ASPIRE to Knockout Pneumonia Readmissions
Designing & Delivering Whole-Person Transitional Care

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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

Designing and Delivering Whole-Person Transitional Care:
The Hospital Guide to Reducing Medicaid Readmissions

ASPIRE Framework

Reduce Pneumonia Readmissions

Design

Deliver

- Analyze Your Data ✓
- Survey Your Current Readmission Reduction Efforts ✓
- Plan a Multi-faceted, Data-Informed Portfolio of Strategies ✓
- Implement Whole-Person Transitional Care for All ✓
- Reach Out and Collaborate with Cross-Continuum Providers ✓
- Enhance Services for High-Risk Patients
<table>
<thead>
<tr>
<th>Webinar</th>
<th>ASPIRE to Knockout Pneumonia Readmissions</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 1</td>
<td>Know your data, understand root causes</td>
<td>• ASPIRE Guide, Section 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASPIRE Tools 1 and 2</td>
</tr>
<tr>
<td>April 5</td>
<td>Align with related efforts and resources, identify gaps</td>
<td>• ASPIRE Guide, Section 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASPIRE Tools 3, 4</td>
</tr>
<tr>
<td>May 3</td>
<td>Design a portfolio of strategies and operational dashboard</td>
<td>• ASPIRE Guide, Section 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASPIRE Tools 5, 6, 7</td>
</tr>
<tr>
<td>June 7</td>
<td><strong>Actively collaborate across the continuum</strong></td>
<td>• ASPIRE Guide, Section 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASPIRE Tools 8, 9, 11, 12</td>
</tr>
<tr>
<td>August 2</td>
<td>Deliver effective post-discharge transitional care</td>
<td>• ASPIRE Guide, Section 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASPIRE Tool 13</td>
</tr>
<tr>
<td>September 6</td>
<td>Self-assessment and preparation for in-person session</td>
<td>• Self-assessment tool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support request form</td>
</tr>
<tr>
<td>October 16</td>
<td><strong>Knockout Pneumonia Readmissions in-person session</strong></td>
<td>• 30 day action plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 90 day action plan</td>
</tr>
<tr>
<td>November 1</td>
<td>Knockout Pneumonia Readmissions: Success Stories Part 1</td>
<td>• We welcome volunteers</td>
</tr>
<tr>
<td>December 6</td>
<td>Knockout Pneumonia Readmissions: Success Stories Part 2</td>
<td>• We welcome volunteers</td>
</tr>
</tbody>
</table>
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

- **Improve hospital-based care**
  - Identify all PNA patients and warm handoff or link to ToC
  - ED flag for 30-day return; care plan used to treat and return

- **Cross-continuum collaboration**
  - Warm handoff and Circle-Back Call for all PNA pts → SNF
  - Warm handoff and Circle Back Call to all PCMH RN Care Managers
  - Warm handoff and Circle Back Call to all residents of group homes
  - Collaborative Service Agreement with AAA to screen Medicare PNA pts for services < 5 days of d/c

- **Enhanced services**
  - 2 ToC RNs follow PNA patients hospital-SNF-home for 5 SNFs
  - 1 RN, 1 SW, 2 CHWs follow PNA patients d/c to home x 30 days

Reduce Medicare PNA Readmissions by 10% by 12/18
Reducing PNA Readmissions Strategy - Example 2

- Reduce PNA Readmissions by 20% over 12 mo
  - Improve hospital-based care
  - Cross-continuum collaboration
  - Enhanced services

- Refer all PNA patients d/c to home for ToC (~2 discharges per day)
- Warm handoff and Circle-Back Call for all PNA pts → SNF (~2 d/cs per day)
- 1 SW, 1 CHW follow PNA patients d/c to home x 30 days
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!

“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

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

“6 simple questions are making a difference in the Richmond community”
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?
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

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