ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

Amy E. Boutwell, MD, MPP

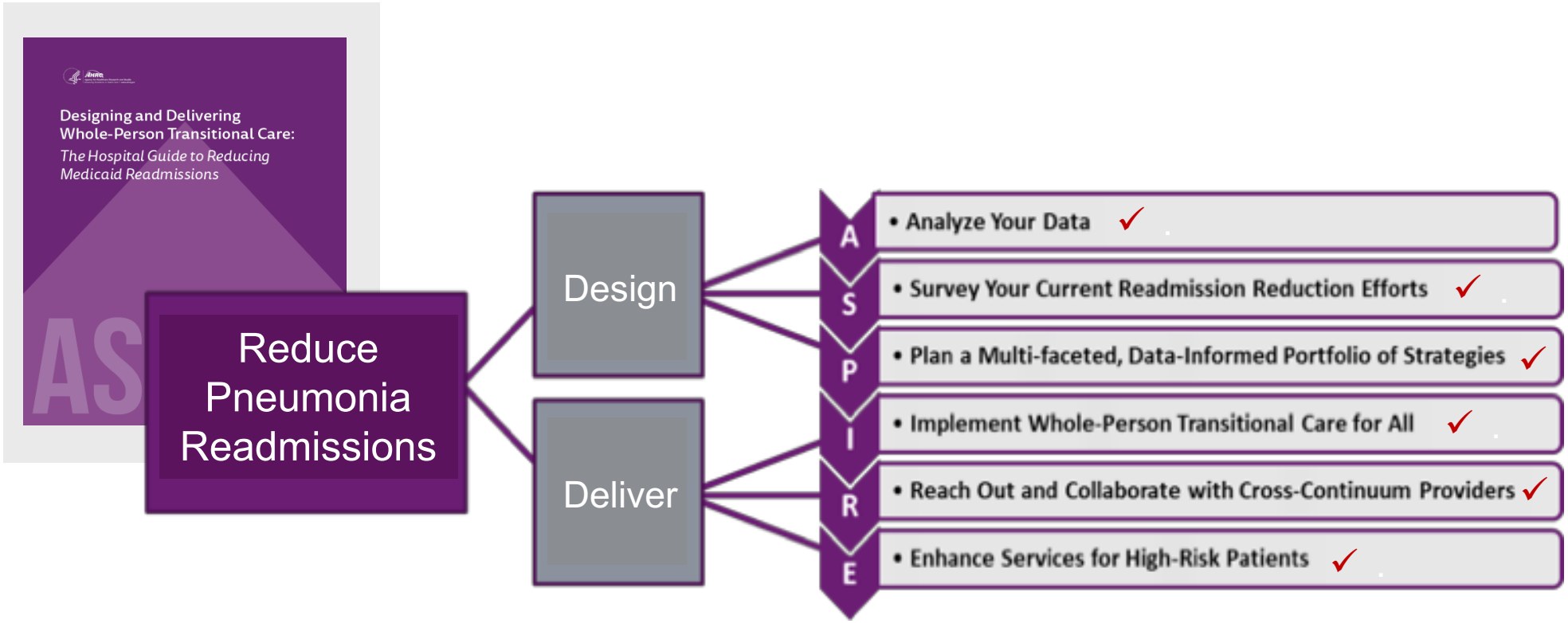
NCHA Knockout Pneumonia Campaign - Webinar 8

December 6, 2018

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 8, 9, 11, 12
August 2	Deliver effective post-discharge transitional care	• ASPIRE Guide, Section 6 • ASPIRE Tool 13
September 6	ASPIRE +: The Implementation Model to Drive Results	• ASPIRE + operational dashboard
October 4	In-Person Workshop Preparation	• Workshop prep slides
November 2	Knockout Pneumonia Readmissions in-person session	• 7 day action plan • 30 day action plan
December 6	**Action Plan Implementation Report-Out and Next Steps**	• **Workshop participants**

ASPIRE Framework



Objectives for Today

1. Learn what you are doing as a result of the Knockout Pneumonia Readmission webinar series & workshop to reduce readmissions

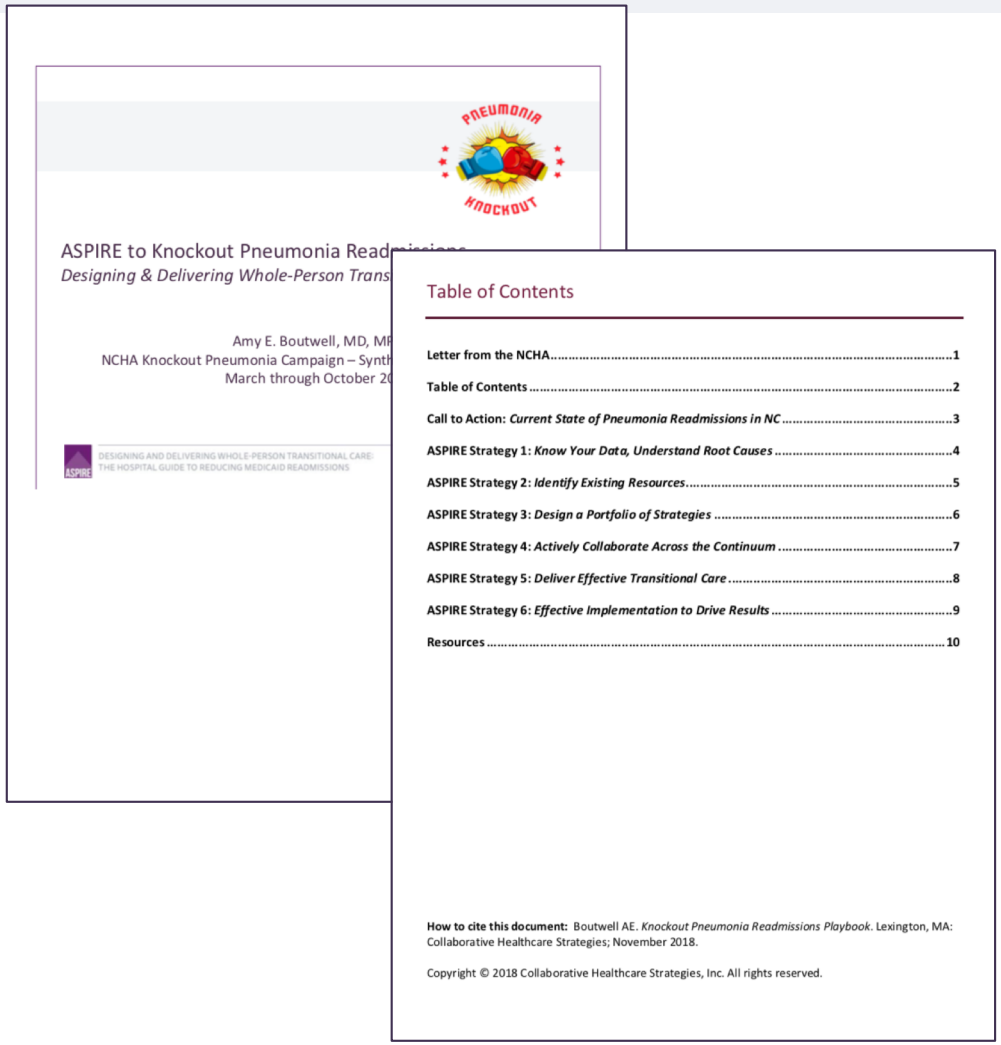
2. Get ideas from each other about feasible, meaningful next steps

3. Celebrate a great year together!

IN PERSON WORKING SESSION

Linking Priorities to Design; Learning from Successes; Action Plans

Knockout PNA Readmissions Playbook



ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Trans

Amy E. Boutwell, MD, MP
NCHA Knockout Pneumonia Campaign – Synth
March through October 20

DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE: THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

Table of Contents

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Resources

Please see the Knockout Pnuemonia webpage to access the full curriculum of recorded webinars:

1.	ASPIRE to Reduce Pneumonia Readmissions	March 2018
2.	Align with Existing Resources, Identify Gaps	April 2018
3.	Design a Portfolio of Strategies and Operational Dashboard	May 2018
4.	Actively Collaborate Across the Continuum	June 2018
5.	Deliver Effective Transitional Care	August 2018
6.	ASPIRE +: Implementation to Drive Results	September 2018
7.	Preparing for the In-Person Workshop	October 2018

Please see the AHRQ webpage to access the full curriculum of the ASPIRE Guide:

- ASPIRE Guide
- ASPIRE Toolkit
- ASPIRE Webinars
  1. Introduction & Overview
  2. Analyze Data and Caregiver Perspectives
  3. Review & Update Readmission Reduction Efforts
  4. Implement Whole-Person Transitional Care for All
  5. Reach Out to Collaborate with Partners Across Settings
  6. Enhance Services for High-Risk Patients

Please see the AHA/HRET HIIN "Readmission Reduction Whiteboard Video Series"

1. Introduction
2. Know Your Data
3. Understand the Root Causes
4. Improve Transitions for All Patients
5. Develop a Customized Transitional Care Plan for All Patients
6. Effectively Communicating with Patients and their Caregivers
7. Engaging the ED in Readmission Reduction Efforts
8. Deliver Enhanced Services Based on Need
9. Improving Care for High Utilizers
10. Collaborating with Clinical and Non-Clinical Community Providers and Services
11. Measure What You Implement

Knockout PNA Readmissions Playbook

ASPIRE Strategy 1: *Know Your Data, Understand Root Causes*

Understand your hospital's patterns of readmissions overall, and the pattern of readmissions for any given target population suc
readmissions. For any
population and the pr
readmissions to your h

- What is your hosp
- What is your hosp
- How many readm
- How many pneum
- What percentage
- How many pneum

The best data analysis
to understand root ca

- Ask your readmitt
  discharge and the
- Listen for all of th
  patient returning
- Use individual rea

Recommendations

- ☐ Analyze your own
- ☐ Interview 10 read

For more information

- ✓ ASPIRE to Knockou
- ✓ ASPIRE Guide Cha
- ✓ AHA/HRET HIIN R

ASPIRE Strategy 2: *Identify Existing Resources*

Many readmission reduction teams perceive limitations to their ability to effectively reduce readmissions because of lack of resources – in thei
do best when they shift their focus fr
resources that do exist.

Within the hospital, consider:

- How do we identify patients at h
- How do we define high risk of re
- Are our target population patient
- What services already exist in to i
  of life or broad supports? Social v
- What structures and process d
  patients? Cancer navigators? Ort

Within the community, consider:

- Which agencies provide social a
  Family service agencies? Conside
  based organizations.
- What are multi-service behavior
  workers, recovery coaches, trai
  benefit assistance. Do not hesitat
- Which practices are Patient-Ce
  managers, provide post-hospital
- Who is paying the bill for your hi

Recommendations:

- ☐ Survey the readmission reduction
- ☐ Survey the readmission reduction

For more information:

- ✓ ASPIRE to Knockout Pneumonia R
- ✓ ASPIRE Guide Chapter 2, Tools 3

ASPIRE Strategy 3: *Design a Portfolio of Strategies*

Successful readmission reduction efforts employ a "portfolio of strategies" to reduce readmissions. It is common to see hospitals, health systems, and even communities with a variety of initiatives and programs – all operating in their own departments or service lines or silos.

As you conduct your survey of resources, pull together a picture of the portfolio of strategies that are currently in place to achieve readmission reduction (hospital-wide or for your specific target population). Use a driver diagram to articulate the strategy – not just the individual programs or projects or practice changes, but the logic of how those relate to achieving your readmission reduction goal. Consider:

- Do you have resources in place to track readmission data and identify root causes?
- Do you have efforts in place to improve transitional care for all patients?
- Do you have efforts in place to effectively collaborate with providers and agencies across the continuum?
- Do you have "enhanced transitional care" services for high risk populations?
- Are there gaps that should be addressed to strengthen your portfolio of strategies?

Recommendations

- ☐ Articulate your current portfolio of strategies using a driver diagram
- ☐ Analyze your strategy to ensure it is designed to get the results you want to achieve

For more information

- ✓ ASPIRE to Knockout Pneumonia Readmissions webinar 3, May 2018
- ✓ ASPIRE Guide Chapters 3 and Tools 5, 6 and 7

ASPIRE Strategy 4: *Actively Collaborate Across the Continuum*

Effective collaboration fo
partnership and relations
our care transition proc
understanding and discus

Many cross-continuum te
Those are necessary but n
that actually improve day

Examples include:

- "Circle-back" phone
  transition to follow u
- Weekly virtual co-ma
  solve by the parties c
- Hospital, ACO, bundl
  address needs, and s
- ED processes to ide
  appropriate alternati

Many readmission reduct
with skilled nursing facilit
risk patient populations.

- Do you have collab
  agencies? payers? AC

For more information

- ✓ ASPIRE to Knockout P
- ✓ HQI's "Circle Back" vi
- ✓ ASPIRE Guide Chapte
- ✓ AHA/HRET Readmissi

ASPIRE Strategy 5: *Deliver Effective Transitional Care*

Transitional care is care that is provided to high risk patients because they are at high risk of readmission.

The purpose of trans

- Additional servic
- Services not prov
- Offered to subgr
- Delivered prior t
- Delivered by hos

It is important to des
risk population or p
population, transitio
– as opposed to narr

Many successful rea
populations – attribu

- *"We look at the v*
- *"We always addr*
- *"We meet the po*
- *"First and foremo*
- *"You can't talk to*
- *"Our navigators*
  incredible interpe
- *"We do whateve*

For more informatio

- ✓ ASPIRE to Knocko
- ✓ ASPIRE Guide Ch
- ✓ AHA/HRET HIIN R

ASPIRE Strategy 6: *Effective Implementation to Drive Results*

You are busy every day trying to implement improved care for your patients. You may be wondering: What are we doing? For which patients? How consistently are we doing it? What are the results? For the target population? For patients who received the service?

An operational dashboard can help you know what services are being delivered, to which patients, with what results? An operational dashboard might contain the following elements:

- All discharges in the target population(s)
- Number of discharges who received the service/process
- % of target population discharges that received the service/process
- Readmission rates of the target population

Before you conclude that a given service/process is not effective to reduce readmissions:

- Quantify the total number of discharges in the target population: How many patients have we defined as being at risk of readmission? Are we effectively identifying all target population patients? Are we effectively engaging them in care? Are we delivering intended services once identified and engaged?
- Drive to a high level of implementation of services for the target population. The services can't reduce readmissions if they are not being delivered to high risk patients!

Recommendations

- ☐ Create an "operational dashboard" to track the implementation of your various strategies
- ☐ Track the % of target population patients who receive the intended service(s)
- ☐ Improve and innovate to drive up the % of target population patients "served"
- ☐ Track the readmission rate for all patients, target population(s), and patients "served"
- ☐ Track, trend, display, share monthly performance and outcome data visibly; use as a tool
- ☐ Start with the information you have, and build a comprehensive dashboard over time

For more information

- ✓ ASPIRE to Knockout Pneumonia Readmissions webinar 6, September 2018
- ✓ AHA/HRET HIIN Readmission Reduction Whiteboard video 10

LINKING PRIORITIES TO DESIGN

Motivation → Goal → Target Population → Intervention

Workshop Participants' Burning Issues

- Root causes of readmission
- SNF readmissions
- Resources for transitional care
- Hospital and home care partnerships
- Readmissions and length of stay
- Post discharge appointments
- Accurate, dynamic medication list

Organizations' Motivations to Reduce Readmissions

- Penalties
  - Disease specific
- VBP
  - HCAHPS, Efficiency (Medicare Spend Per Beneficiary)
- HCAHPS
  - Experience = communication & understanding
- Star Ratings
  - Readmissions, Experience
- Commercial (Blue, United) plan incentives
- Throughput, capacity
  - Free up beds, reduce diversion

Organizations' Aim Statements

- Reduce all cause, all payer PNA readmissions by 7.5% in FY19
- Reduce all cause readmissions from 0.9 to 0.8 by EOY 2018
- Reduce all cause readmissions to 11% by 6/30/19

Organizations' Target Populations

- COPD, HF, PNA, AMI
- Sepsis
- UTI
- Sickle cell
- Uninsured
- High risk score (cerner, epic, jvion, lace)
- Multi-visit patient

Design

- ✓ Does your organization's **motivation** to reduce readmissions align with your organization's readmission reduction **aim** statement?
- ✓ Does your **target population** criteria align with your readmission reduction **aim** statement?

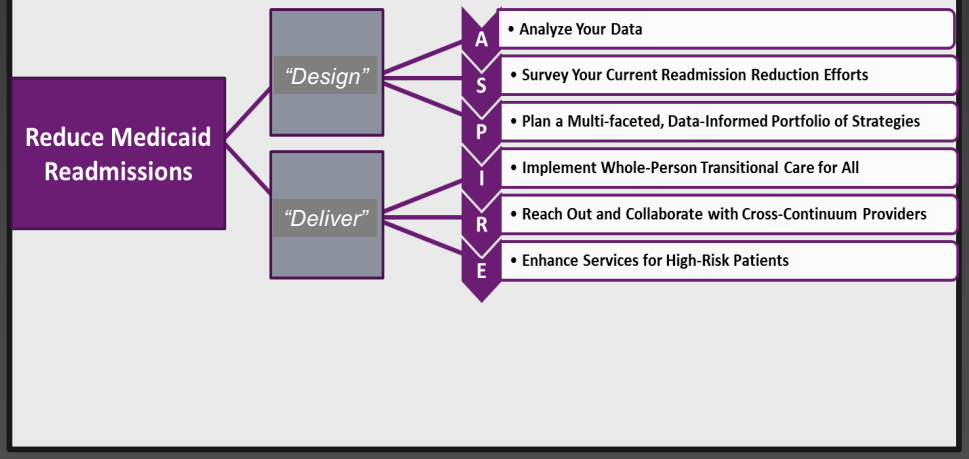
LEARNING FROM SUCCESSES

What does success look like? What are universal success factors?

ASPIRE +

Design and Execution → Results

Design Elements



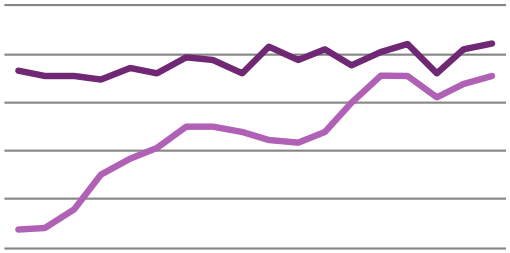
Implementation Elements

- Data and root cause analysis
- Real-time identification
- Timely engagement
- Whole-person approach
- Service across settings and over time
- Collaboration across the continuum
- Implementation and outcomes measurement

“+” = Execution

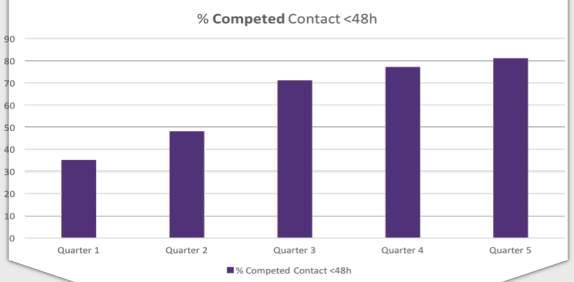
Only Execution Drives Results

Close the Gap



Patients “Served” vs. Total Target Population

Drive Up Completion



Attempts Don’t Count in Readmissions!

Increase Contacts

Drive Up Patient-Facing Contacts with Same FTEs

Lessons from Success - Video 1

- “We learned it’s not the medical, it’s the social”
- Teach-back, reassess
- High touch, close contact
- Follow up calls, visits at home, appointments
- Home visit with the RN & SW
- Collaborate with SNF
- Case conference with the next team
- ”We now have a lot of players at the table”
- “It’s all about relationships”
- https://www.youtube.com/watch?v=ftAzr3aXyQM

Lessons from Success – Video 2

Mrs. MacDonald, hospitalized with pneumonia

- "When I got home, I was overwhelmed"
- "I didn't think……then I realized"
- Coach came twice to my home
- Not rushed, explained everything
- "Best of all….it was free"
- https://www.youtube.com/watch?v=5uS6hBh1Qtg

Lessons from Success – Video 3

Thaddeus Eison, multi-visit patient

- 30M homeless, addiction, CVA, CHF, OSA, PPM/AICD, DJD
- “Talk about lonely”
- “The only person who cared about me….she gone”
- “I don’t know how to deal with the hurt”
- ”I don’t know which way to turn”
- Recovery coach: “we will help you”
- ”Now I have a plethora of choices”
- “Sometimes you need to give power and allow others to help you”
- “I think you will be some kind of proud of me”
- “I’m grateful”
- https://www.youtube.com/watch?v=5uS6hBh1Qtg

Lessons from Success – Video 4

”Circle Back”

- RN-RN verbal handoff
- ToC RN calls back 1 day after transfer
- Asks a set of 6 questions
  - Do you have everything you need to take excellent care of the patient?”
- Consistent point of contact between hospital – SNF
  - “It’s nice to have someone follow up”
  - Allows for as-needed problem solving
- Follow up on all issues
  - Provides real time feedback to staff
- “26% of the time there was an issue….not it is 8%”
  - Shows we are getting better at the transition
- https://www.youtube.com/watch?v=0wCZc3hkPdY

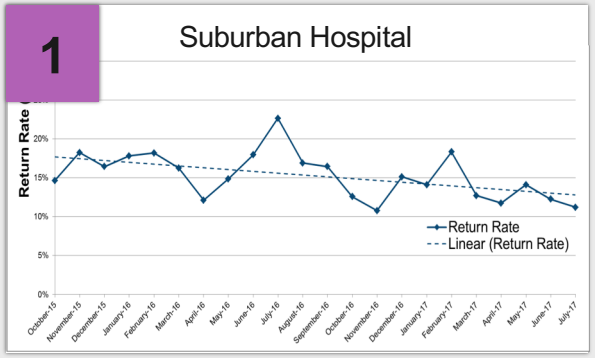
Hospitals with Hospital-Wide Results

- Know their data –
  - *Analyze, trend, track, display, share, post*
- Broad concept of “readmission risk”
  - *Whole-person needs, not just medical*
- Multifaceted strategy
  - *Hospital, cross-continuum, post-hospital*
- Use technology to make this better, quicker, automated
  - *Automated notifications, implementation tracking, dashboards*

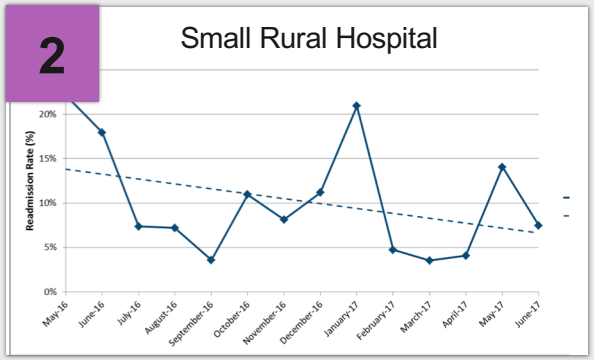
Key Actions

1. *Know* your data
2. *Understand* root causes
3. *Develop* a portfolio of strategies
4. *Improve* hospital-based transitional care for all
5. *Collaborate* with cross setting providers & payers
6. *Provide* enhanced services for high risk patients
7. *Track* implementation to *drive* key processes

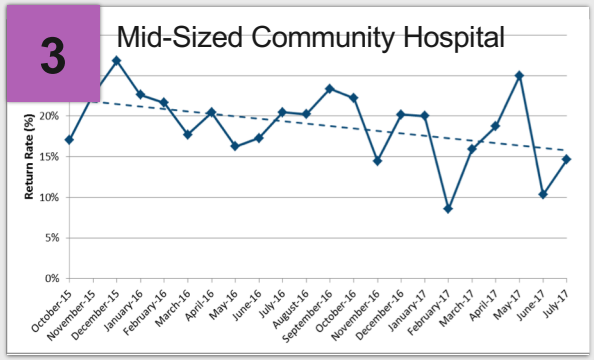
ASPIRE +



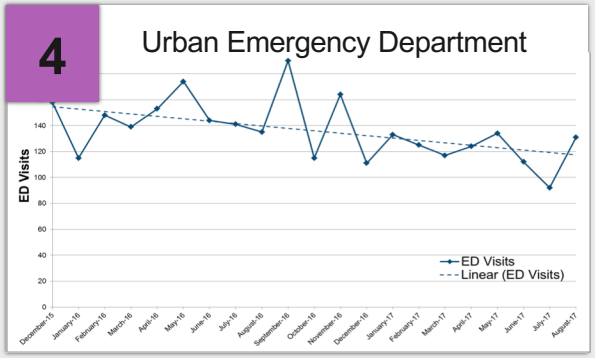
"Return" Reduction 27%



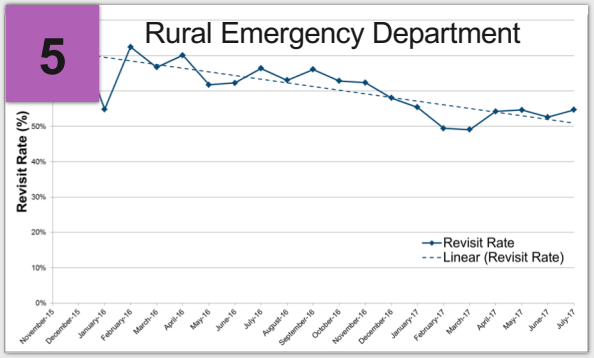
Readmission Reduction 58%



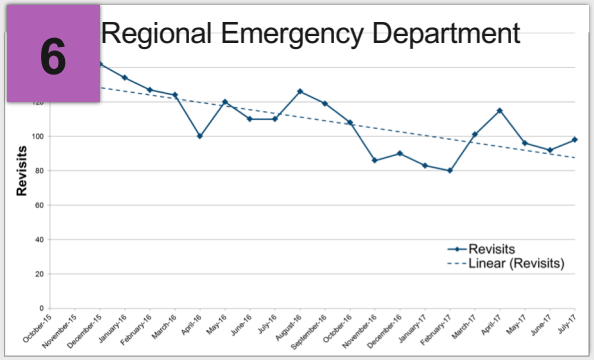
"Return" Reduction 29%



ED HU Visit Reduction 24%



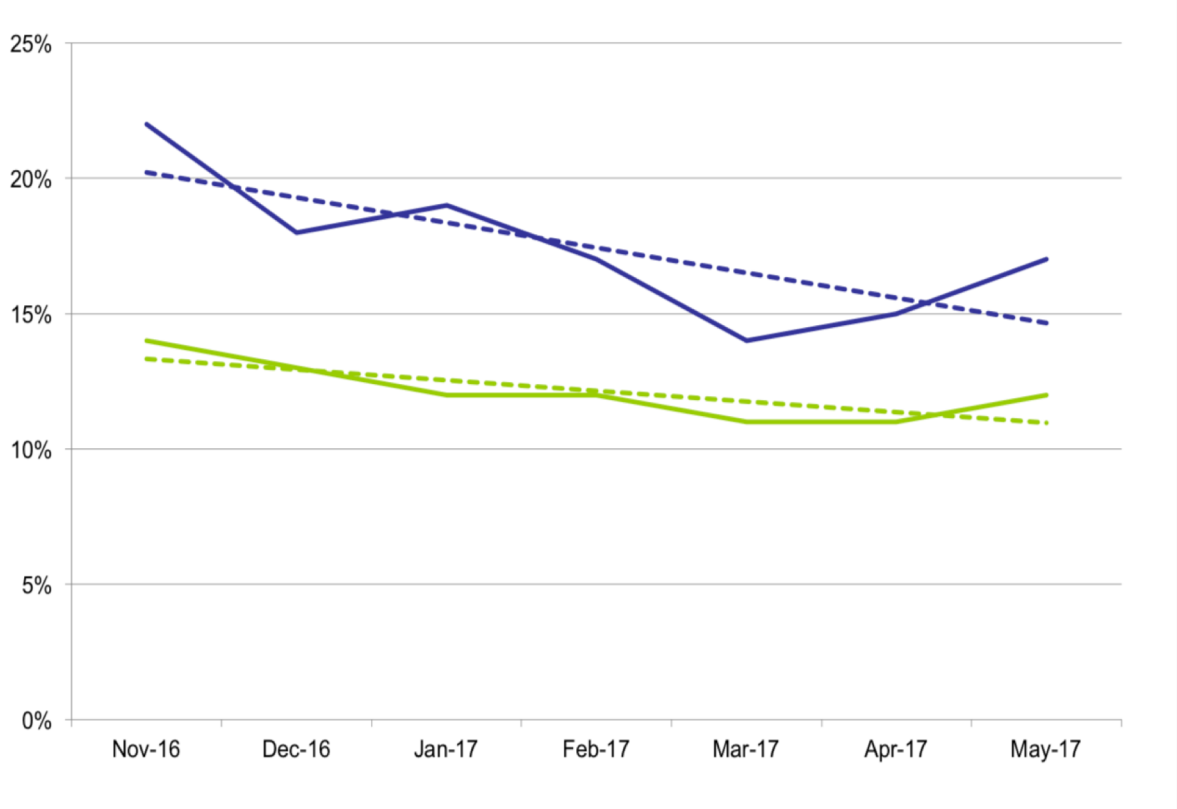
ED HU Revisit Reduction 27%



ED BH Revisit Reduction 34%

ASPIRE

The AHRQ Hospital Guide to Reducing Medicaid Readmissions



Target Population & Hospital-Wide

Target Pop: 25% Reduction
Hospital-Wide: 15% Reduction

ACTION PLANS

Feasible, Meaningful and Within Our Sphere of Influence

Participants' High Impact Improvement Ideas

- Broaden concept of "high risk"
  - Develop criteria, based on data
- Identify all SNF patients as high risk
- Conduct readmission interviews
- Establish a pathway to serve high risk patients
- Extend transitional care services into the home

Participants' Action Steps

7 days

- Look at our own data
- Update our readmission A3
- Ask volunteers to conduct readmission interviews
- Look into where we can post an ED care plan

30+ days

- Analyze data to identify the populations with high readmission rates
  - Share with UR committee
- Start to draft ED care plans
- Develop high risk patient pathway(s)

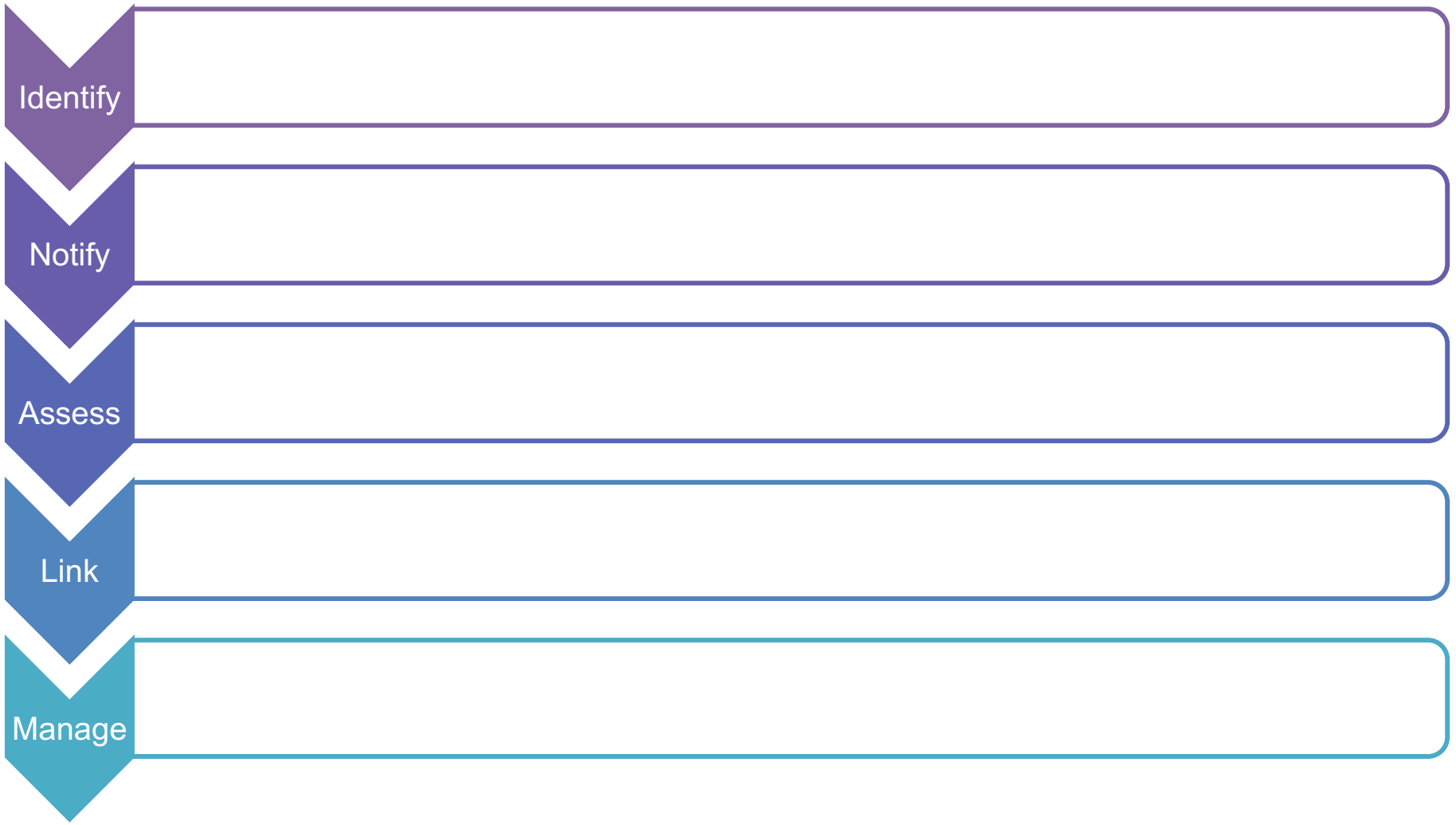
DISCUSSION

What are you doing? For which patients? How can you continue to improve service delivery to get better results?

FINAL WORDS

Measure what you implement

Articulate your transitional care process

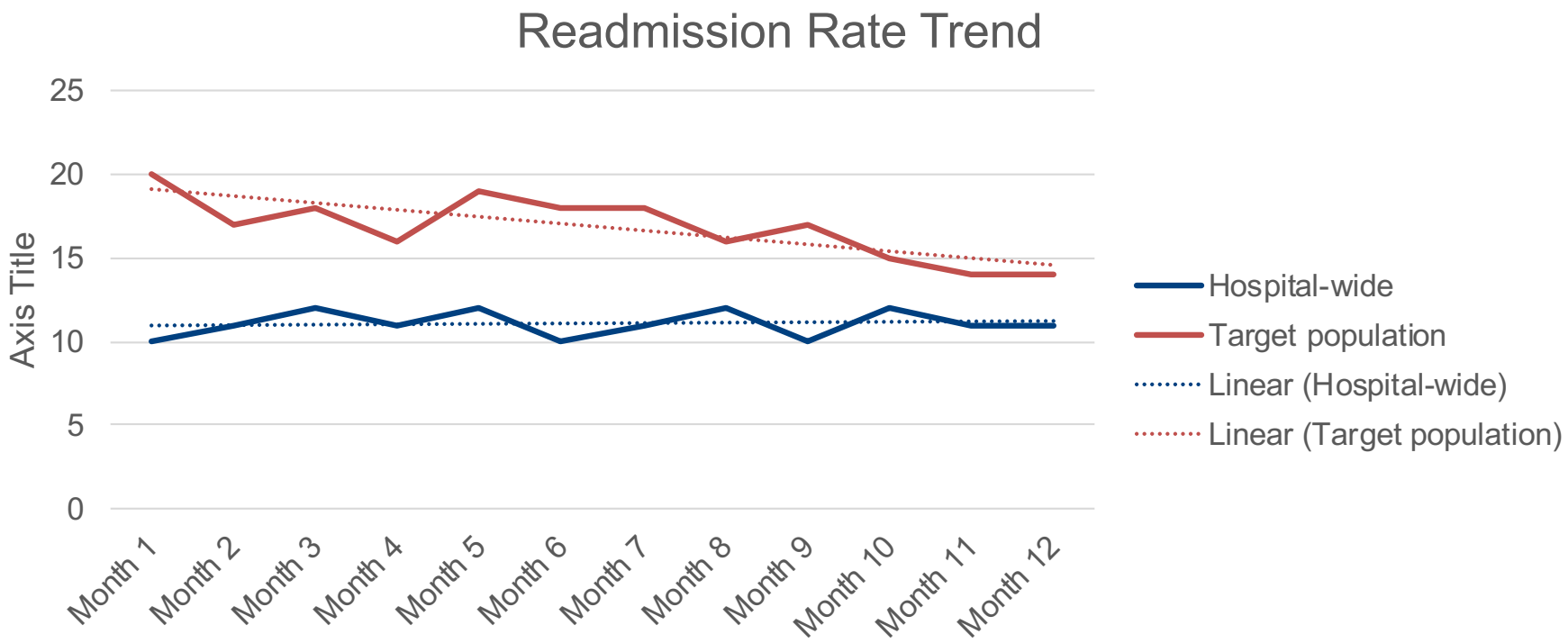


Maintain an Operational Dashboard

	This month	Last month
Total # target population discharges		
Total # (%)target population discharges “served” in-house		
Total # (%) target population discharges “served” post-discharge		
Other [specific to your program]		
Other [specific to your program]		

Use implementation data to increase the % completed service delivery

Trend Monthly for the Hospital and Target Population



Thank you for your commitment to reducing readmissions!

It's been a pleasure to work with you!

Amy E. Boutwell, MD, MPP
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Developer, AHRQ "ASPIRE" Guide to Reducing Readmissions
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