



ASPIRE to Knockout Pneumonia Readmissions

Knockout Pneumonia Readmissions Workshop
November 2, 2018



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



COLLABORATIVE
HEALTHCARE STRATEGIES

Working Session Agenda

- Welcome
 - Objectives, structure of day
 - Your burning issues
- Knocking out readmissions is possible!
 - Examples from ASPIRE implementation sites
- 8-part working session
 - Motivation, goals
 - Data
 - Target pop
 - Root causes
 - Interventions
 - Implementation
 - Operational dashboard
 - Measurement
- Action plan development, report out



Structure of the Workshop

- Facilitated, interactive discussion
- Ground rules
 - *Our time is precious; we are here to do important work today*
 - *Be present and participate*
 - *Please step out of the room to email or text*
 - *We are here to generate concrete meaningful next steps*
 - *We will focus on what we can do, rather than what we can't do*



YOUR BURNING ISSUES

What would you like to discuss/address today?



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WHAT WORKS

Success is possible!



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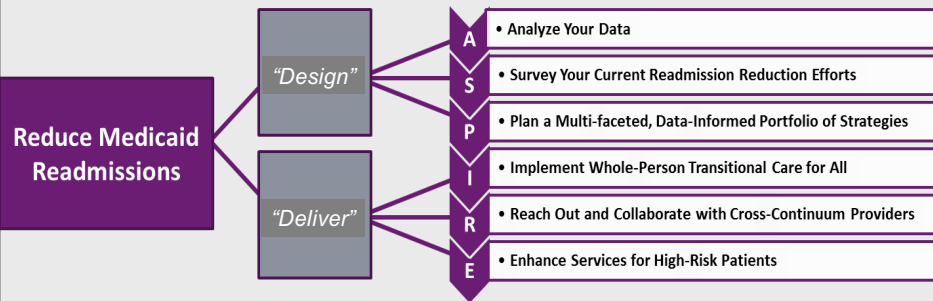


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ASPIRE +

Design and Execution → Results

Design Elements



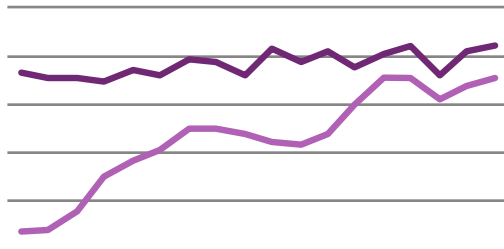
Implementation Elements

- 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

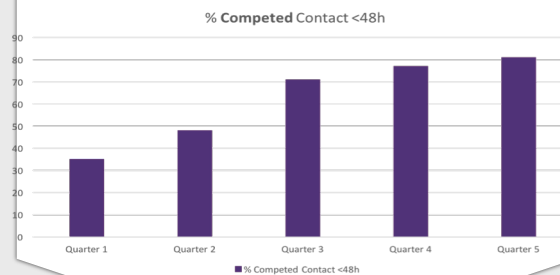
Only Execution Drives Results

Close the Gap



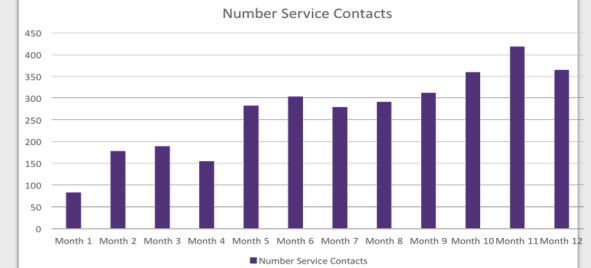
**Patients “Served” vs. Total
Target Population**

Drive Up Completion



**Attempts Don't Count in
Readmissions!**

Increase Contacts



**Drive Up Patient-Facing
Contacts with Same FTEs**

Bay Area Readmission Reduction Collaborative

<https://www.youtube.com/watch?v=ftAzr3aXyQM>



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“Circle Back” call with SNFs

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



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“Coaching” - Mrs. MacDonald

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



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“Interdisciplinary Transitional Care” – Mr. Anderson

<https://www.youtube.com/watch?v=QfKgsfgXkik>



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“MVP Care” – Mr. Eison

<https://www.youtube.com/watch?v=t80ikD-UG94>



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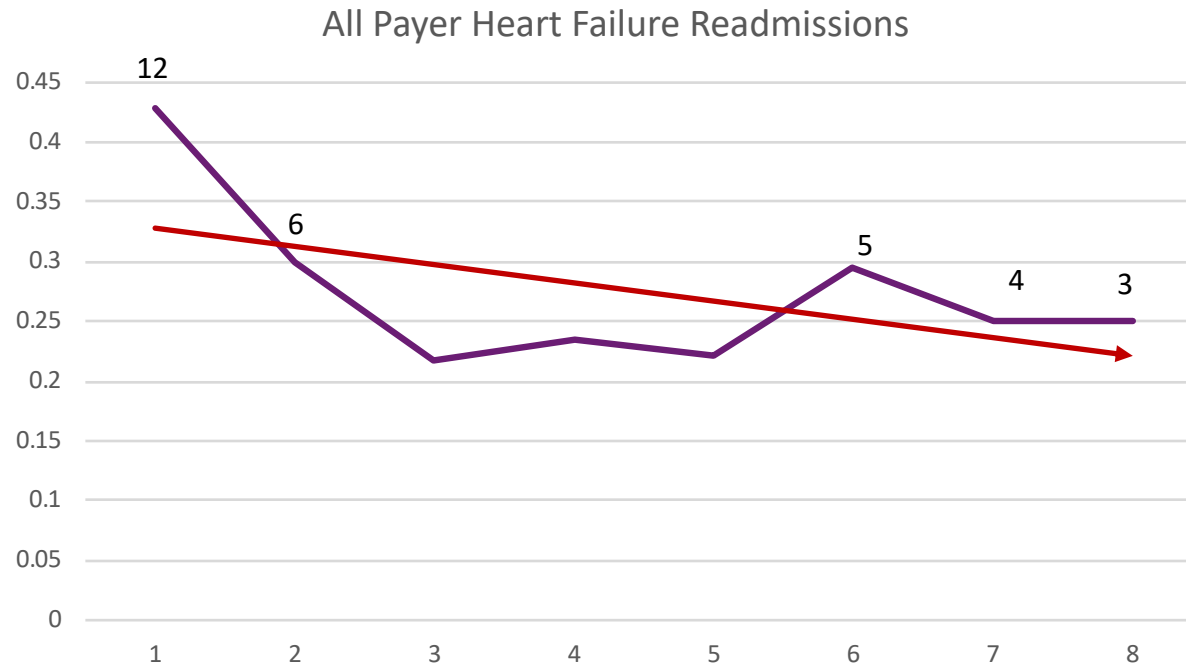
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Hospitals with Hospital-Wide Results

- 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*



Rural Hospital: All Payer Heart Failure



- ED CM flags all HF admits
- List to HF ToC RN
- 1-2 new patients / day
- Brief visit in-hospital
- Phone calls x 30 days
- Transportation
- Medication – affordability
- Care seeking patterns

Team:

- ED CM, 1 RN
- Finance/ Quality Analyst

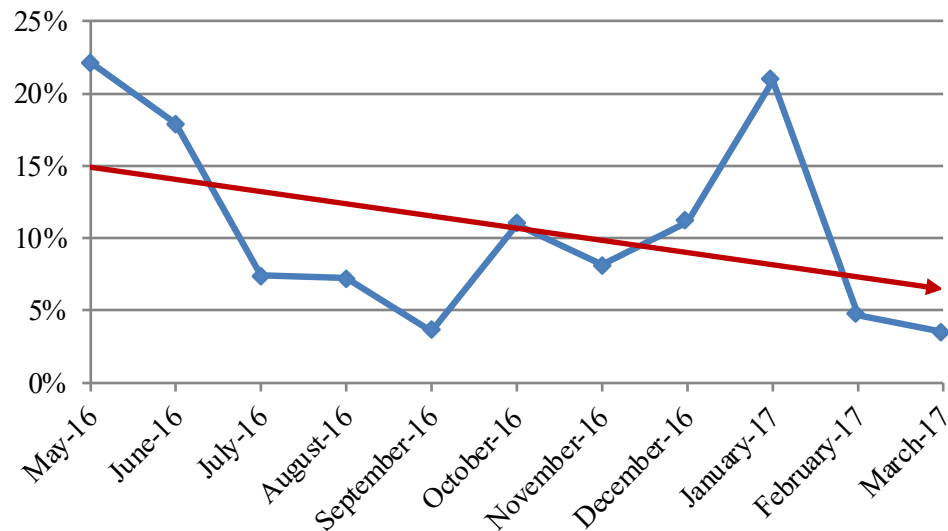


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Rural Hospital, Broad High Risk: All cardiac, pulmonary, BH

Readmission Rate



Team:

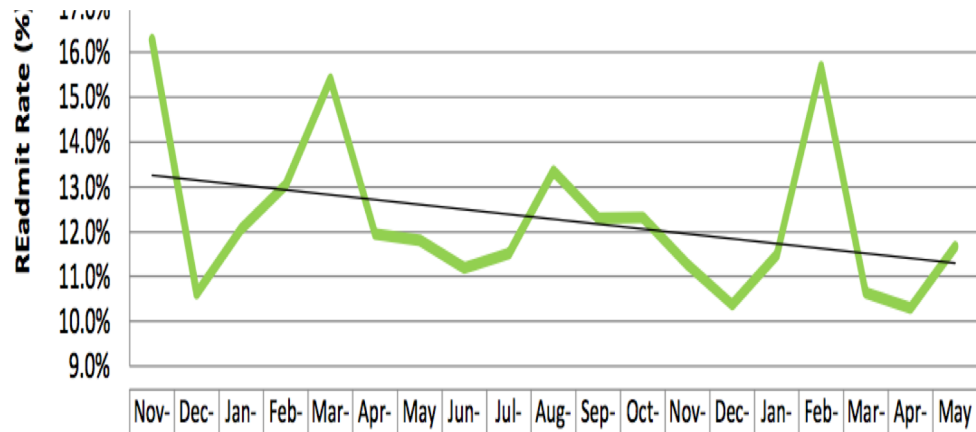
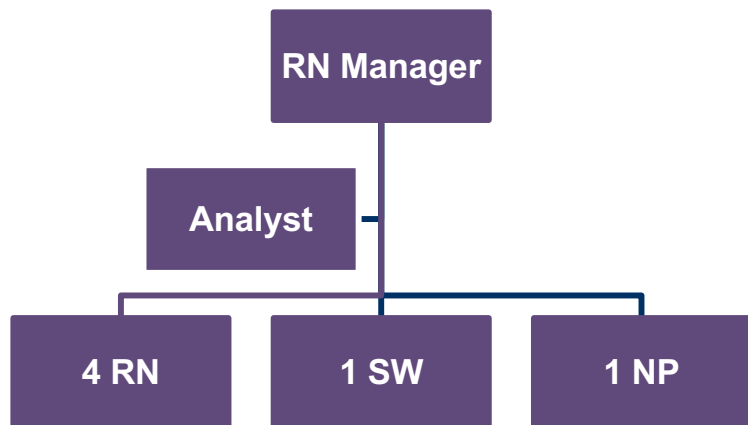
- 1 RN, 1 SW
- 56% reduction in readmissions

- Daily review of inpatient census
- High risk: all cardiac, pulmonary or behavioral health condition
- ~50% of inpatients “high risk”
- Only 4-6 people per day
- Brief meet & greet in-hospital
- 48h follow up call
- Home visit “just to see if we can help with anything you might need”
- SW and RN did visit together
- Identified needs, mobilized services



Population Design: All Discharges to Post-Acute Care

Team

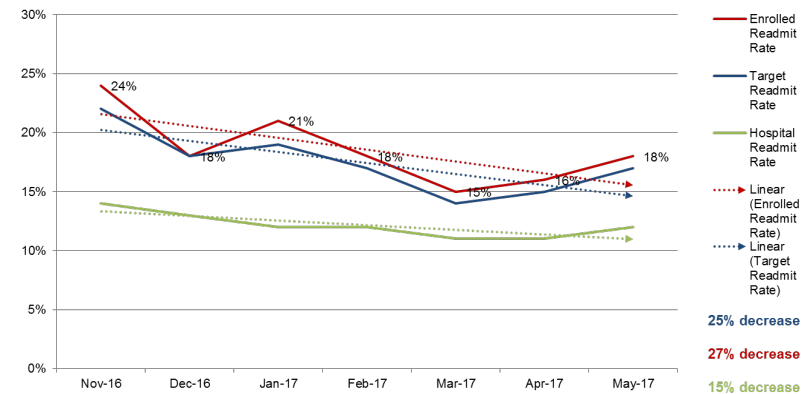
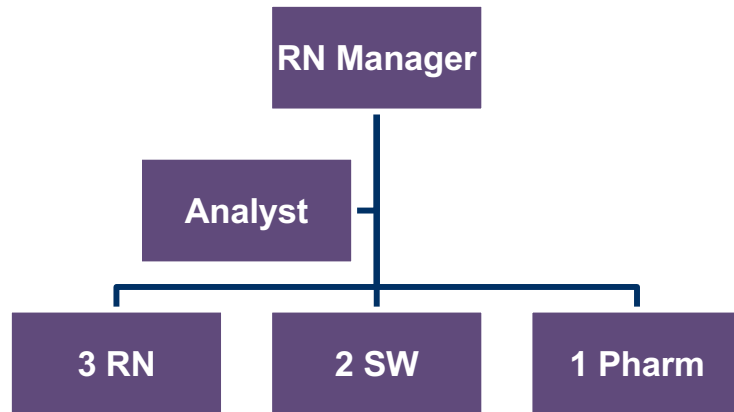


Success factors

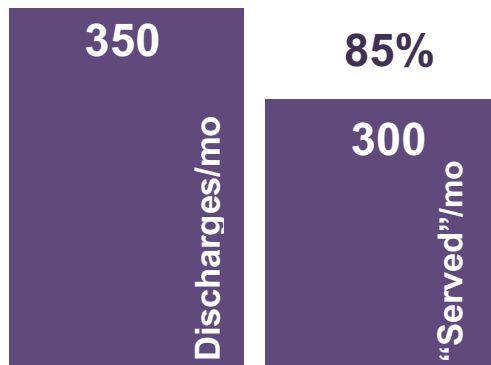
- ✓ Building relationships with SNF staff
- ✓ Warm handoff; circle-back
- ✓ SNF co-management
- ✓ Readmission prevention plans



Hospital-Wide Readmission Reduction Design: Targeted Highest Risk All Medicaid, Medicare <65, Behavioral Health



Volume (discharges, patients)



Success factors

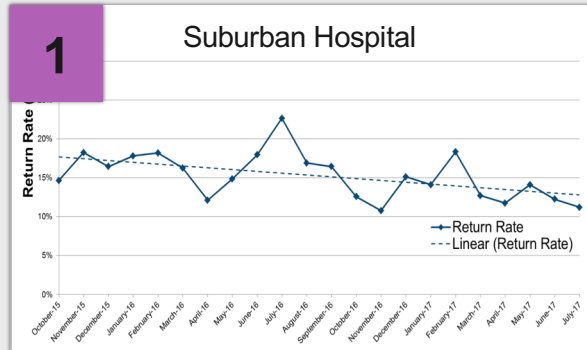
- ✓ **Year 1 no progress; took time to learn**
- ✓ **Effective engagement, timely contact**
- ✓ **ED Care Plans with cross agency input**
- ✓ **Home visits**

Key Actions

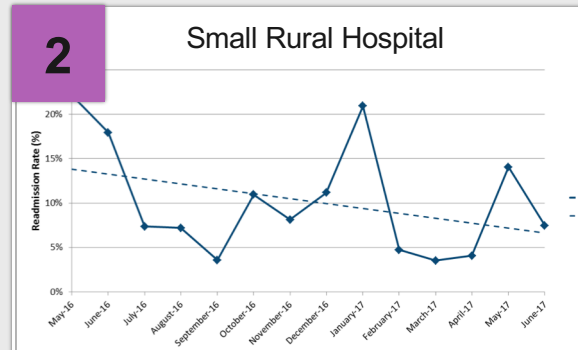
1. *Know your data*
2. *Understand* root causes
3. *Develop* a portfolio of strategies
4. *Improve* hospital-based transitional care for all
5. *Collaborate* with cross setting providers & payers
6. *Provide* enhanced services for high risk patients
7. *Track* implementation to *drive* key processes



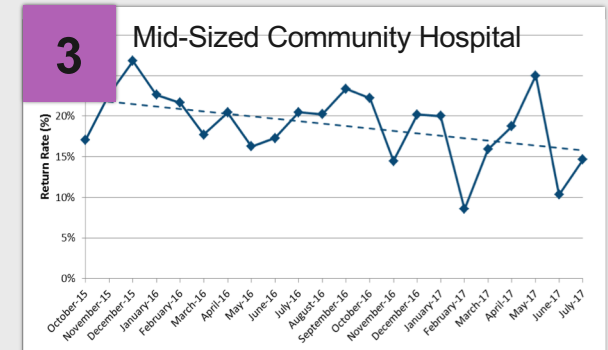
ASPIRE +



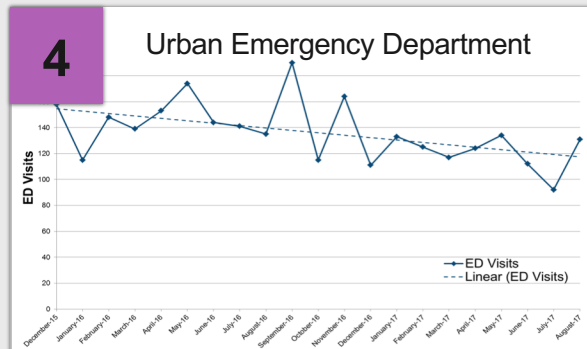
"Return" Reduction 27%



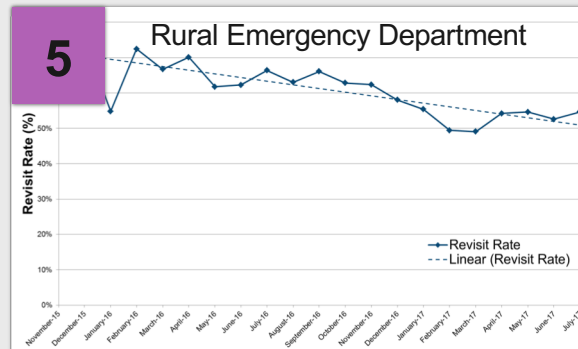
Readmission Reduction 58%



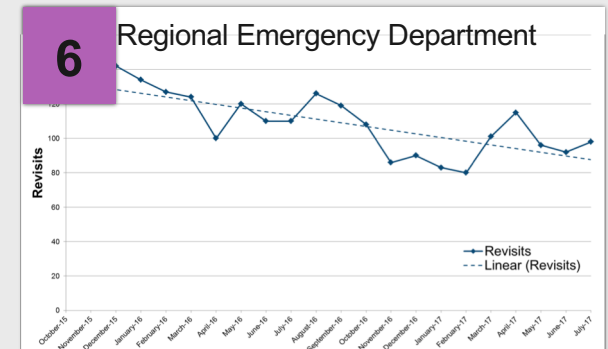
"Return" Reduction 29%



ED HU Visit Reduction 24%



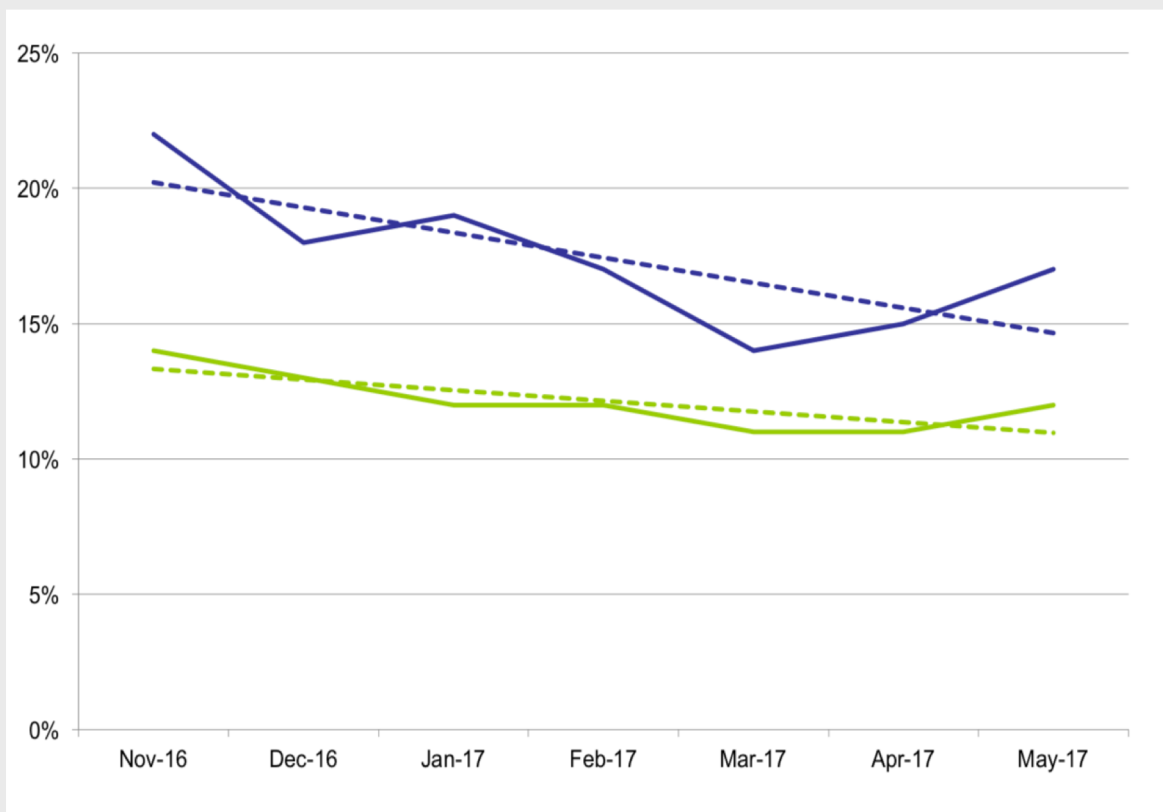
ED HU Revisit Reduction 27%



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

BUILDING A SUCCESSFUL PROGRAM

8-part working session



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Reducing Readmissions Workshop

Design and Deliver Whole-Person Transitional Care

To Design and Deliver a Successful Readmission Reduction Program:

1. Motivation, goal (why are we doing this and what is success?)
2. Data (what are the patterns of readmissions at our hospital?)
3. Target Population (how will we focus our efforts?)
4. Root Causes (why do our target population patients return?)
5. Interventions (what will we do to address root causes?):
6. Implementation (how will we deliver those interventions?):
7. Operational Dashboard (how consistently are we delivering?):
8. Measurement (what is the impact on readmissions?)



1. Motivation, Goal

Why are we doing this and what is success?

Why are you (your organization) working to reduce readmissions?

What is your readmission reduction goal? (fill in elements of goal, below)

- What?
- For whom?
- By how much?
- By when?



2. Data

Who is high risk? and how many high risk patients are there?

EXAMPLE	All	Medicare	Medicaid
Total number of adult, non-OB discharges	1000	500	250
Total number of readmissions	150	80	50
Readmission rate	15%	16%	20%
Readmission rate, d/c to SNF or Home Care	20%		
Readmission rate, d/c to home	12%		
Top diagnoses leading to most readmissions	Sepsis HF COPD	Sepsis HF COPD	Sickle PNA DKA
Total # discharges, target population (HF d/c to home)	50	40	10
Total # readmissions, current target population	10	7	3
Readmission rate, current target population	20%	17.5%	30%



Discharge Diagnoses Leading to Most Readmissions

Medicare	Medicaid	Comm.	Unins.	Total
ARF (1384)	Sickle Cell (478)	Chemo (290)	Pancreatitis (187)	Sepsis (1859)
Sepsis (1366)	Sepsis (175)	CVA (276)	Chemo (157)	ARF (1800)
PNA (1336)	Chemo (175)	Arthritis (260)	DKA (136)	PNA (1750)
COPD (1211)	COPD (173)	Sepsis (222)	CVA (125)	CVA (1622)
CVA (1140)	DKA (156)	PNA (188)	COPD (109)	COPD (1608)
UTI (1038)	PNA (145)	ARF (182)	ARF (97)	UTI (1608)
Afib (851)	ARF (137)	CAD (181)	Sepsis (96)	HF (1115)
HF (822)	HF (129)	Pancreatitis (153)	PNA (81)	CAD (1092)
CAD (746)	Pancreatitis (127)	Afib (152)	ETOH w/d (76)	Afib (1092)

Source: Boutwell in collaboration with South Carolina Hospital Association



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



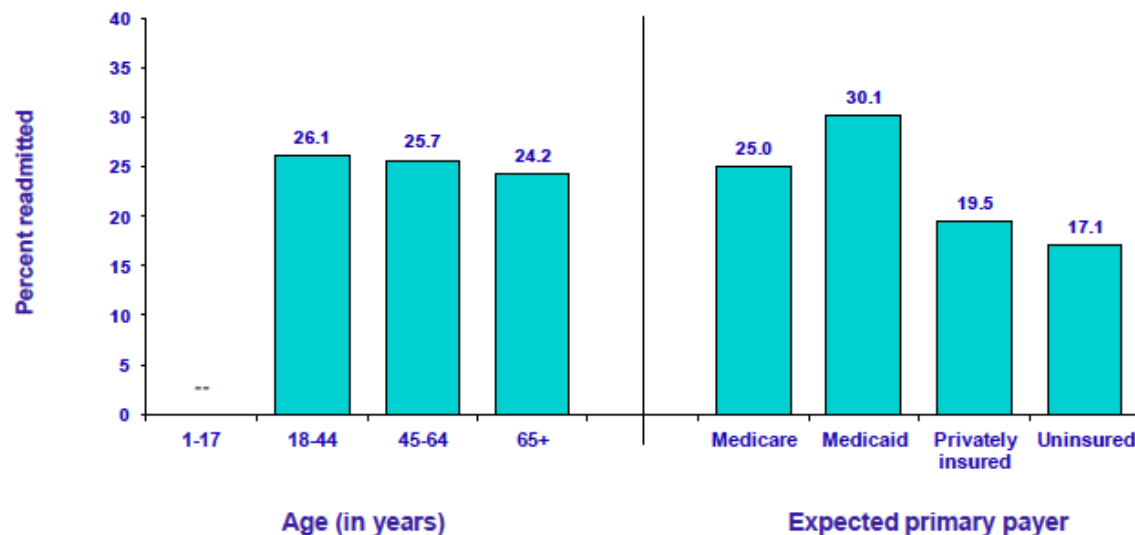
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Readmissions by Age



Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

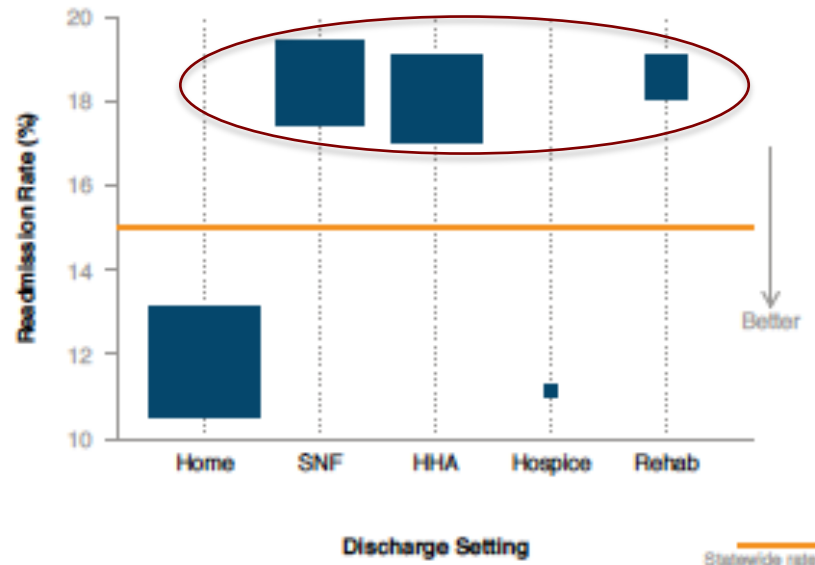
-- Indicates too few cases to report.

Readmissions by Discharge Disposition

3. READMISSIONS BY DISCHARGE SETTING

Figure 3: All-Payer Readmission Rates by Discharge Setting, July 2012 to June 2013

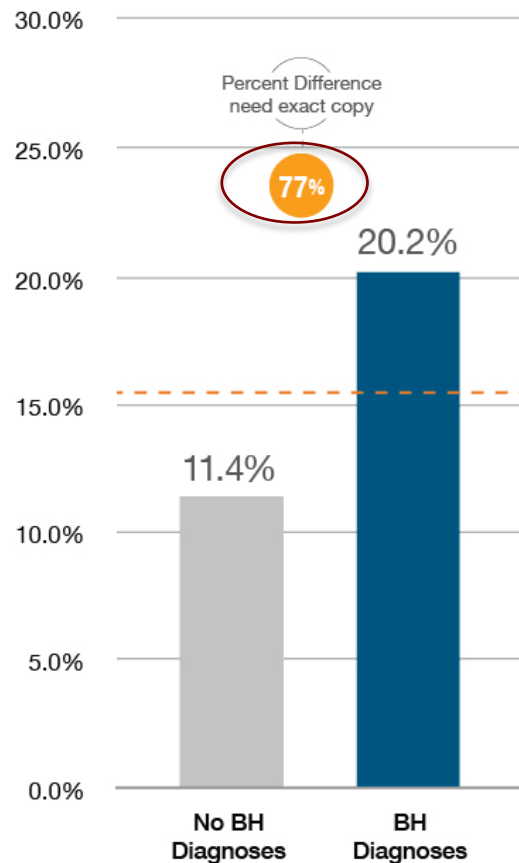
Patients discharged to home (without home health agency care) and hospice have lower readmission rates than those discharged to post-acute care.



Readmission rates among all patients discharged to post-acute care are high

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

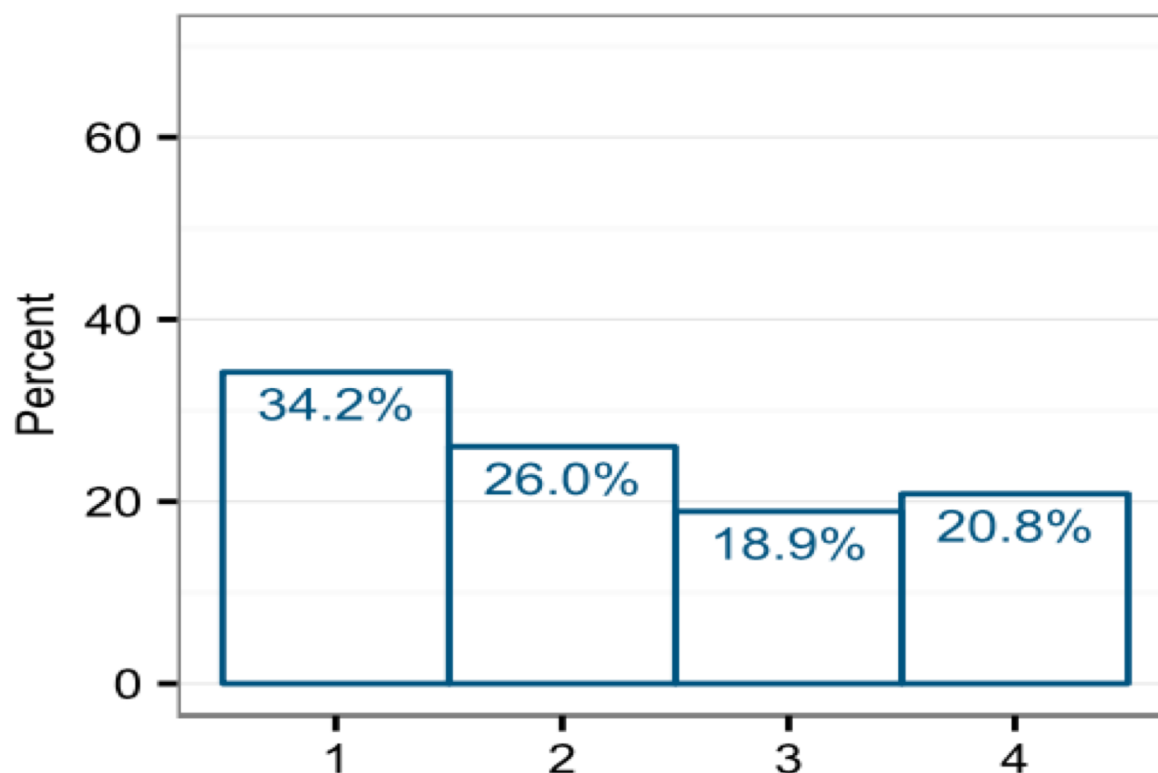
Readmission Rates for People with BH conditions



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

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

Timing of Readmissions



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

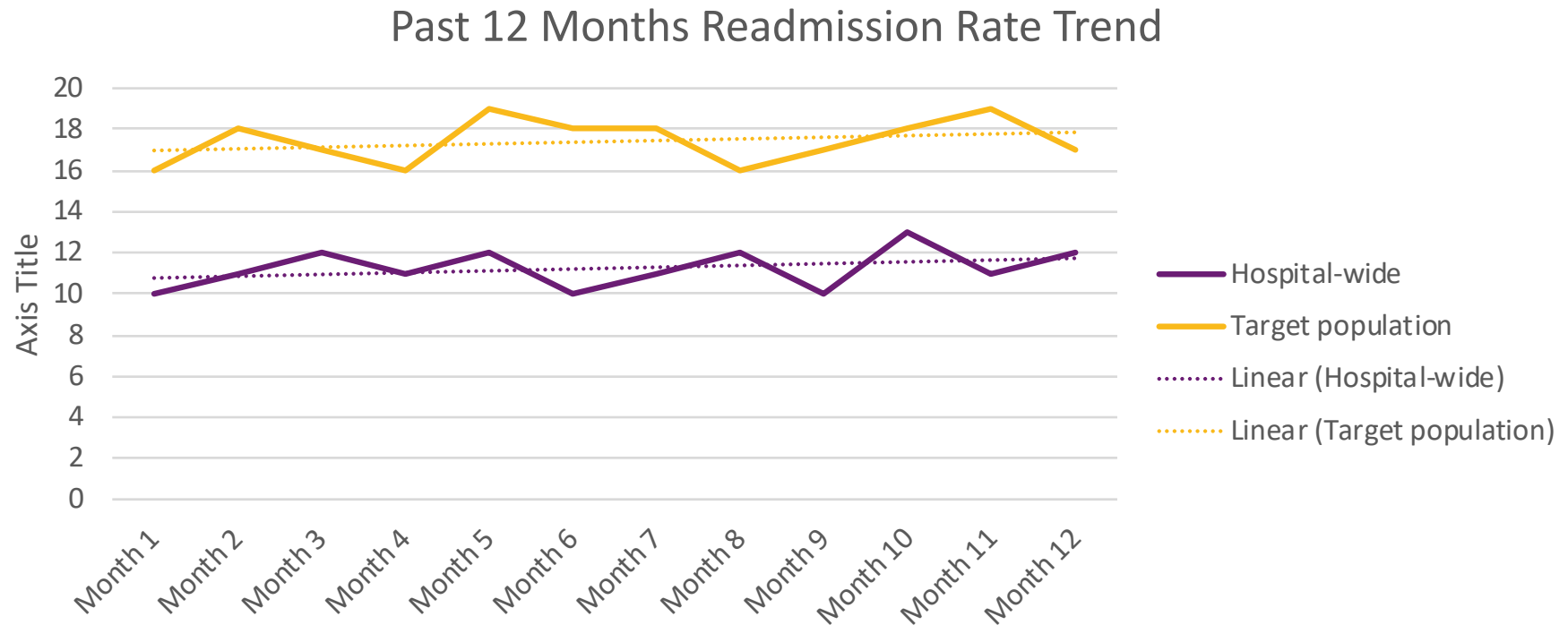


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2. Data

What are our readmission rate trends over time?



- Do you track and trend readmission rates monthly?
- Is the trend getting better? Worse? Same?

3. Target Population

Who are we focusing efforts on and why?

- What is your target population?
- Does your target population align with your goal and your data?
- Can you identify your target population in day to day workflow?
- How many discharges per day are in your target population?
- What is the readmission rate of your target population?
- Is the readmission rate of your target population > the hospital rate?



4. Root causes

Why, why, why, why, why do our patients return to the hospital < 30days?

- What are the root causes of readmissions for your target population?
- How do you identify root causes of readmissions?
- Can you think of a readmitted patient story? What was the root cause? (ask “why” 5 times)



Readmission Interview 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? 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*

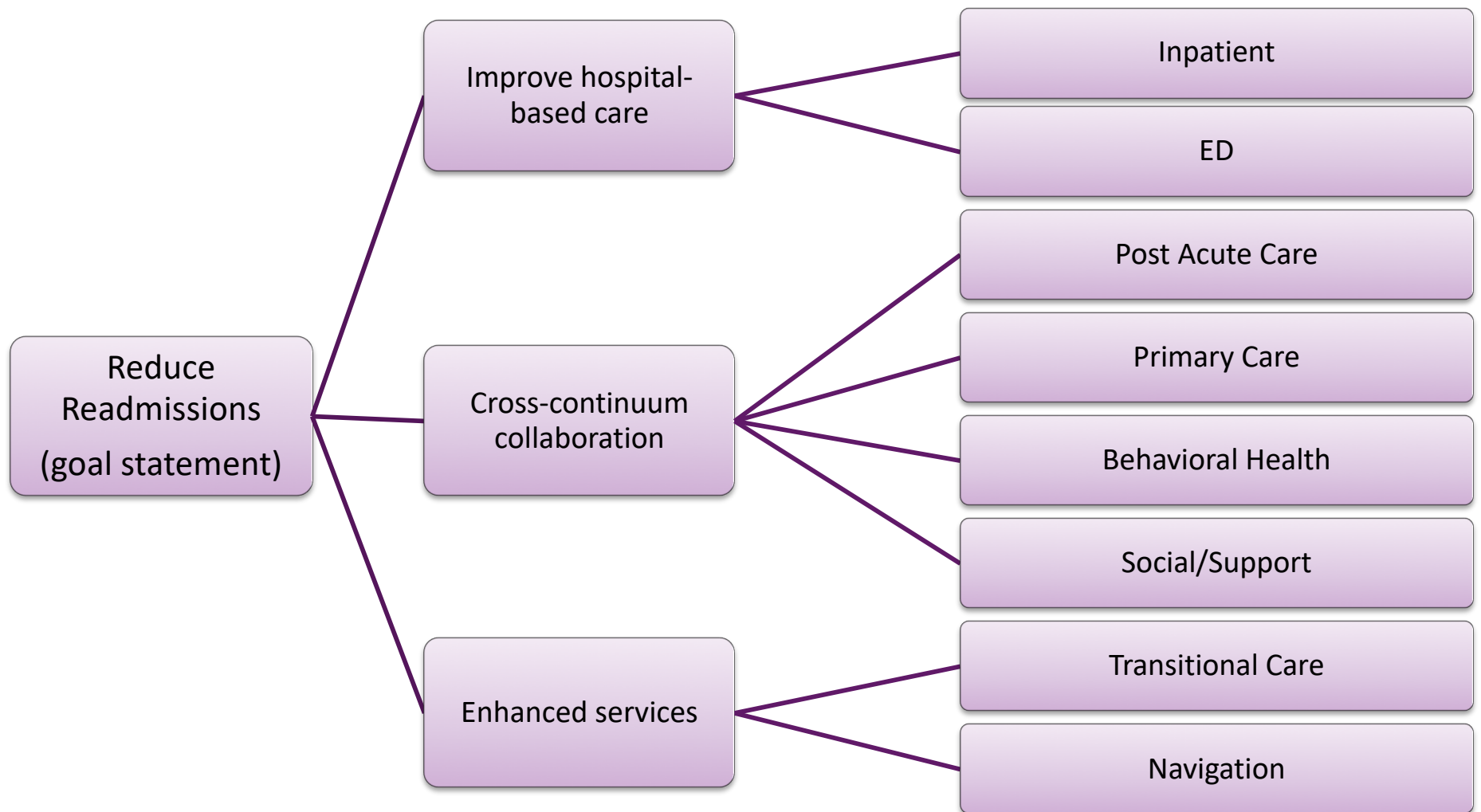


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5. Interventions

What are we doing to reduce readmissions?



5. Interventions

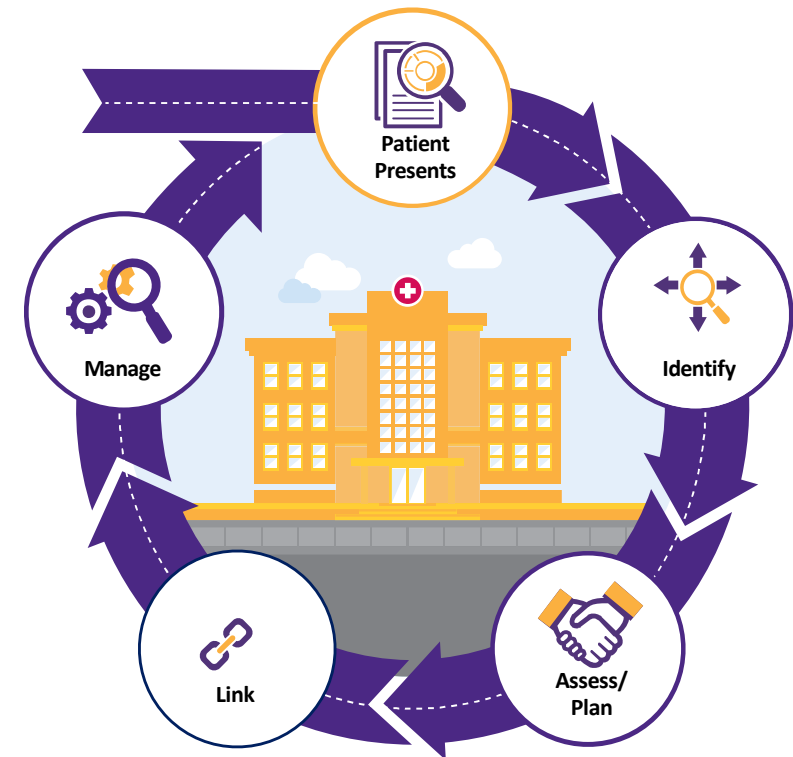
Do our interventions address the root causes of readmissions?

- Do your readmission reduction efforts address root causes of readmissions?
- What do your patients “really need” in order to reduce readmissions?
- How can you adapt your efforts to more effectively address root causes?
- Can you strengthen collaborations with community agencies/payers?



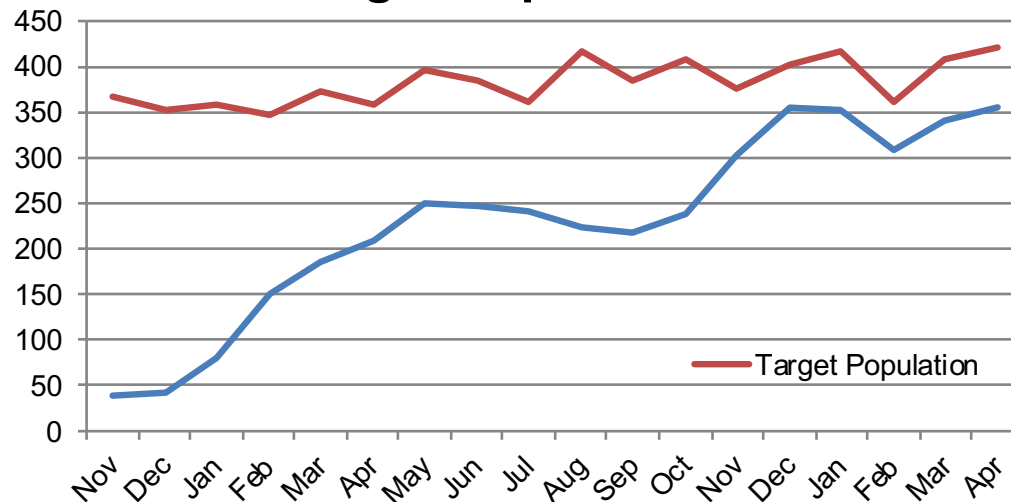
6. Implementation

How do we deliver the services we intend to deliver? Who does what, when?



Percent of Target Population Patients Served

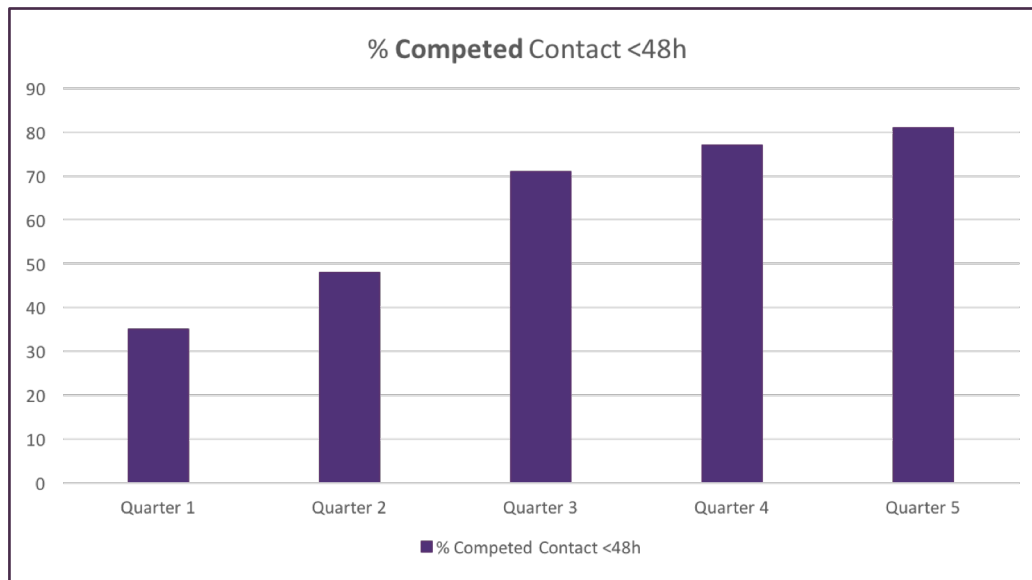
Target Population Served vs Total Target Population



Key lessons:

- Reliably identify target pop
- Face to face in-hospital
- Opt-out approach
- Continuation of your care
- Avoid “special program”

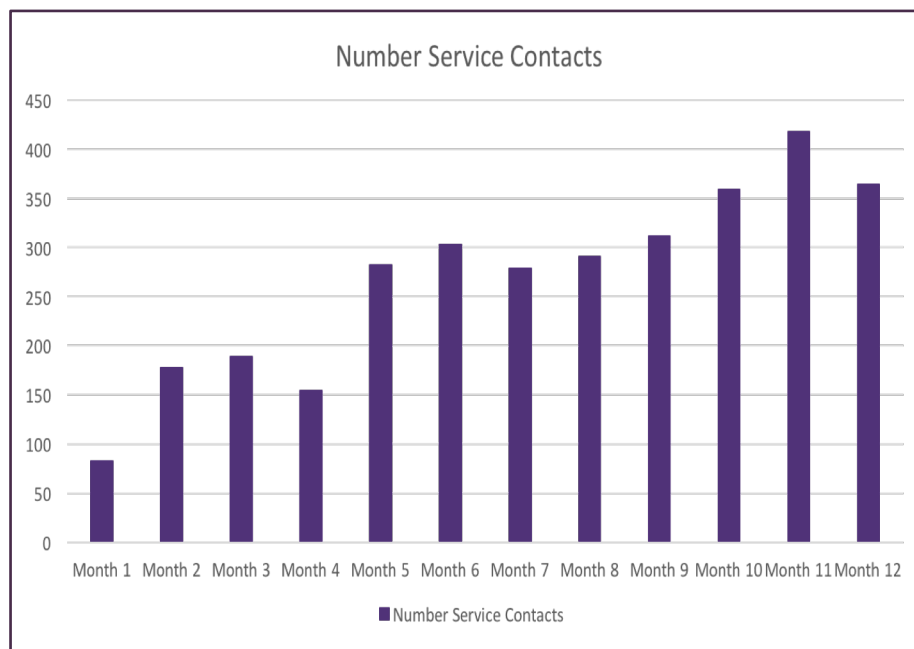
Timely Contact Post-Discharge



Key lessons:

- “It’s my job to check on you once you go home”
- Use texting
- Any relevant contact
- Call their cell prior to discharge to confirm #

Intensify Patient-Facing Service Delivery: Work Smarter



Key lessons:

- Brief in-hospital visit
- Prioritize community visits
- Batch SNF visits
- Batch home visits
- Batch documentation

7. Operational Dashboard

How consistently do we deliver what we intend to deliver?

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

Use implementation data to increase the % completed service delivery

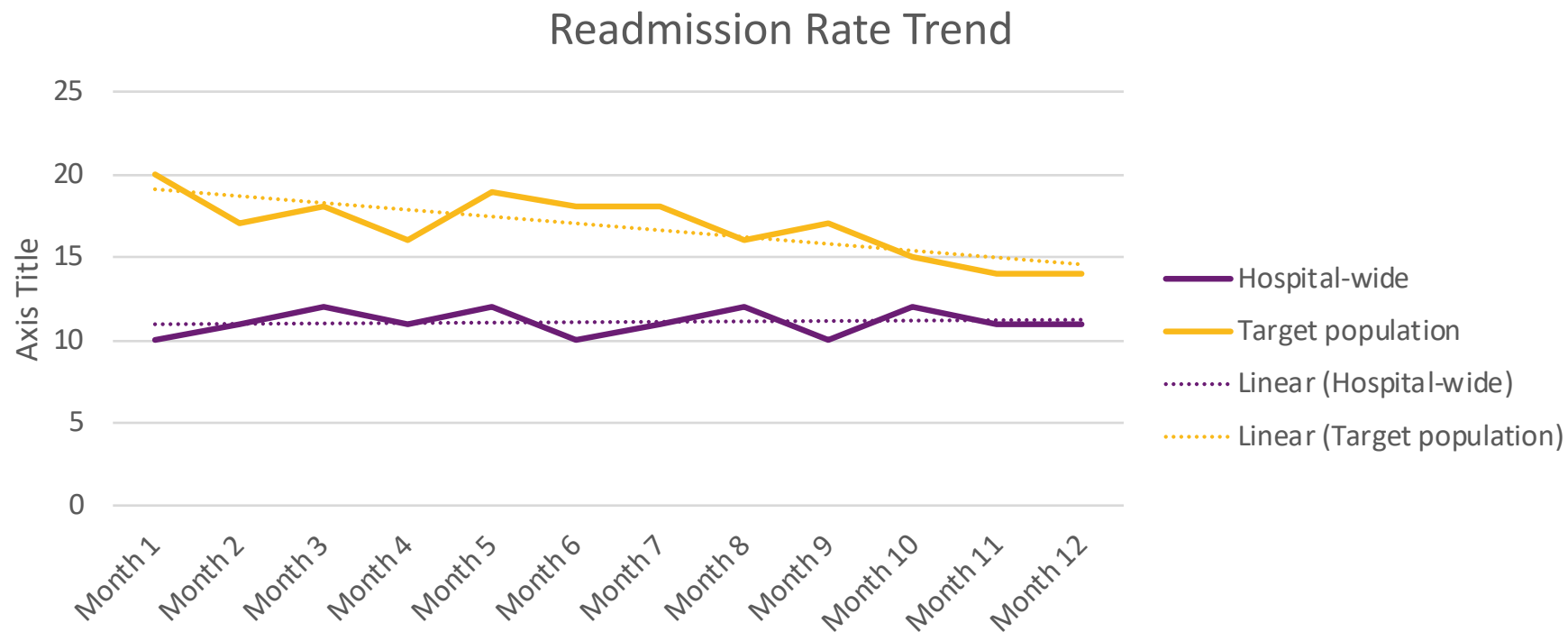


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8. Measurement

What is the impact on readmissions?



Summary

- Employ a ***data-informed approach*** to designing efforts
- Design efforts targeted at ***root causes*** of readmissions
- Develop a ***portfolio of strategies*** to achieve hospital-wide results
- ***Adapt*** strategies to serve whole-person needs
- ***Deliver interventions*** to a high percentage of the target population
- ***Measure implementation*** to drive to higher levels of performance



Brainstorm

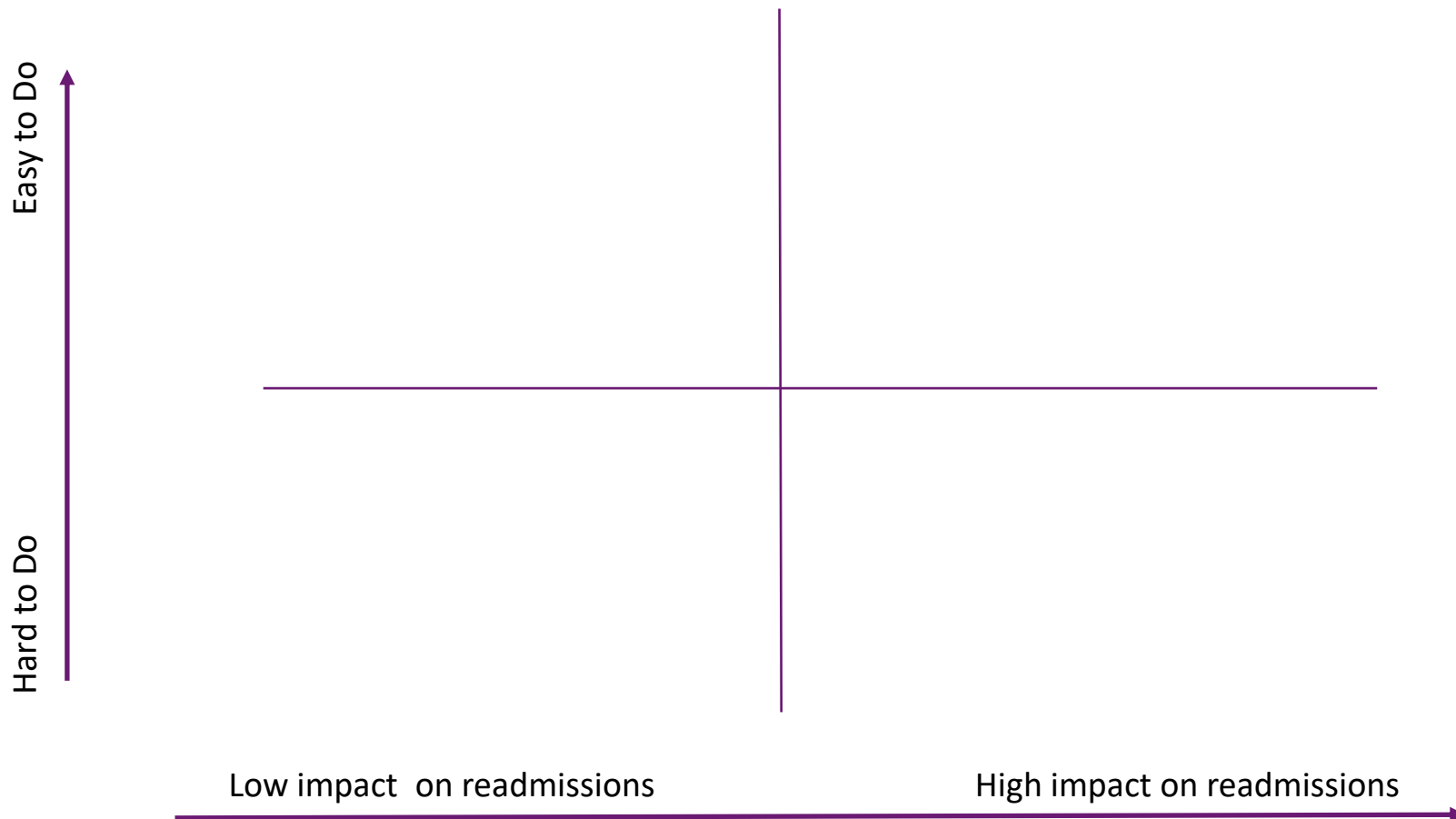


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Prioritize



Action Plan: Next 7 days

"I will go back next week and do this"

Action steps	By Whom?	By When?
1.		
2.		
3.		
4.		
5.		
Stakeholders (who needs to be engaged):		
Expected benefit (on results):		
Measurement plan (how will you know if you did it and the impact):		



Action Plan: Next 30 days

"We can do this in the next couple weeks"

Action steps	By Whom?	By When?
1.		
2.		
3.		
4.		
5.		
Stakeholders (who needs to be engaged):		
Expected benefit (on results):		
Measurement plan (how will you know if you did it and the impact):		



Action Plan: Next 90 days

"This is important to have in place by February"

Action steps	By Whom?	By When?
1.		
2.		
3.		
4.		
5.		
Stakeholders (who needs to be engaged):		
Expected benefit (on results):		
Measurement plan (how will you know if you did it and the impact):		



Thank you for your commitment to reducing readmissions

Amy E. Boutwell, MD, MPP

President, Collaborative Healthcare Strategies

Developer, MVP Method of Improving Care for Multi-Visit Patients

Developer, AHRQ Hospital Guide to Reducing Medicaid Readmissions

Developer, IHI STAAR (State Action on Avoidable Readmissions) Initiative



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