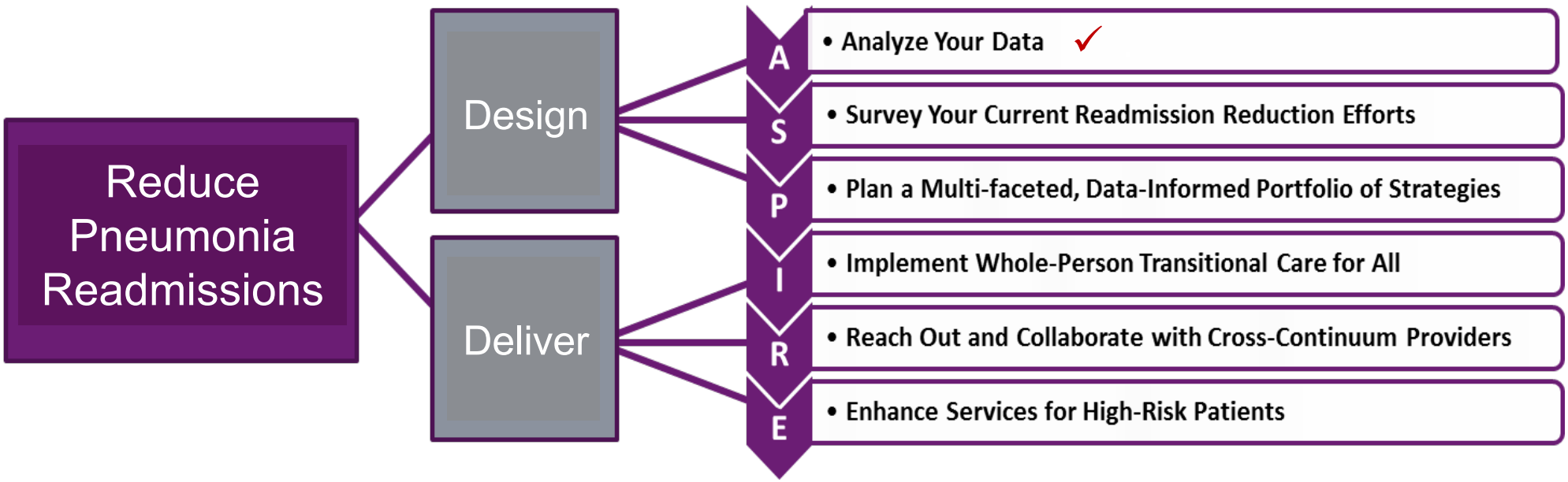


13 customizable tools

6-part webinar series

https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

ASPIRE Framework



Hospitals with Hospital-Wide Results

- Know their data –
  - *Analyze, trend, track, display, share, post*
- Broad concept of "readmission risk"
  - *Way beyond case finding for diagnoses*
- Multifaceted strategy
  - *Improve standard care, collaborate across settings, enhanced care*
- Use technology to make this better, quicker, automated
  - *Automated notifications, implementation tracking, dashboards*

KNOW YOUR DATA

North Carolina analyses; know for your own hospital

Discharges, Pneumonia Discharges, and Readmissions

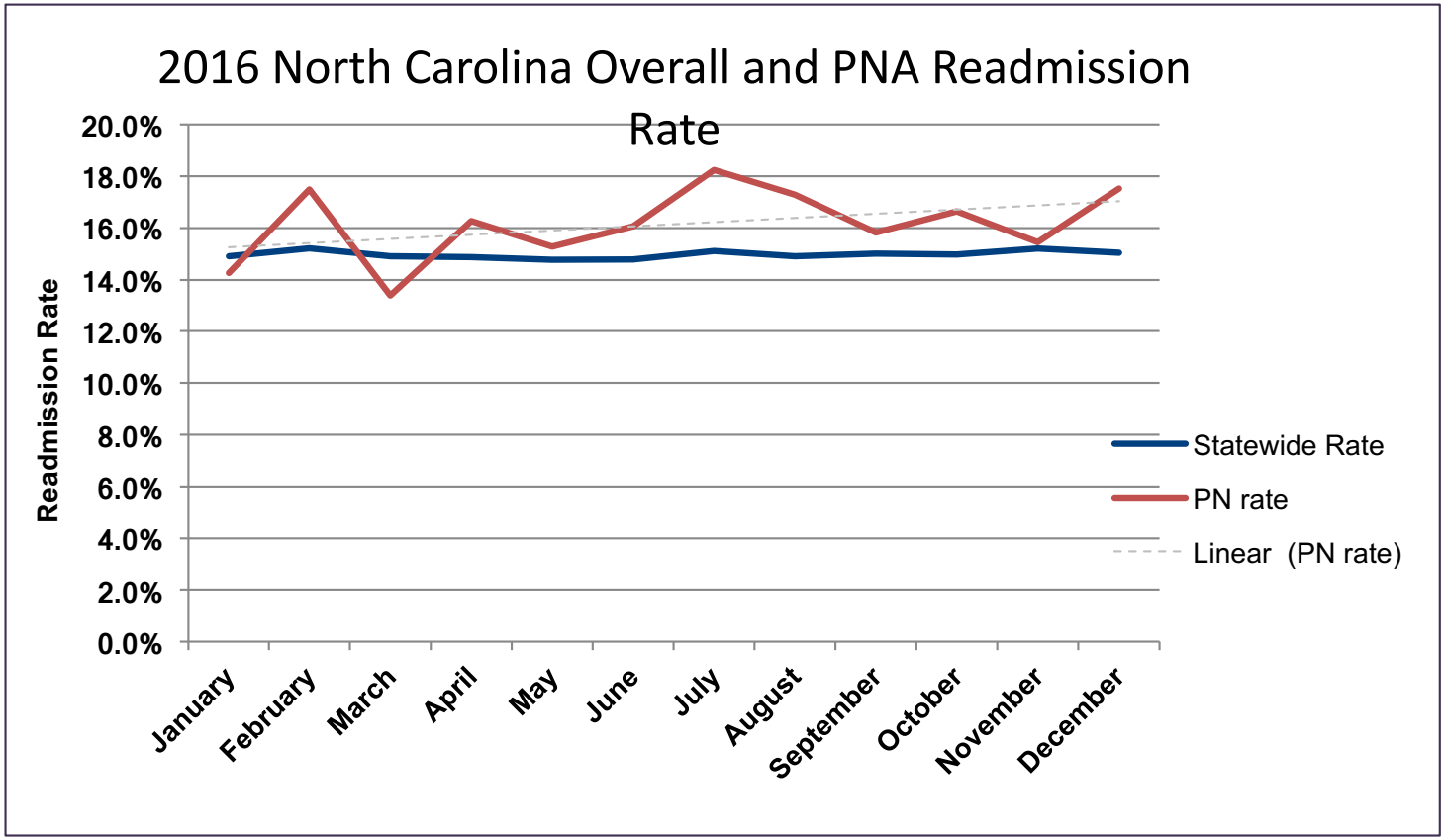
	All	Pneumonia	
Adult* discharges	723,698	18,281	2.5% discharges
Readmissions	108,345	2,920	2.7% readmissions
Readmission rate	15%	**16%**	

Stats to know:

- ~18k pneumonia discharges/ year
- ~3k pneumonia readmissions/ year
- ~2-3% of all discharges

** adult, non-OB, North Carolina 2016*

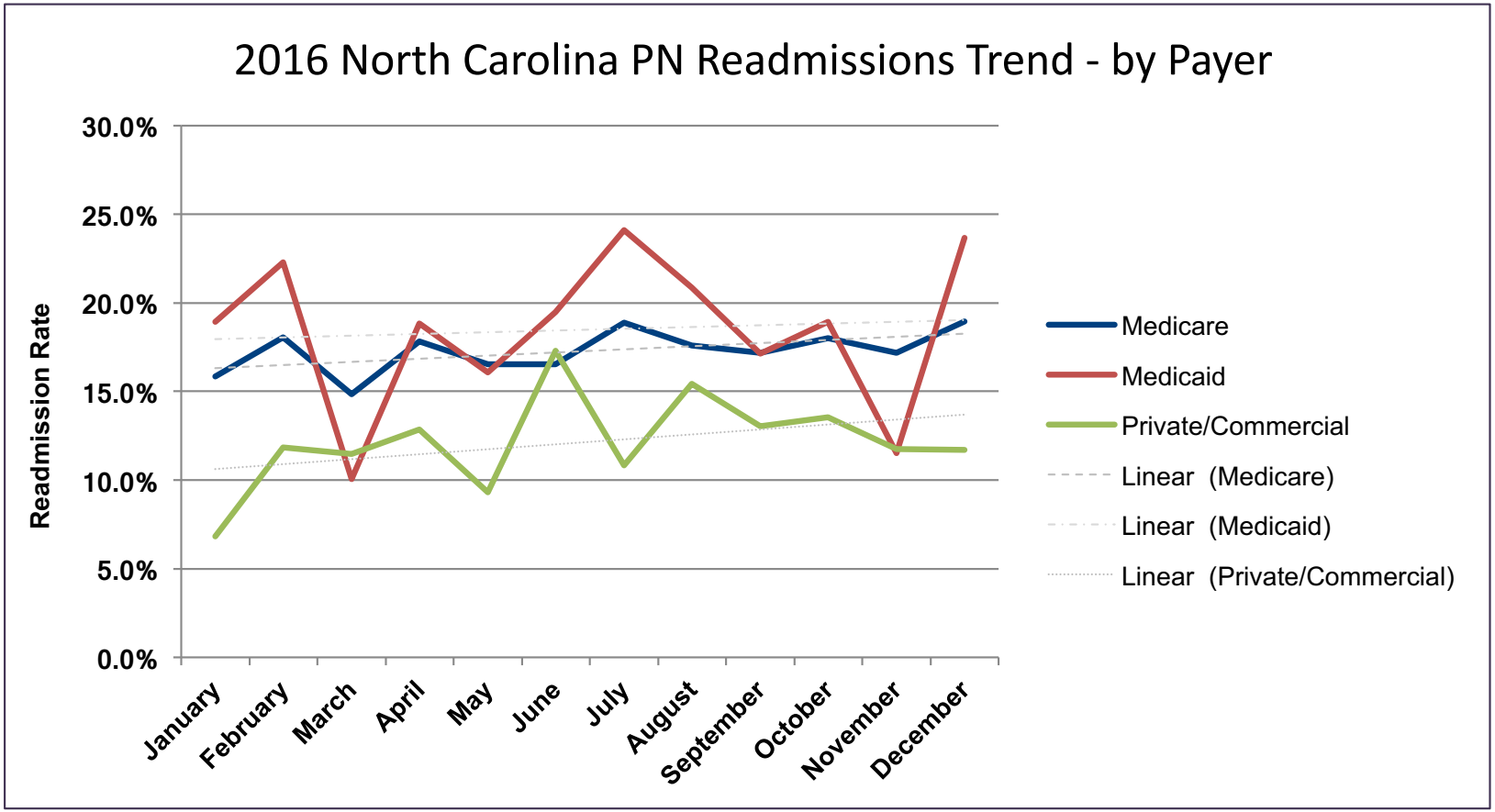
North Carolina All Payer Pneumonia Readmission Rates



All-cause rate: 15%
Pneumonia rate: 16%

North Carolina PNA readmissions trended upward by 13% over 2016

Pneumonia Readmissions, by Payer



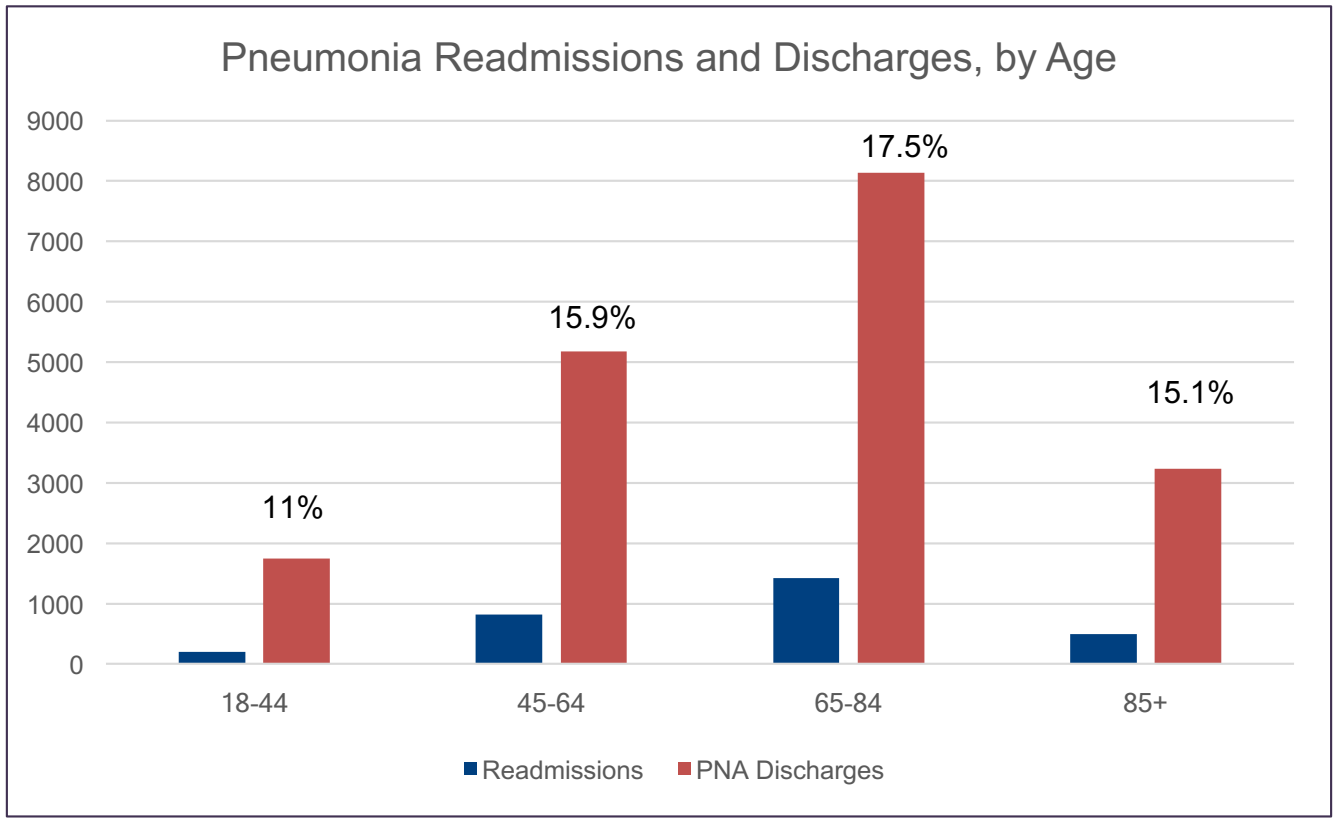
All payers see upward trend in PNA readmission rates

10 Discharge Diagnoses* Leading to the Most Readmissions

Medicare	Medicaid	Private	All
Sepsis (n=4,501)	Sepsis (n=768)	Chemo	Sepsis (n=6,413)
COPD (n=2,188)	Sickle Cell (n=557)	Sepsis	COPD (n=2,997)
Acute Kidney Failure	COPD (n=457)	Acute Kidney Failure	Acute Kidney Failure
Pneumonia (1,748)	DKA (n=381)	**Pneumonia (278)**	**Pneumonia (n=2,374)**
Heart Failure (dias.)	Chemo	NSTEMI	Chemo
Heart Failure (systolic)	Acute Kidney Failure	Major Depression	Heart Failure (dias.)
NSTEMI	**Pneumonia (n=234)**	COPD	Heart Failure (systolic)
UTI	Heart Failure	Bipolar	NSTEMI
Heart Failure (both)	Schizoaffective	Morbid Obesity	UTI
HF + CKD	Major Depression	Heart Failure	Sickle Cell

** adult, non-OB, North Carolina 2016*

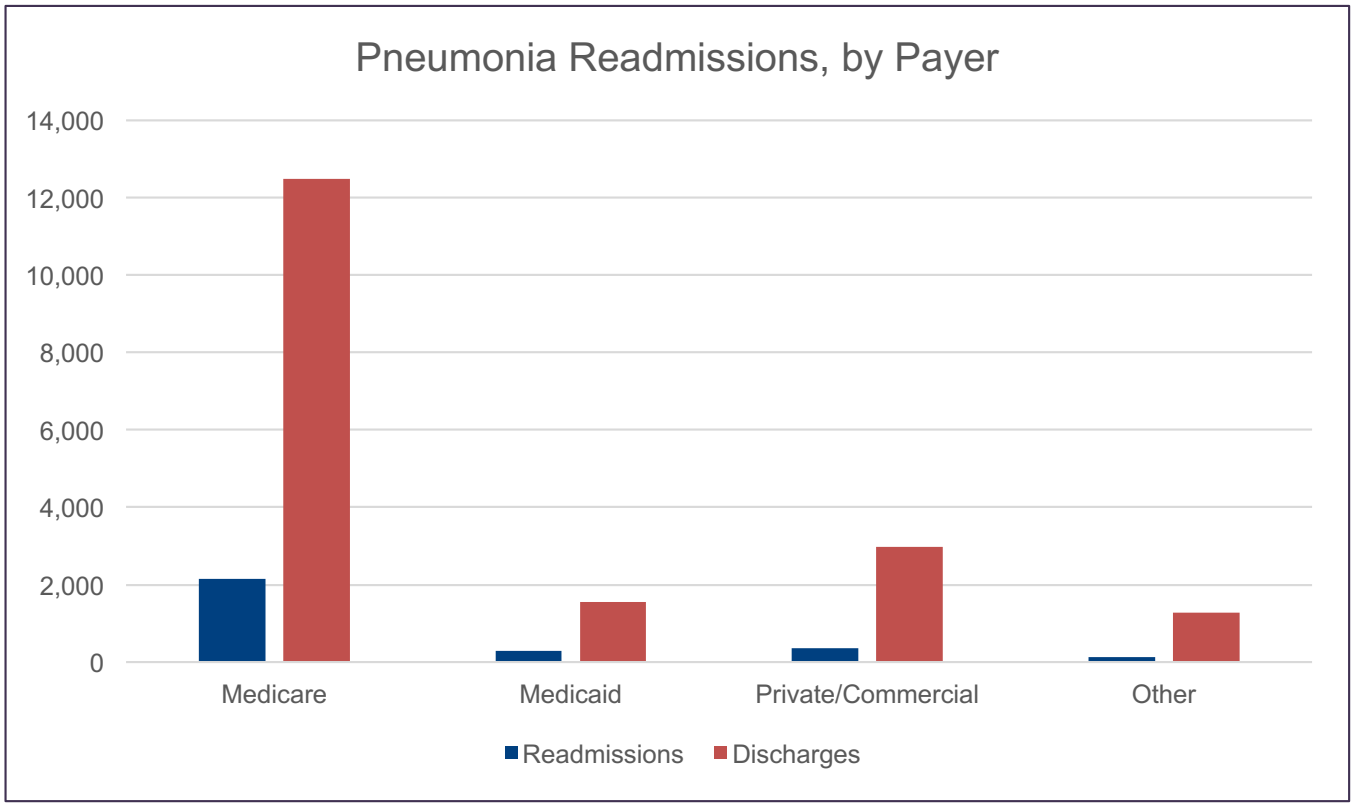
Pneumonia Readmissions, by Age



Statewide RA rate:	16%
Rate 65-84:	17.5%
Rate 45-64:	15.9%

77% PNA readmissions age 45-84

Pneumonia Readmissions, by Payer



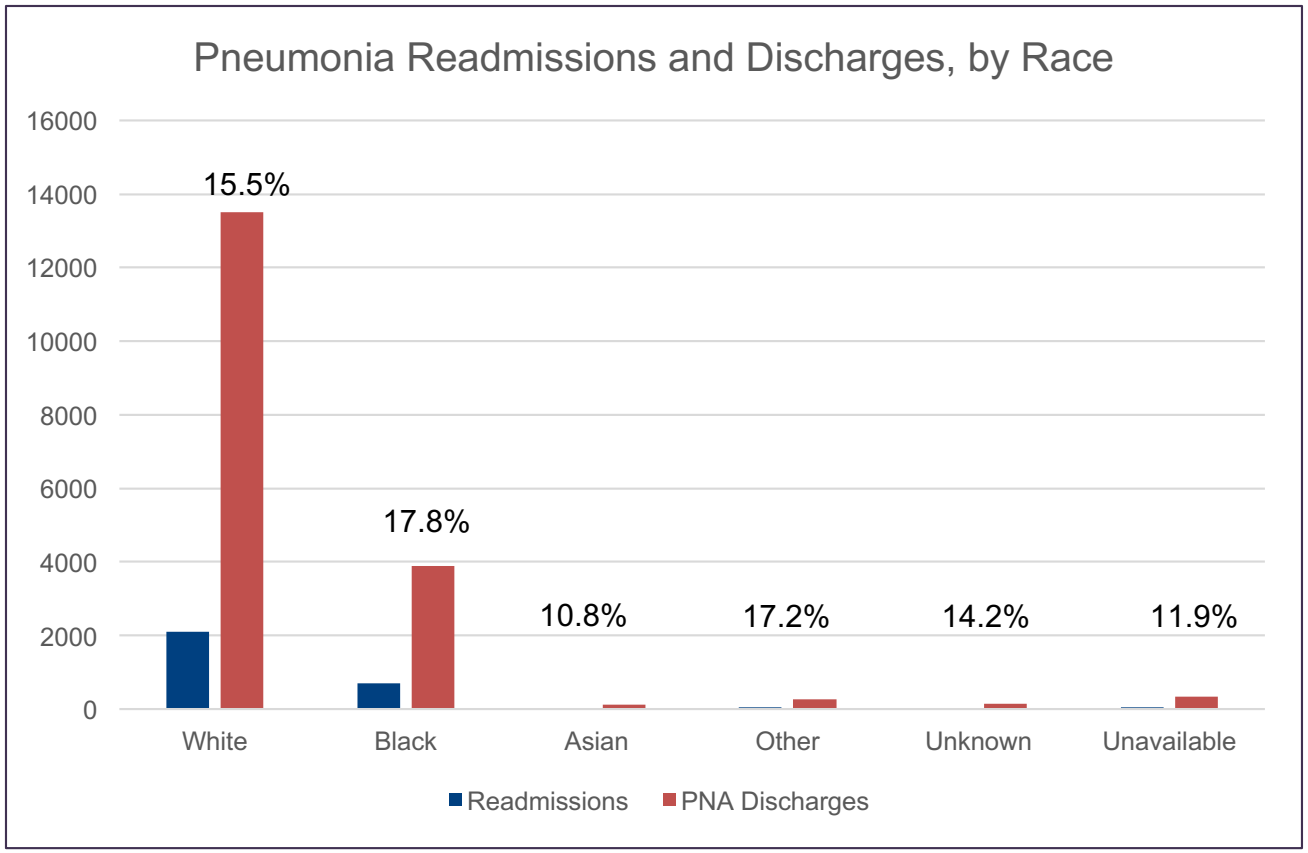
Statewide RA rate: 16%

Medicare: 17.2%

Medicaid: 18.3%

77% PNA readmissions age 45-84

Pneumonia Readmissions, by Race



Statewide RA rate: 16%

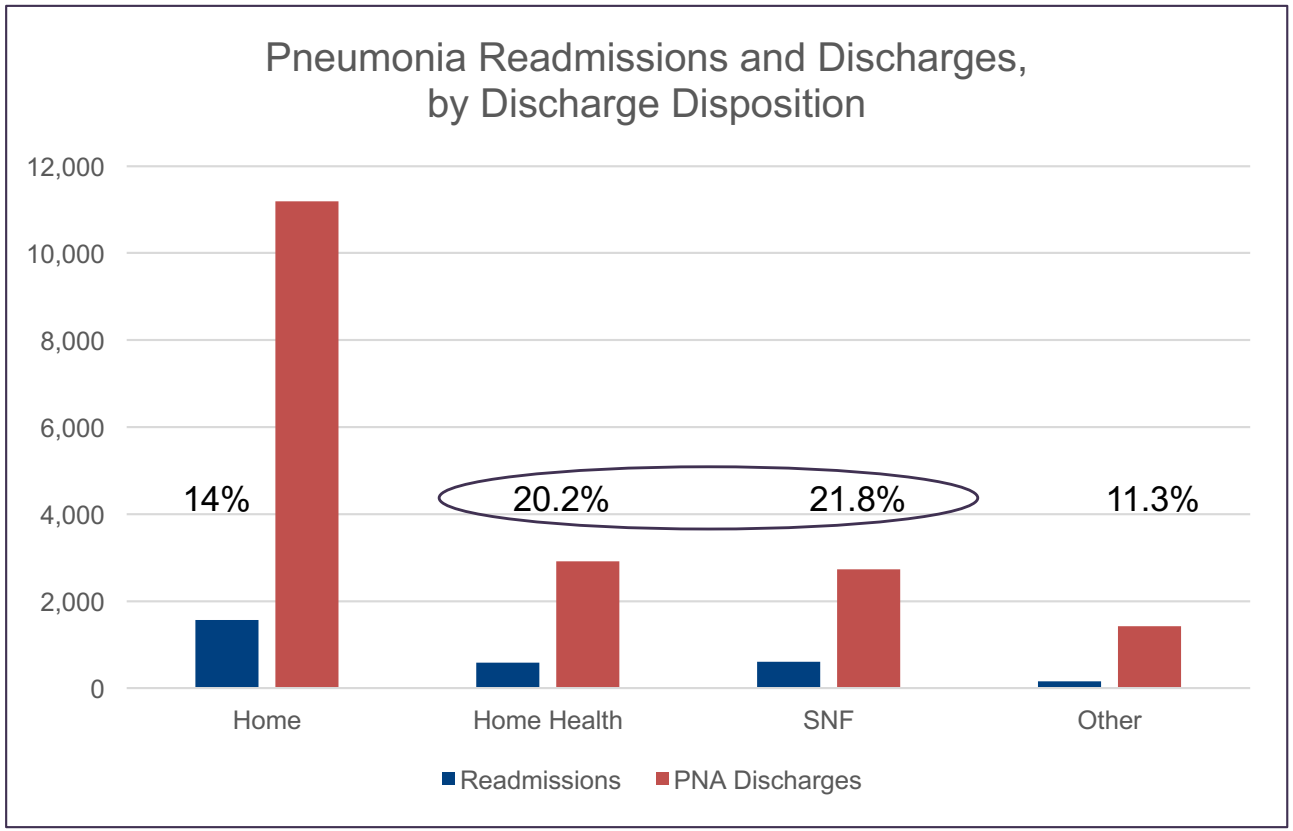
Rate by race, white: 15.5%

Rate by race, black: 17.8%

21% PNA discharges black race

23% PNA readmissions black race

Pneumonia Readmissions, by Discharge Disposition



Statewide RA rate:	16%
Discharged SNF:	21.8%
Discharged HH:	20.2%

61% PNA discharges to home

53% PNA readmissions to home

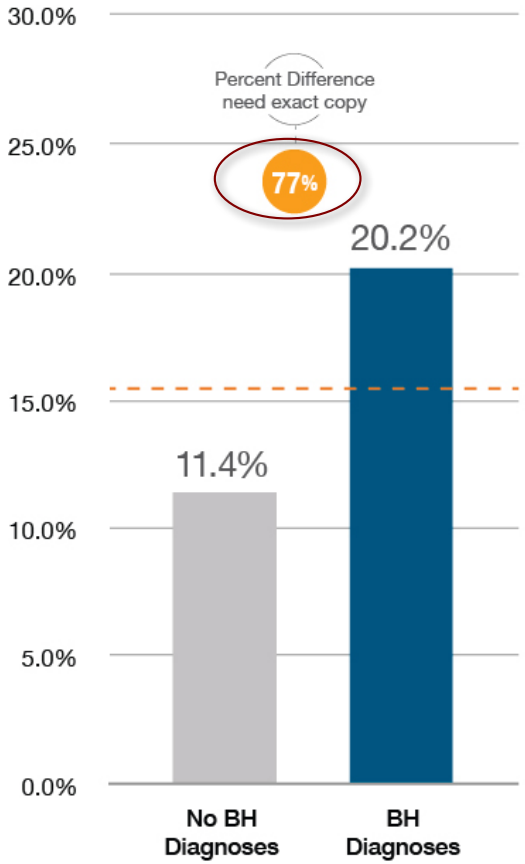
16% PNA discharges to HH

20% PNA readmissions to HH

15% of PNA discharges to SNF

20% of PNA readmissions to SNF

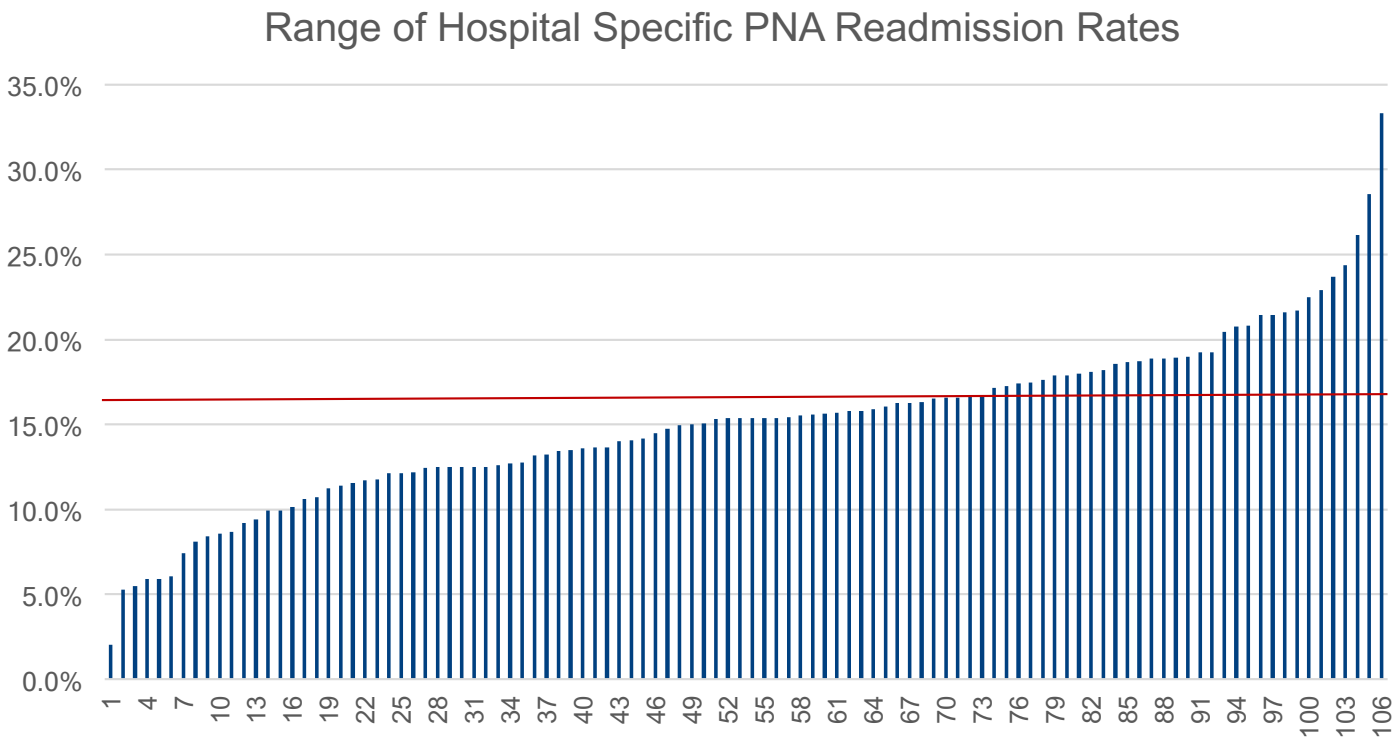
Readmission Rates, if Behavioral Health Comorbidity



- **40%** of adult hospitalized patients had at least 1 behavioral health condition
- Patients with a BH condition had **77%** higher readmission rates

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016

Hospital-Specific Pneumonia Readmission Rates

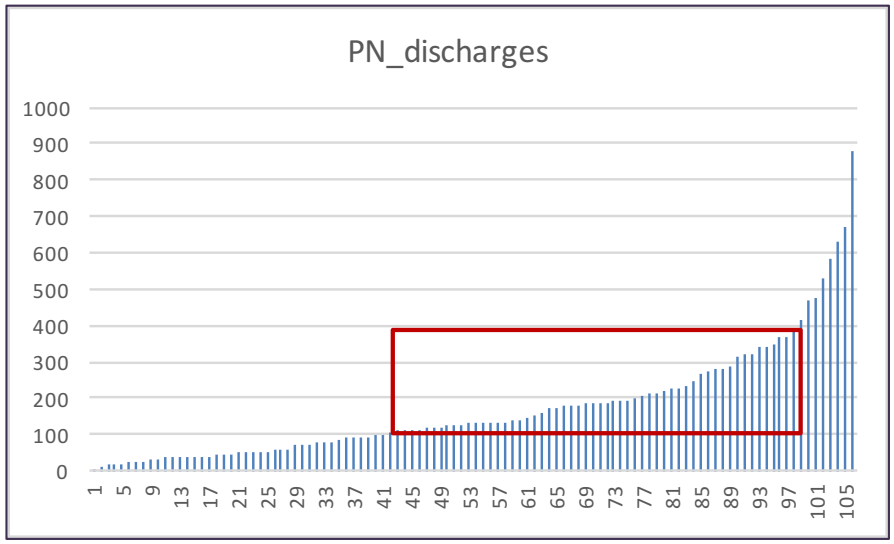


106 NC hospitals

Wide range 5% to 33%

State average: 16%

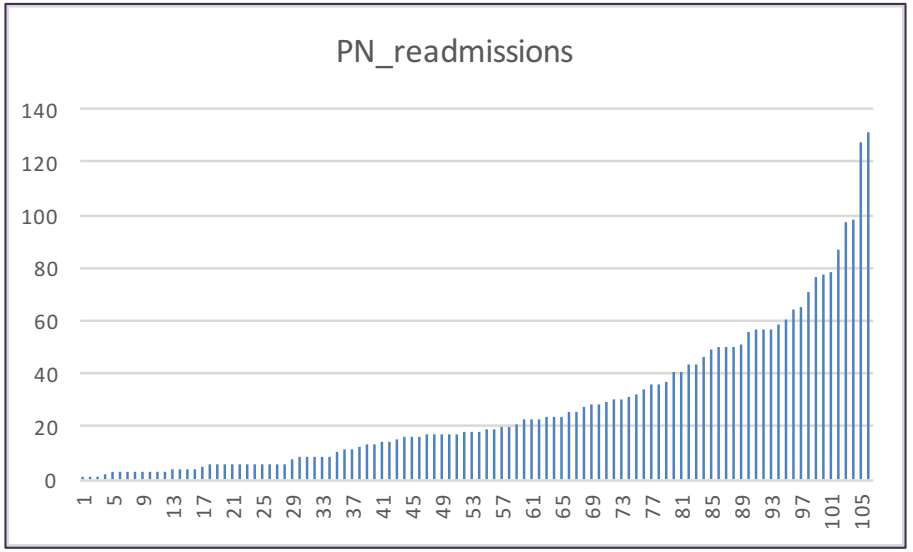
Number PNA Discharges and Readmissions per Hospital



106 hospitals
PNA discharges/year: 3 to 877
PNA readmissions/year: 1 to 131

Most hospitals have 100 to 400 PNA discharges

- Divide your # PNA discharges by 365
- Compute # PNA discharges / day
- 300 PNA discharges / year = <1 discharge/day
- We can serve 1 patient per day!



Insights From Data Analysis re: Pneumonia Readmissions

- Adult, Medicaid
- Age >45
- African American
- Discharged to post-acute care
- Any behavioral health comorbidity
- There are a manageable number of PNA discharges/ day to ***serve all***

Ask your patients “Why”

Elicit the story behind the chief complaint; identify root causes

Understand the "story behind the chief complaint"

- 77F discharged following sepsis returns to the hospital 8 days later with shortness of breath.
- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.
- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with cough.

Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families, care partners, providers

The Readmission Interview

77 year old woman with ESRD, HTN, HF, osteoporosis

Index admission was to have line place to initiate dialysis

- Developed bacteremia, sepsis
- ICU stay, on pressors, all home meds held
- Stabilized, transferred to floor, BP “stable off pressors”
- Patient eager to go after 2 days on floor- “lipstick sign”
- Married, highly educated, has PCP, cardiologist, nephrologist

Readmitted 8 days later with shortness of breath

- Scared, fearful; honestly worried this was the “beginning of the end”
- Crackles up to her clavicles; 3+ peripheral edema

The Readmission Interview

"Tell me about what happened between the day you were first discharged and today. How did you feel when you went home?"

- Felt fine, glad to be going home!
- Day 2-3-4 post discharge took to bed – had been through an ordeal
- Day 5 tried to resume expected activity, but "wiped out"
- Day 6 noted was getting easily winded
- Day 7 missed appointment because didn't feel well enough to go
- Finally, on day 8 knew she had to come in – couldn't breathe

"Let's review your medications….."

- Find out that she was not instructed to resume her anti-HTN and lasix on discharge, so she had not been taking them!!!

The Readmission Interview

Lessons from this readmission interview

- Didn't feel rushed out the door; no evidence of premature d/c
- Issue: instructions regarding medications, monitoring volume status

How could have avoided this readmission?

- Post discharge contact (phone call, home visit, appointment)
- Check in on symptoms – would have caught it
- Check in on appointments – would have caught it
- Check in on medications – would have caught it

Return Visits to the Emergency Department: The Patient Perspective

Kristin L. Rising, MD, MS*; Kevin A. Padrez, BA; Meghan O'Brien, MD, MBE; Judd E. Hollander, MD; Brendan G. Carr, MD, MA; Judy A. Shea, PhD

- Interviewed 60 patients who returned to ED <9days of visit
  - Average age 43 (19-75)
  - Majority had a PCP,
  - Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
  - Most reported no problem filling medications
  - 19//60 thought they didn't get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis

- Primary reason: ***fear and uncertainty*** *about their condition*
- Patients need *more* ***reassurance*** *during and after* episodes of care
- Patients need access to ***advice between*** visits

Annals of Emergency Medicine

Readmission Interview: Example Script

"I see you were discharged a [few days, weeks] ago. Can I ask you to remember back to the day you were discharged? How did you feel when you left the hospital? Tell me about how thing went [over the next few days]. Did you have any problems or questions or challenges with anything? Did you have any interaction with any health care providers, or anyone who checked in on you? At what point did you – or someone else – decide you needed to return to the hospital? We're glad you're here with us now, and we're going to take good care of you, but looking back over the past [few days, weeks], is there anything that you think could have been done to help you after you left the hospital the first time?"*

*You = patient and/or care partner. Engage any informant who was involved in the care following the first discharge

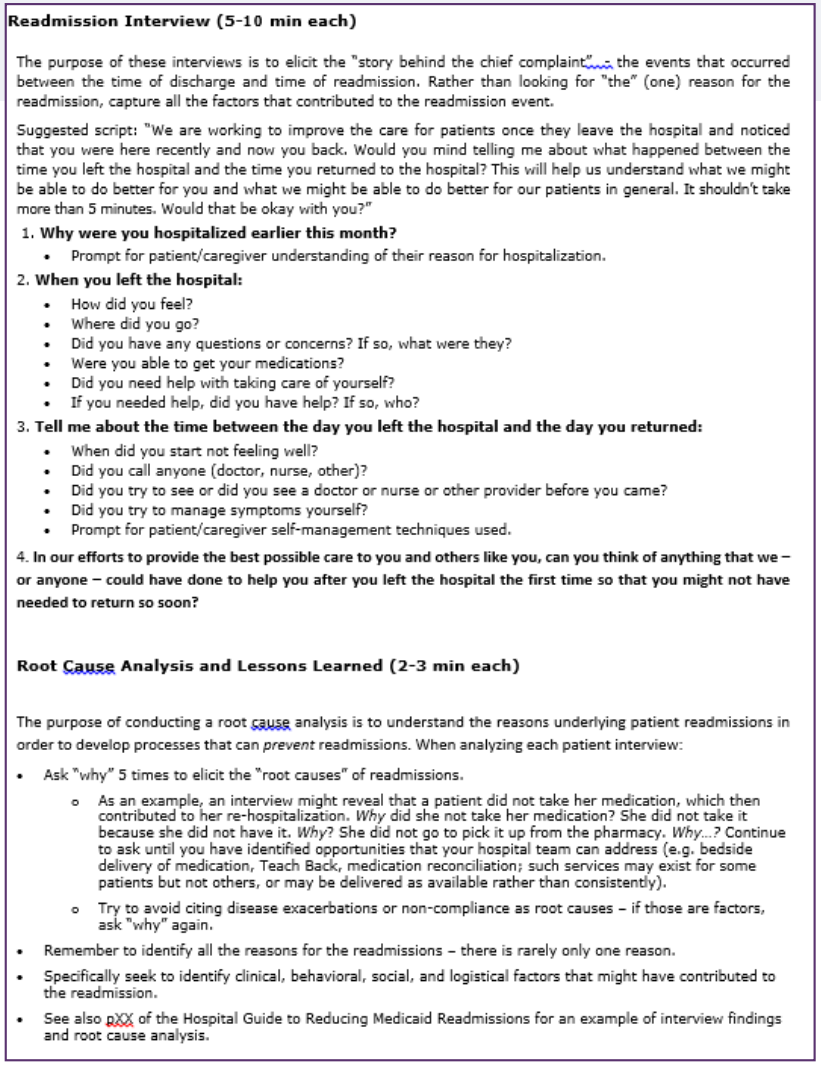
ASPIRE Tool 2

Purpose:

- To understand patient perspective
- To understand root causes
- To understand there are multiple factors
- To identify opportunities for improvement
- To develop a better plan for the patient
- To develop better services to offer

Recommendation:

- ***Conduct at least 5*** this month!
- Best practice: do for all readmissions



Readmission Interview (5-10 min each)

The purpose of these interviews is to elicit the "story behind the chief complaint"… the events that occurred between the time of discharge and time of readmission. Rather than looking for "the" (one) reason for the readmission, capture all the factors that contributed to the readmission event.

Suggested script: "We are working to improve the care for patients once they leave the hospital and noticed that you were here recently and now you back. Would you mind telling me about what happened between the time you left the hospital and the time you returned to the hospital? This will help us understand what we might be able to do better for you and what we might be able to do better for our patients in general. It shouldn't take more than 5 minutes. Would that be okay with you?"

1. **Why were you hospitalized earlier this month?**
   - Prompt for patient/caregiver understanding of their reason for hospitalization.
2. **When you left the hospital:**
   - How did you feel?
   - Where did you go?
   - Did you have any questions or concerns? If so, what were they?
   - Were you able to get your medications?
   - Did you need help with taking care of yourself?
   - If you needed help, did you have help? If so, who?
3. **Tell me about the time between the day you left the hospital and the day you returned:**
   - When did you start not feeling well?
   - Did you call anyone (doctor, nurse, other)?
   - Did you try to see or did you see a doctor or nurse or other provider before you came?
   - Did you try to manage symptoms yourself?
   - Prompt for patient/caregiver self-management techniques used.
4. **In our efforts to provide the best possible care to you and others like you, can you think of anything that we – or anyone – could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?**

Root Cause Analysis and Lessons Learned (2-3 min each)

The purpose of conducting a root cause analysis is to understand the reasons underlying patient readmissions in order to develop processes that can *prevent* readmissions. When analyzing each patient interview:

- Ask "why" 5 times to elicit the "root causes" of readmissions.
  - As an example, an interview might reveal that a patient did not take her medication, which then contributed to her re-hospitalization. *Why* did she not take her medication? She did not take it because she did not have it. *Why*? She did not go to pick it up from the pharmacy. *Why…?* Continue to ask until you have identified opportunities that your hospital team can address (e.g. bedside delivery of medication, Teach Back, medication reconciliation; such services may exist for some patients but not others, or may be delivered as available rather than consistently).
  - Try to avoid citing disease exacerbations or non-compliance as root causes – if those are factors, ask "why" again.
- Remember to identify all the reasons for the readmissions – there is rarely only one reason.
- Specifically seek to identify clinical, behavioral, social, and logistical factors that might have contributed to the readmission.
- See also pXX of the Hospital Guide to Reducing Medicaid Readmissions for an example of interview findings and root cause analysis.

Boutwell, ASPIRE Tool 2 at https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

Based on your readmission interviews, what factors contribute to readmissions?

Take a Data-Informed Approach

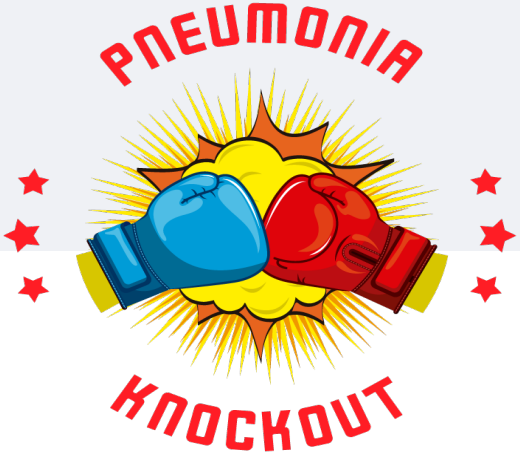
1. What is our aim?
2. What does our data show?
3. Who should we focus on?
4. What services should we deliver?

Many teams start in the ***reverse*** order!

Recommendations

- ✓ Ensure you know the following:
  - Your hospital's* overall readmission rate
  - Your hospital's pneumonia readmission rate
  - The # of pneumonia discharges per day
  - The discharge disposition of pneumonia discharges (eg with whom you need to collaborate)
- ✓ Conduct "readmission interviews" for all of your pneumonia readmissions
  - Have a system in place to identify your readmitted patients on a daily basis (daily list)
  - Delegate someone to conduct readmission interview for all pneumonia patients in March
  - Collect and discuss findings as a group – and share with us for our next webinar in April!
- ✓ Start to identify services and supports to reduce pneumonia readmissions
  - Based on data insights (eg stratify efforts based on discharge dispo)
  - Based on root causes (eg some patients need medication management, others need navigation support)
- ✓ Come to April and future webinars with questions!
  - Let us know what you are working on and what challenges you face – you are not alone!

** If you are leading a system effort, please evaluate each hospital's data separately*



Thank you for your commitment to reducing readmissions

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