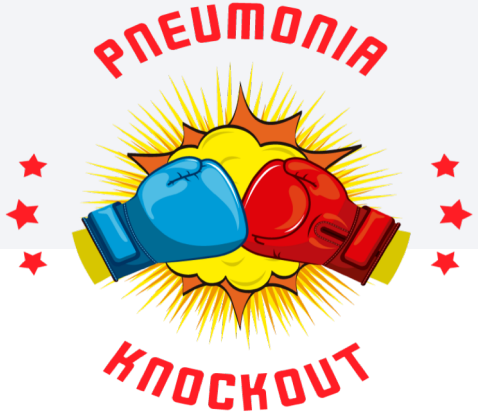


ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

Amy E. Boutwell, MD, MPP

NCHA Knockout Pneumonia Campaign - Webinar 4

June 7, 2018

Purpose of the Knockout Pneumonia Readmissions Series

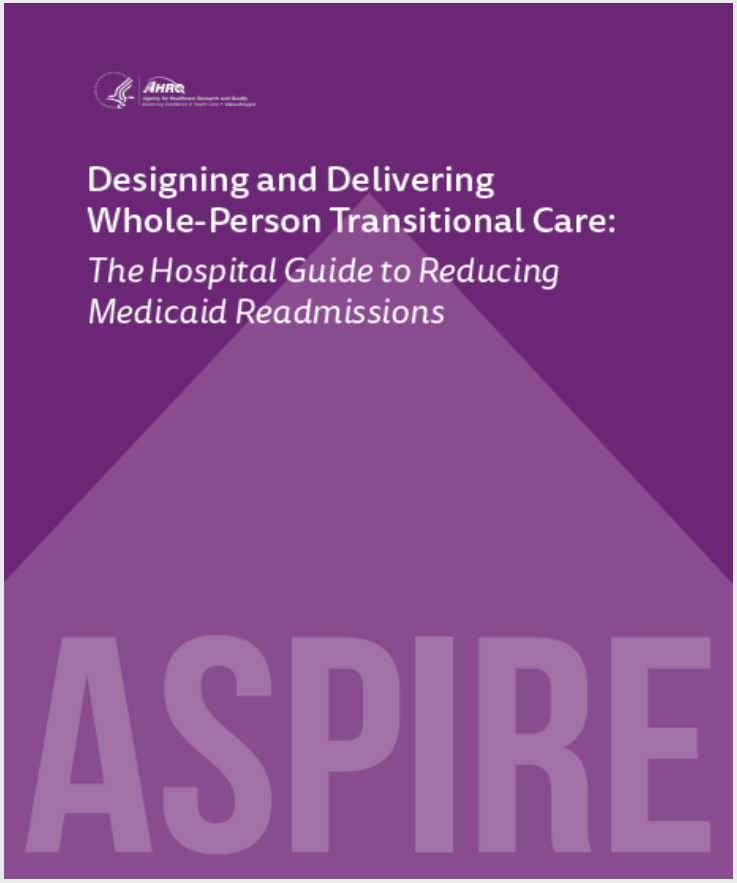
This series is to support your work to reduce pneumonia readmissions

- 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

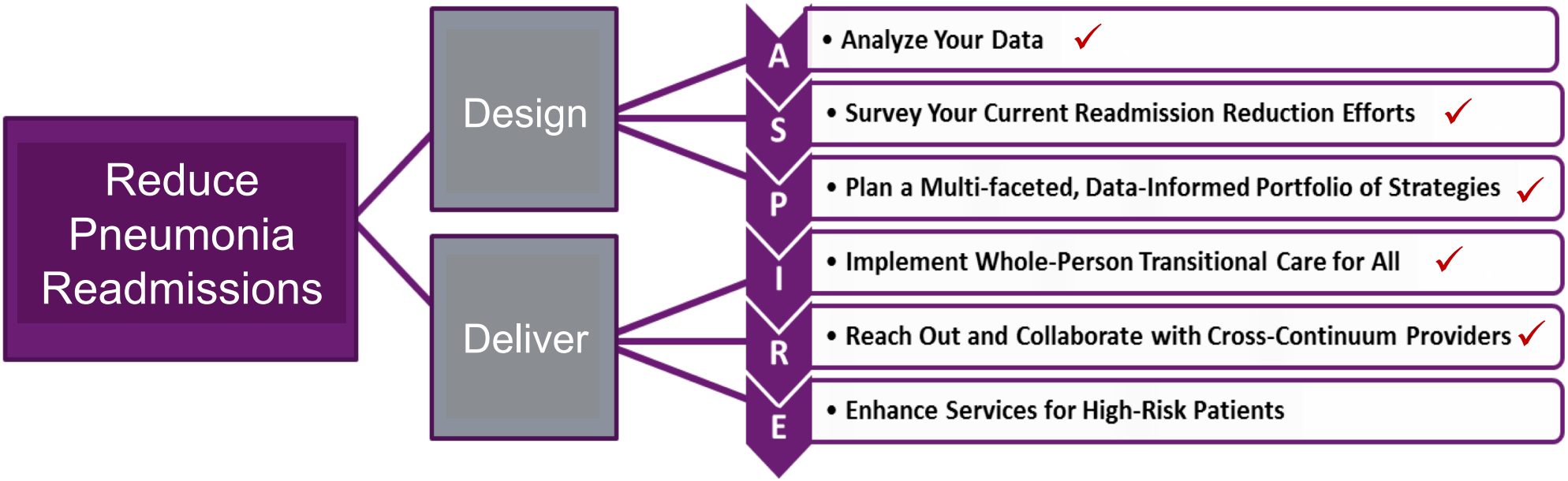
Partnership for Patients — Proud to be Partners in Better Care at Lower Costs. · vizient™ · SCHA South Carolina Hospital Association

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 8, 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 Today

- Identify providers and agencies who share in the care of your high risk pneumonia patients
- Develop working relationships to build new processes to ensure “definitive, timely linkage” to post-hospital services
- Recognize that ”refer to” is passive and success requires active effort, circle back, continuous refinement

Reducing readmissions is NOT only about high-quality inpatient medical care – it is a cross-continuum, interdisciplinary TEAM sport!

Take a Data-Informed Approach to Design

1. What is our aim?
2. What does our data and root cause analysis show?
3. Who should we focus on (specific target population)?
4. What should we do to achieve our aim (actions to address data/root causes)?

Aim
- Reduce PNA readmissions by 10% by year-end 2018, from 20% to 18%

Data
- Data: Post-acute care, behavioral health comorbidities, end of life
- RCA: Difficulty navigating, lack of transportation, unclear goals of care

Target
- All PNA patients discharged to SNF
- All PNA patients screening + on palliative care screen

Act
- "Circle Back" for all PNA-SNF transitions and weekly co-management rounds
- Screen all PNA patients with pall care tool and obtain pall care consults for + screens

Your Patients, Their Needs, Your Readmissions

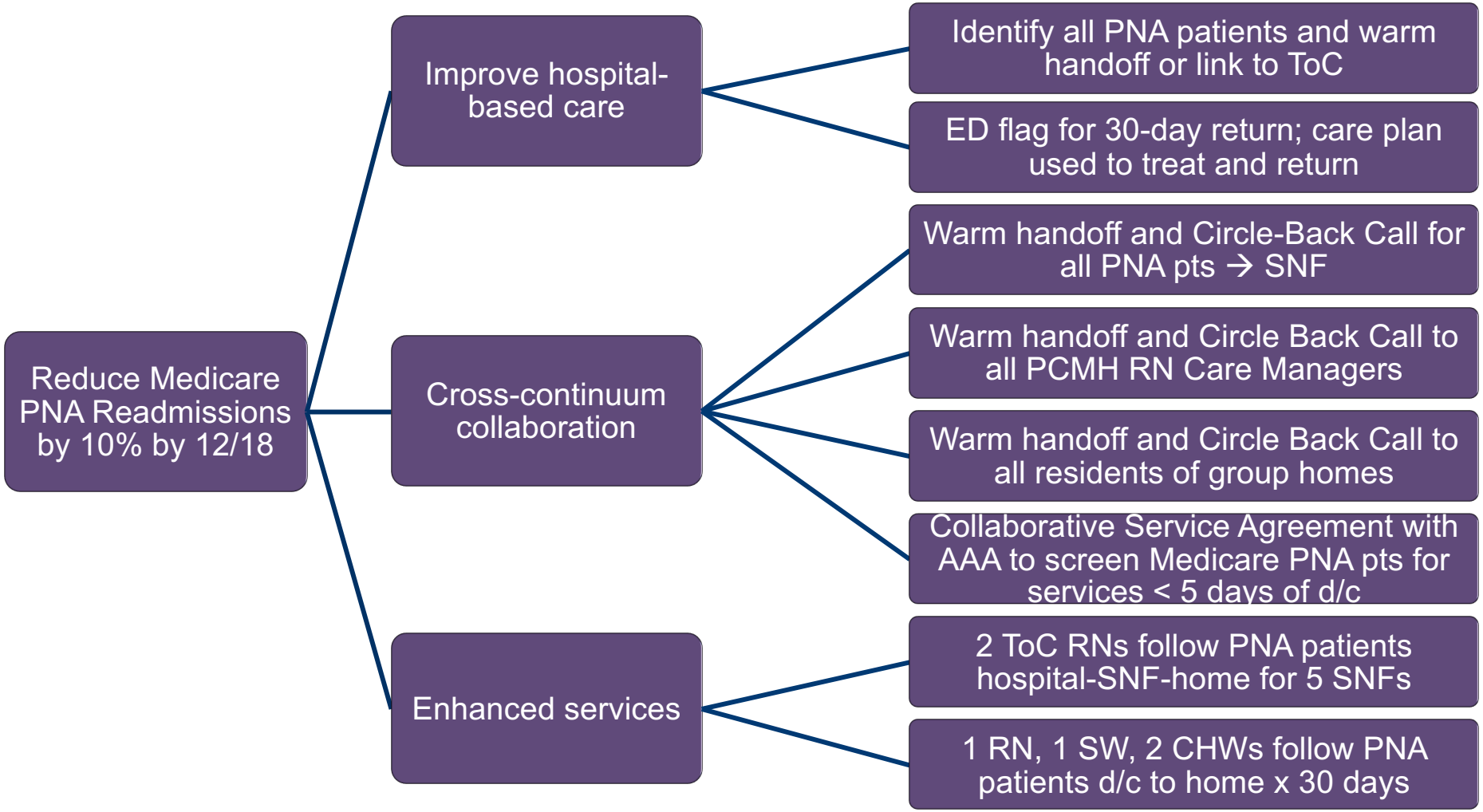
1. Which PNA patients do you consider "high risk" of readmission?
   - *not LACE…if you don't know why, ask me]*
   - *Dementia, aspiration, PAC discharge, lack care partner, BH comorbidity, etc*

2. What needs or challenges place them at high risk of readmission?
   - *not non-adherence…what is the need or root cause of what you are thinking*
   - *SNF patients not usually non-adherent, so what is their reason for readmit?*

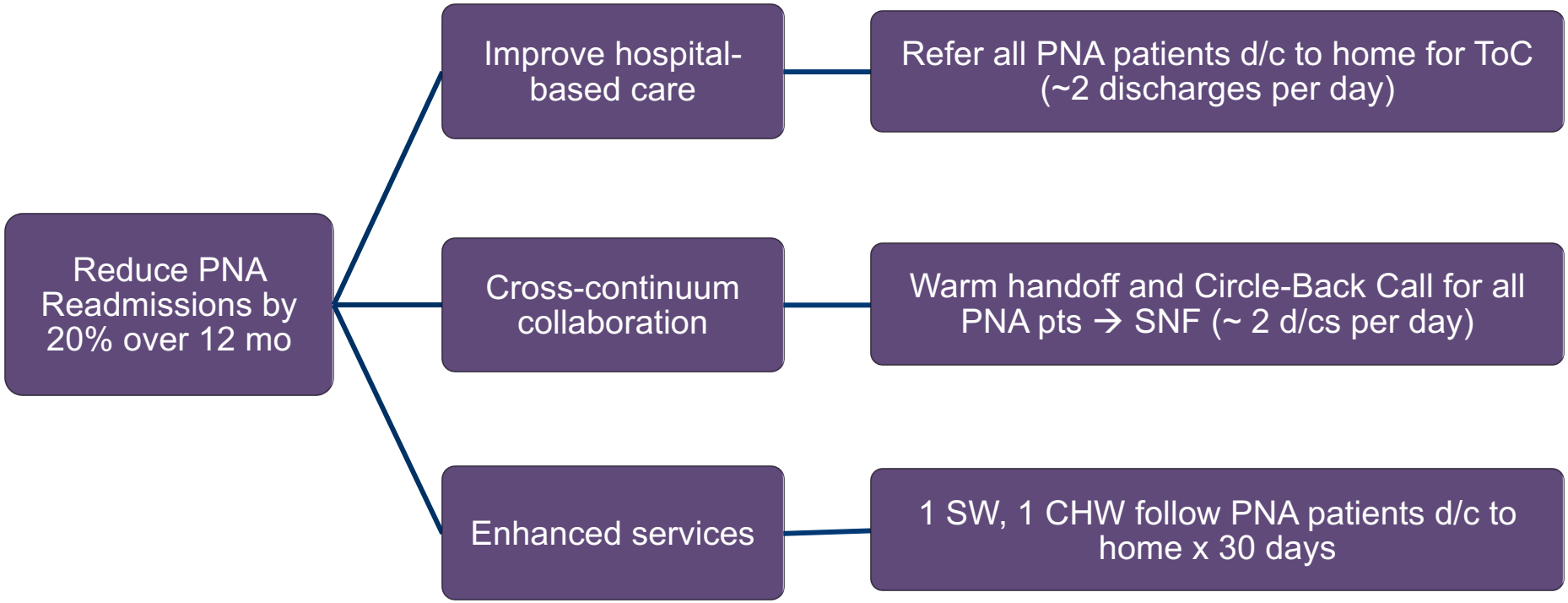
3. What services would they need post-discharge to address those needs?
   - *what would your PNA patient need to address the root cause?*
   - *what would you do if you were financially accountable for outcomes?*

4. Who could address those needs or how can you get those needs met?
   - *Have you met with providers/agencies outside of your hospital or system?*
   - *Adult day, PCMH care managers, CCNC, AAA, CHWs, peers, plans, etc.*

Reducing PNA Readmissions Strategy - Example 1



Reducing PNA Readmissions Strategy - Example 2



COLLABORATE ACROSS SETTINGS

Not just a handoff; a purposeful, measured, managed collaboration

Cross-Continuum Collaboration: Whose Job is It?

- It's the hospital's job!
- CMS policies signal that hospitals are expected to lead delivery system transformation to more effectively deliver care across settings
- Hospitals that do reach out to post-acute and community based providers and agencies find those partners are very receptive

"We would be thrilled if someone from the hospital called us"

Practice #1: Warm Handoffs with "Circle Back" Call

An effective, best practice I learned from NC 8 years ago that has spread nationally!

SNF Circle Back Questions (Hospital calls back SNF 3-24h after d/c):

- ✓Did the patient arrive safely?
- ✓Did you find admission packet in order?
- ✓Were the medication orders correct?
- ✓Does the patient's presentation reflect the information you received?
- ✓Is patient and/or family satisfied with the transition?
- ✓***Have we provided you everything you need to provide excellent care to the patient?***

Key Lessons:

- Transitions are a ***process*** (forms are useful, but need intent)
- Best done ***iteratively with communication***

Source: Emily Skinner, Carolinas Healthcare System

Circle Back: "Ideas that Work"

Implementation Example: A webinar in VA stimulated successful test of change!

"6 simple questions are making a difference in the Richmond community"

https://www.youtube.com/watch?v=SG28aJhs63s

"Anytime I discover an issue, I always follow up. When I started making the calls, I found issues 26% of the time; last month I only had issues 8% of the time"

- Hospital-based Transition of Care RN

Practice #2. “Warm Follow Up”

“***Warm follow-up***” – check in call after transfer to SNF

Process with SNFs:

- ***Support staff*** facilitated logistics (patient lists, meeting time, etc)
- Telephonic ***“card flipping”*** between ACO team & SNF

Key lessons:

- ***Took a while*** to develop collaborative rapport v. “in-charge”
- ***No substitute*** for verbal communication and problem solving

Practice #3: Co-Management Over Time

Example of what we do when we are accountable for outcomes

- ***Dedicated Team***: A Point Person
  - ACO or Bundle clinical ***coordinator***

- ***Co-Management:*** Physical or Virtual Rounds in SNF
  - RN / NP to see patient, discuss plan with SNF staff
  - Respond to changes in clinical status to ***manage in setting***
  - Weekly telephonic rounds ACO/bundle coordinator and SNF
  - LOS, progress toward discharge goals, transitional care planning
  - Tele-medicine consults in SNF to manage on-site

- ***Direct admit back*** to SNF from home

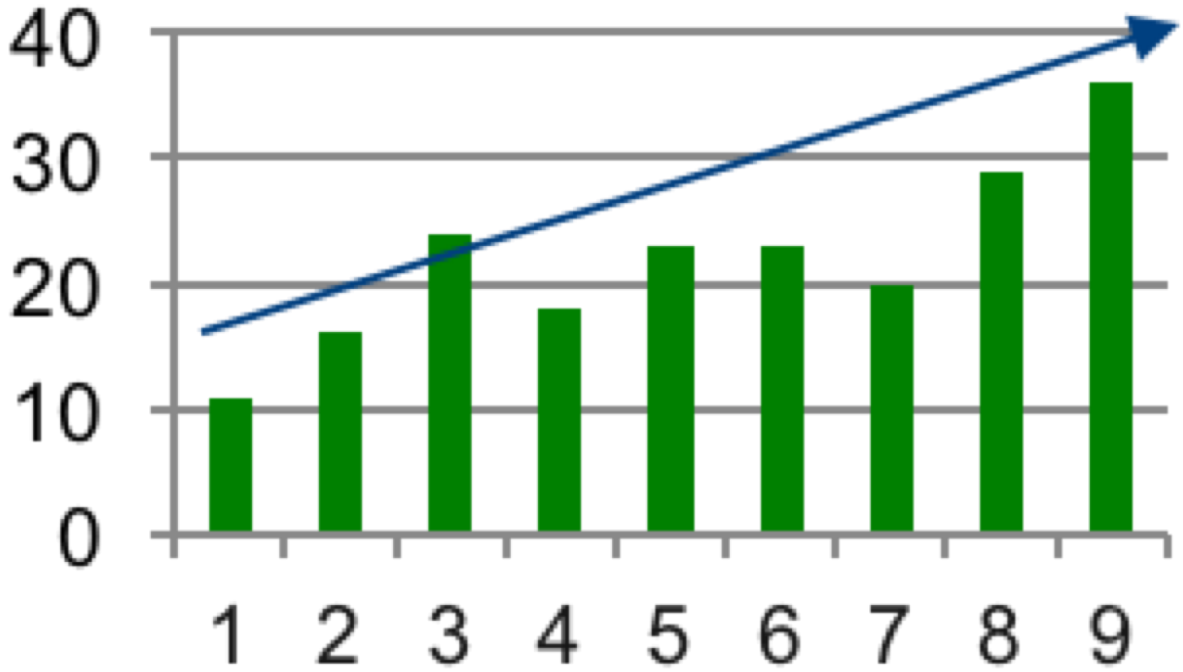
Practice #3: Co-manage Across the Continuum

- Transitional care staff (RN, SW, CHW, etc) follow patients for 30 days post discharge; this includes patients who are in SNF or receiving home care
- Hospital-based transitional care staff (readmission, bundle, ACO) track which patients are discharged to which PAC
- Hospital-based transitional care staff “round” (see patients, talk with SNF staff, families) in person at facilities
- Hospital-based transitional care staff “case conference” with SNF-based staff via phone

Practice #4. ED Treat-and-Return

- Data & Root Causes:
  - “Why are almost all SNF patients admitted?”
  - “Patients only seen once a month”; “they can’t do IVs”, etc
  - “If they send them here they can’t take care of them”
- Actions:
  - Asked ED providers to consider returning patient to SNF
  - Education: posted INTERACT SNF capacity sheets in ED
  - Simplicity: establish contacts, standard transfer information
  - Reinforce: Thanked providers when ED-SNF return occurred
- Results: Increased number of patients returned to SNF after ED evaluation

ED Treat-and-Return



Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA

New Frontier of Collaboration: the ED

1. Create a 30-day return **flag** on the ED Tracker Board
2. Use the 30-day return flag to **notify** the high risk care team
3. Use ***ED care alerts*** to inform treating providers; connect with care team
4. Develop ***"treat and return"*** pathways

"In previous times, the path would've been to simply admit the patient, and we'll sort it out later. We're becoming more accustomed to working in ER to help discharge patients from the ED. That's a culture change."

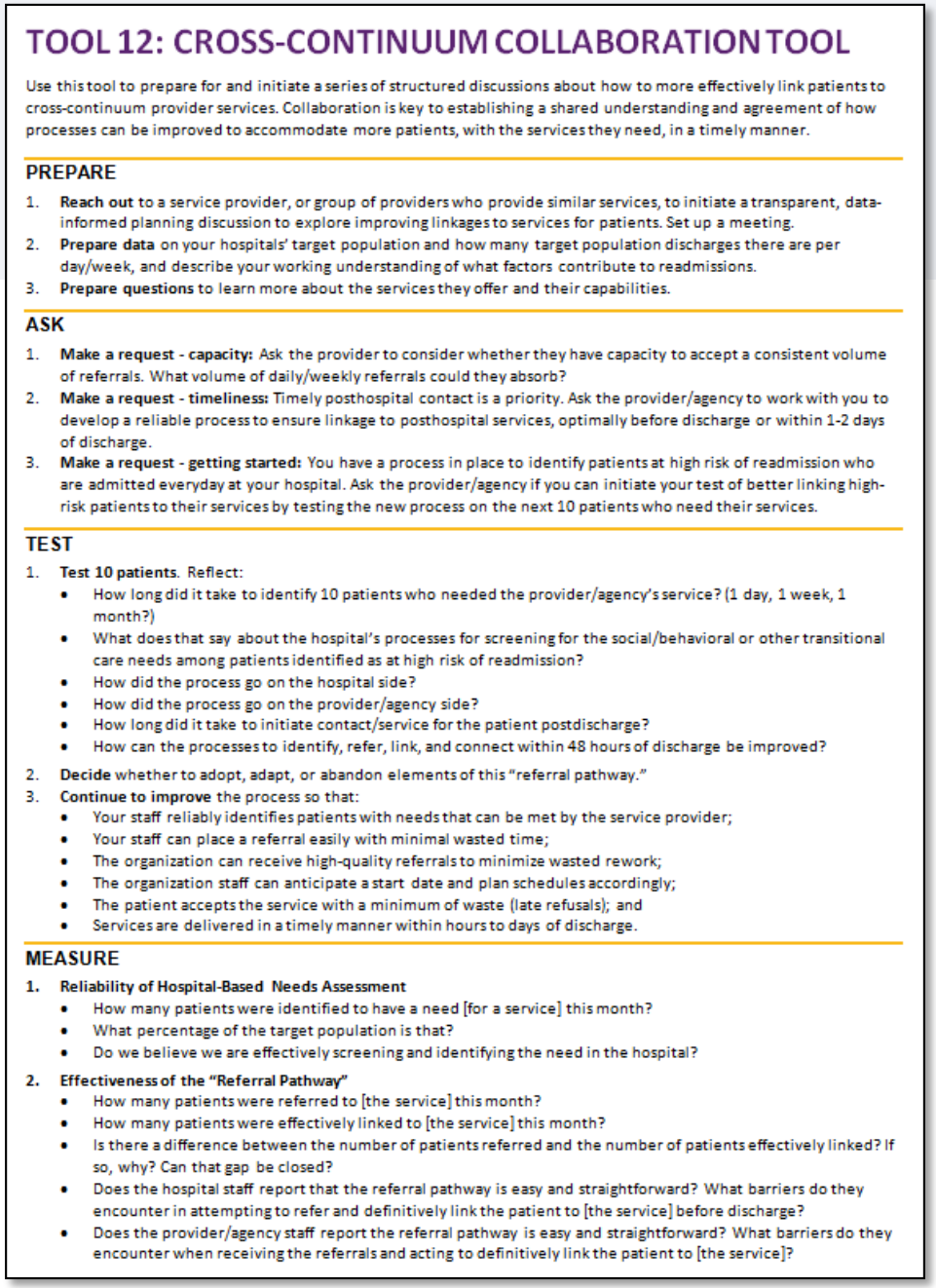
Cross-Continuum Collaboration

1. Do you have a working relationship with a point person at a key set of providers/agencies who serve your high risk PNA patients?
2. Do you meet regularly with providers/agencies who serve your high risk PNA patients?
3. Do you review data together?
4. Do you review root causes of readmissions together?
5. Have you identified opportunities to jointly improve care for shared patients?

Cross Continuum Collaboration – Getting Started

If you are just getting started:

- Hold regularly scheduled monthly meetings
- Start with a “coalition of the willing” – doesn’t need to be perfect
- Invite new partners/ agencies as you learn about them
- Allow 3-4 months for the group to gel
- Start with common agenda items:
  - Readmission data
  - Readmitted patient stories
  - Readmission stories from “receiver” perspective
  - Handoff communication
  - What information do “receivers” need that they frequently don’t have?



TOOL 12: CROSS-CONTINUUM COLLABORATION TOOL

Use this tool to prepare for and initiate a series of structured discussions about how to more effectively link patients to cross-continuum provider services. Collaboration is key to establishing a shared understanding and agreement of how processes can be improved to accommodate more patients, with the services they need, in a timely manner.

PREPARE

1. **Reach out** to a service provider, or group of providers who provide similar services, to initiate a transparent, data-informed planning discussion to explore improving linkages to services for patients. Set up a meeting.
2. **Prepare data** on your hospitals' target population and how many target population discharges there are per day/week, and describe your working understanding of what factors contribute to readmissions.
3. **Prepare questions** to learn more about the services they offer and their capabilities.

ASK

1. **Make a request - capacity:** Ask the provider to consider whether they have capacity to accept a consistent volume of referrals. What volume of daily/weekly referrals could they absorb?
2. **Make a request - timeliness:** Timely posthospital contact is a priority. Ask the provider/agency to work with you to develop a reliable process to ensure linkage to posthospital services, optimally before discharge or within 1-2 days of discharge.
3. **Make a request - getting started:** You have a process in place to identify patients at high risk of readmission who are admitted everyday at your hospital. Ask the provider/agency if you can initiate your test of better linking high-risk patients to their services by testing the new process on the next 10 patients who need their services.

TEST

1. **Test 10 patients**. Reflect:
   - How long did it take to identify 10 patients who needed the provider/agency's service? (1 day, 1 week, 1 month?)
   - What does that say about the hospital's processes for screening for the social/behavioral or other transitional care needs among patients identified as at high risk of readmission?
   - How did the process go on the hospital side?
   - How did the process go on the provider/agency side?
   - How long did it take to initiate contact/service for the patient postdischarge?
   - How can the processes to identify, refer, link, and connect within 48 hours of discharge be improved?
2. **Decide** whether to adopt, adapt, or abandon elements of this "referral pathway."
3. **Continue to improve** the process so that:
   - Your staff reliably identifies patients with needs that can be met by the service provider;
   - Your staff can place a referral easily with minimal wasted time;
   - The organization can receive high-quality referrals to minimize wasted rework;
   - The organization staff can anticipate a start date and plan schedules accordingly;
   - The patient accepts the service with a minimum of waste (late refusals); and
   - Services are delivered in a timely manner within hours to days of discharge.

MEASURE

1. **Reliability of Hospital-Based Needs Assessment**
   - How many patients were identified to have a need [for a service] this month?
   - What percentage of the target population is that?
   - Do we believe we are effectively screening and identifying the need in the hospital?
2. **Effectiveness of the "Referral Pathway"**
   - How many patients were referred to [the service] this month?
   - How many patients were effectively linked to [the service] this month?
   - Is there a difference between the number of patients referred and the number of patients effectively linked? If so, why? Can that gap be closed?
   - Does the hospital staff report that the referral pathway is easy and straightforward? What barriers do they encounter in attempting to refer and definitively link the patient to [the service] before discharge?
   - Does the provider/agency staff report the referral pathway is easy and straightforward? What barriers do they encounter when receiving the referrals and acting to definitively link the patient to [the service]?

ASPIRE Tool 12

Use this tool to link to service/agency:

- Prepare
- Ask
- Test
- Measure

Once to establish a relationship, with a shared aim, don't waste valuable time in months of planning meetings!

Build the new process as you go! Start sending your next 10 (eligible) PNA patients, learn, discuss, adapt.

Recommendation

Strengthen your Cross-Continuum Partnerships as a Summer Priority

1. Do you have a working relationship with a point person at a key set of providers/agencies who serve your high risk patients?
2. Do you meet regularly with providers/agencies who serve your high risk patients?
3. Do you review data together?
4. Do you review root causes of readmissions together?
5. Have you identified opportunities to improve care for shared patients?
6. Can you test linking the next 10 patients who need post discharge support to a new provider/agency partner?

Thank you for your commitment to reducing readmissions

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Advisor, NCHA Pneumonia Knockout Campaign
Co-Developer AHRQ "ASPIRE" Guide to Reducing Readmissions
Amy@CollaborativeHealthcareStrategies.com
617-710-5785

Contact Us

Karen Southard, RN, MHA

Vice President, Quality and Clinical Performance

ksouthard@ncha.org

Trish Vandersea, MPA

Program Director

tvandersea@ncha.org