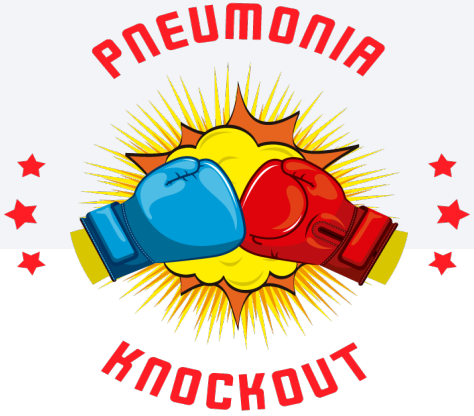


ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

Amy E. Boutwell, MD, MPP

NCHA Knockout Pneumonia Campaign - Webinar 2

April 5, 2018

Purpose of the Knockout Pneumonia Readmissions Series

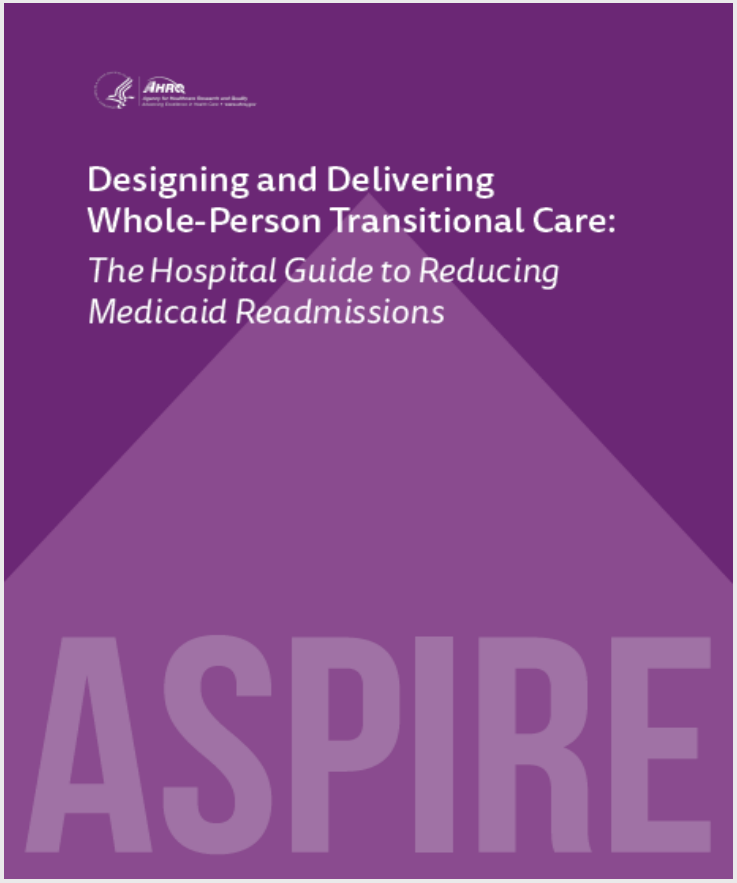
This series is to support your work to reduce pneumonia readmissions

- 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 this time 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

ASPIRE to Reduce Readmissions



AHRQ

PREMIER

American Hospital Association

Maryland Hospital Association

Partnership for Patients — Proud to be Partners in Better Care at Lower Costs.

vizient™

SCHA South Carolina Hospital Association

IHA Illinois Hospital Association

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION
An alliance of hospitals and health delivery systems

MHA MASSACHUSETTS Health & Hospital ASSOCIATION

MASSACHUSETTS HEALTH POLICY COMMISSION

NCHA

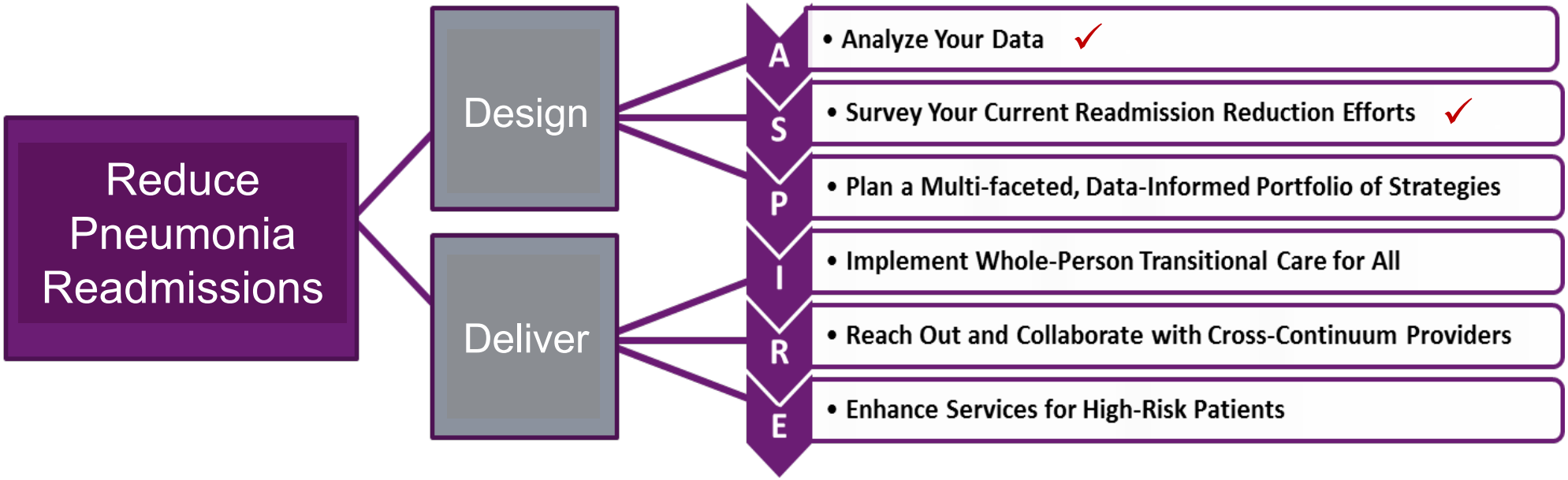
Partnership for Patients — New York State Partnership for Patients

IHC Iowa Healthcare Collaborative
A Partnership for Quality, Patient Safety & Value

New Jersey Hospital Association NJHA

GHA Georgia Hospital Association

ASPIRE Framework



Knockout Pneumonia Readmissions Series

Webinar	ASPIRE to Knockout Pneumonia Readmissions	Resources
March 1	Know your data, understand root causes	• ASPIRE Guide, Section 1 • ASPIRE Tools 1 and 2
April 5	Align with related efforts and resources, identify gaps	• ASPIRE Guide, Section 2 • ASPIRE Tools 3, 4
May 3	Design a portfolio of strategies and operational dashboard	• ASPIRE Guide, Section 3 • ASPIRE Tools 5, 6, 7
June 7	Actively collaborate across the continuum	• ASPIRE Guide, Section 4, 5 • ASPIRE Tools 9, 11, 12
August 2	Deliver effective post-discharge transitional care	• ASPIRE Guide, Section 6 • ASPIRE Tool 13
September 6	Self-assessment and preparation for in-person session	• Self-assessment tool • Support request form
October 16	*Knockout Pneumonia Readmissions in-person session*	• *30 day action plan* • *90 day action plan*
November 1	Knockout Pneumonia Readmissions: Success Stories Part 1	• We welcome volunteers
December 6	Knockout Pneumonia Readmissions: Success Stories Part 2	• We welcome volunteers

Objectives for this Session

- ***Know*** what transitional care practices, processes, tools, services ***already exist*** in your hospital
- ***Know*** what transitional care services and supports are in place in the ***post-acute and ambulatory*** settings
- ***Know*** what services and supports are available in the ***community***, including behavioral health, social, and supportive services

Reflection on your past month of readmission work

What did you learn in the past month about your pneumonia readmission patterns?

- What is your hospital's PNA readmission rate?
- How many PNA discharges do you have per day?
- How many PNA patients are d/c to home per day? To SNF?
- What is your PNA d/c to SNF readmission rate?
- What % of your PNA readmissions return < 7 days of discharge?

What did you learn in the past month about <u>why</u> your pneumonia patients return to the hospital?

https://www.youtube.com/watch?v=5uS6hBh1Qtg

What did Mrs. MacDonald need?

- Reminder
- Clarification
- Repetition
- Support
- Confidence
- Point of Contact
- Home Visit

Is this what you are providing to your patients?

What did you learn in the past month about why your pneumonia patients return to the hospital?

Segment your pneumonia population, by root cause:

Root Cause	Response
End of life trajectory	Family meeting, Goals of care Referral to hospice
Recurrent aspiration	Goals of care ED care plan Alternatives (admit to SNF)
Abx-Assoc. Diarrhea	Anticipatory pathway (what to do if..) Treat and return (SNF, home care) Alternatives (admit to SNF)
High INR 2/2 abx	Titration, close follow up duration of therapy
Forgot, confused, worried	Post-discharge calls to clarify, reinforce "Call me first" instructions
Lack self-efficacy	In-person navigation, in-home follow up

Now that we know patterns and root causes, what are we going to do about it?

Especially if you don't have a magic wand….

"We run the care coordinator pilot; I think nursing is working with IT on getting a high-risk flag in the record. I don't know how that is coming…."

Inventory Hospital-Based Efforts & Resources

- Readmission reduction activities have proliferated over time
- Some efforts may have developed in isolation from one another
  - Not all would necessarily include pneumonia in their target population
- Resources or assets may exist that could be leveraged
  - Readmission flags, high risk flags in EMR (do they include PNA?)
  - Post-discharge follow up calls (do they include PNA?)
  - Centralized appointment scheduling (do they include PNA?)
  - Pharmacists or pharmacy technicians (review for PNA patients?)
  - ACO, bundled payment teams (do they target PNA?)

Hospital Inventory Tool

Use this tool to:

- Identify readmission reduction efforts across departments
- Identify whether efforts are coordinated
- Identify whether there is duplication
- Identify gaps – in administrative support
- Identify gaps – in clinician engagement
- Get specific – which patient groups (dx, services, program) get what? can we add ant or all PNA patients to that service?

TOOL 3: HOSPITAL INVENTORY TOOL

You probably have multiple types of readmission reduction activities underway at your hospital. You probably also have access to "assets" relevant to a robust readmission reduction effort. An inventory of readmission reduction efforts will reveal the administrative, clinical, health information technology, and other organizational assets already in place. Once you know what efforts and assets already exist, you can consider whether they are optimally aligned and coordinated. The inventory will also serve as an implicit gap-analysis of activities or assets not currently in place. You may identify the need to implement new practices as part of this process.

READMISSION ACTIVITY/ASSET	FOR WHICH PATIENTS?
ADMINISTRATIVE ACTIVITIES/ASSETS	
❑ Specified readmission reduction aim	
❑ Executive/board-level support and champion	
❑ Readmission data analysis (internally derived or externally provided)	
❑ Monthly readmission rate tracking (internally derived or externally provided)	
❑ Periodic readmission case reviews and root cause analysis	
❑ Readmission activity implementation measurement and feedback (PDSA, audits, etc.)	
❑ Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)	
❑ Other:	
HEALTH INFORMATION TECHNOLOGY ASSETS	
❑ Readmission flag	
❑ Automated ID of patients with readmission risk factors/high risk of readmission	
❑ Automated consults for patients with high-risk features (social work, palliative care, etc.)	
❑ Automated notification of admission sent to primary care provider	
❑ Electronic workflow prompts to support multistep transitional care processes over time	
❑ Automated appointment reminders (via phone, email, text, portal, or mail)	
❑ Other:	
TRANSITIONAL CARE DELIVERY IMPROVEMENTS	
❑ Assess "whole-person" or other clinical readmission risk	
❑ Identify the "learner" or care plan partner to include in education and discharge planning	
❑ Use clinical pharmacists to enhance medication optimization, education, reconciliation	
❑ Use "teach-back" to improve patient/caregiver understanding of information	
❑ Schedule followup appointments prior to discharge	
❑ Conduct warm handoffs to postacute and/or community "receivers"	
❑ Conduct postdischarge followup calls (for patient satisfaction or followup purposes)	
❑ Other:	
CARE MANAGEMENT ASSETS	
❑ Accountable care organization or other risk-based contract care management	
❑ Bundled payment episode management	
❑ Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)	
❑ High-risk transitional care management (30-day transitional care services)	
❑ Other:	
CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	
❑ Skilled nursing facilities	
❑ Medicaid managed care plans	
❑ Community support service agencies	
❑ Behavioral health providers	
❑ Other:	

“You don’t understand, there are just no resources in the community”

Inventory Community Efforts & Resources

- Post-acute and community providers may offer services and supports hospital staff are unaware of
  - PMCH post-discharge calls, transitional care management
  - Front-loaded home visits
  - SNF to home transitional care phone calls, arranging appointments, in home services

- Health plans may offer high risk patients care management
  - NJ Wellcare: “advocacy team”
  - SC all MCOs: transitional care teams to do pre-discharge in person visit

- Resources or assets may exist that could be leveraged
  - Community based care management
  - Behavioral health clinics with peers, advocates, groups, transportation
  - Volunteer, faith-based, elder service and social service agencies

Community Inventory Tool

Use this tool to identify:

- Peer supports?
- Navigators?
- Medical-legal advocates?
- Senior services?
- Faith based or community volunteers?
- Formal partnerships?
- Informal arrangements?
- Optimizing available resources?
- Is linkage as easy as it needs to be?
- Gaps in services and supports?

Provider or Agency	Transitional Care Services [Examples]	Use?	
Clinical and Behavioral Health Providers		Yes	No
Community health centers, federally qualified health centers	[ability to accept new patients; timely post-hospital follow up; co-located social work, nutritional, pharmacy services, etc.]	☐	☐
Accountable care organization with care management or transition care	[high-risk-care management, transitional care to reduce readmissions, etc.]	☐	☐
Medicaid managed care organizations	[high-risk-care management, social work, wraparound services, etc.]	☐	☐
Program of All-Inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	[capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs]	☐	☐
Medicaid health homes	[engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions]	☐	☐
Multiservice behavioral health centers, including behavioral health homes	[prioritized post-hospital follow up; availability for new patients; co-located support services, etc.]	☐	☐
Behavioral health providers	[accepting new patients, prioritizing post-hospital follow up, etc.]	☐	☐
Substance use disorder treatment providers	[effective processes for linking patients from acute care to substance use disorder treatment]	☐	☐
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics	[urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.]	☐	☐
Pain management or palliative care	[symptom management over time, often with behavioral health specialists and social workers, education, etc.]	☐	☐
Physician/provider home visit service	[timely post-discharge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.]	☐	☐
Skilled nursing facilities	[onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions To Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.]	☐	☐
Home health agencies	[warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.]	☐	☐
Hospice	[warm handoffs, joint readmission reviews, same-day home visits, etc.]	☐	☐
Adult day health	[daily clinical, nutritional, medication management, socialization, etc.]	☐	☐
Public health nurses	[home visits, outreach, education, clinical coordination, etc.]	☐	☐
Pharmacies	[bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.]	☐	☐
Durable medical equipment	[same-day delivery; 30-day transitional care monitoring, education services, etc.]	☐	☐
Other			
Social Services			
Adult protective services	[safety evaluation, case management]	☐	☐
Area Agency on Aging (AAA)	[self-management coaching, chronic disease self-management, in-home personal support services, etc.]	☐	☐
Aging and Disability Resource Centers	[evaluate for eligibility for benefits and services; link to vetted providers]	☐	☐
Assisted living facilities	[onsite clinical, onsite behavioral, self-management coaching, adherence support, transportation, etc.]	☐	☐
Housing with services	[care management, onsite social work, onsite clinical, nutritional/food support, transportation, etc.]	☐	☐
Housing authority or agencies	[case management, facilitated process of pursuing housing options]	☐	☐
Legal aid	[securing benefits, access to treatment, utilities, rent, etc.]	☐	☐
Faith-based organizations	[personal and social support, transportation, meals, etc.]	☐	☐
Transportation	[transportation to meet basic and clinical needs]	☐	☐
Community corrections system	[case workers, social workers, collaboration on follow up]	☐	☐
Other			

Medicaid Managed Care Organizations (MCOs)

MCOs can assist with:

- Identify PCP
- Home Nursing
- Medication adherence
- Discharge planning from all levels of care
- Disease Management
- Complex Case Management
- Coordination of services

- Examples:
  - Transitional care staff
  - Complex care managers
  - Behavioral health care managers
  - Mobilize resources to meet basic health-related needs

Adult Day Health Care

- Adult Day Services provides an organized program in a community group setting to promote social, physical and emotional well being. These programs offer a variety of activities designed to meet the needs and interests of each older adult who receives care.

- Interdisciplinary Team consisting of a : Center Director, Registered Nurse, Licensed Social Worker, Dietician, CNA , GNA, CMA , and Therapeutic Recreational Director.

- Services: Individualized Care Plans, Daily Nurse Assessments, PT, OT, medication administration, wound care.

- If you have questions about adult day services contact:
  The local Department of Social Services
  The Area Agency on Aging

https://www.ncdhhs.gov/assistance/adult-services/adult-day-services

Bon Secours Baltimore Health System

Internal Inventory

- Peer recovery coaches in the ED
- Outcomes Management
- Social Work
- Behavioral Health Program
- Clinics provide post-discharge follow up <7-10 days for anyone
- IT: ACO patients flagged
- IT: Use CRISP for notifications

Community Inventory

- Health Enterprise Zone
- The Coordinating Center
- Homeless Outreach Program
- Transitional Housing Providers
- Home Health Agencies
- Skilled Nursing Facilities
- Baltimore Area Agency on Aging
- Collaboration w UM Midtown

What's needed next:

- Care coordination model for high risk patients
- Create care plans for high utilizers
- Integrate medical and behavioral health care clinical information
- Continue to innovate to meet need of patients

Source: presentation to HSCRC Care Coordination workgroup, Dec 2014

Reflect on Findings to Date

- Which internal hospital-based processes or resources could be mobilized to better serve our pneumonia patients (pall care, pharmacist, SW, ToC)?
- What processes or services exist with post acute partners, and are they being applied to our pneumonia patients (warm handoffs, circle back, virtual co-management, SNF MD/PAs, ED treat and return pathways)?
- What services exist in ambulatory care and are they being delivered to our pneumonia patients (real time notification of PCP, timely post discharge contact, transitional care management, PCMH care management)?
- What services exist in the community that can better address our pneumonia patients' needs for supportive services, check-ins, contact, reassurance?

Recommendations

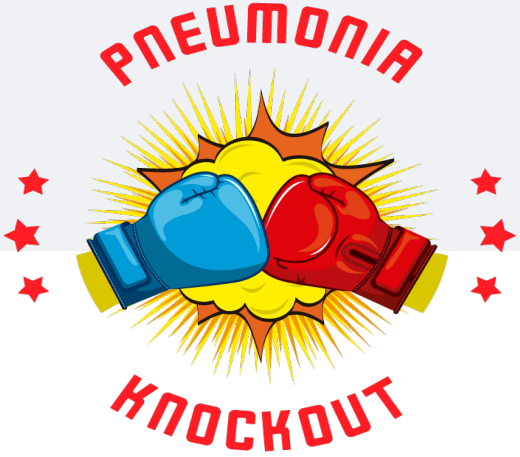
1. ***Develop*** a running list of the root causes of PNA readmissions

2. ***Develop*** a working list of strategies to address those root causes

3. ***Know*** if you have hospital-based services that can address those root causes

4. ***Ask*** your SNFs, Home Health, and PCP practices if they have enhanced supports and services – know what they do, for whom, and whether this applies to pneumonia patients as well

5. ***Learn more about*** the community services and supports that exist that could be mobilized for your pneumonia patients



Thank you for your commitment to reducing readmissions

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