
# ASPIRE to Knockout Pneumonia Readmissions

## *Designing & Delivering Whole-Person Transitional Care*

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NCHA Knockout Pneumonia Campaign - Webinar 3

May 3, 2018

# Purpose of the Knockout Pneumonia Readmissions Series

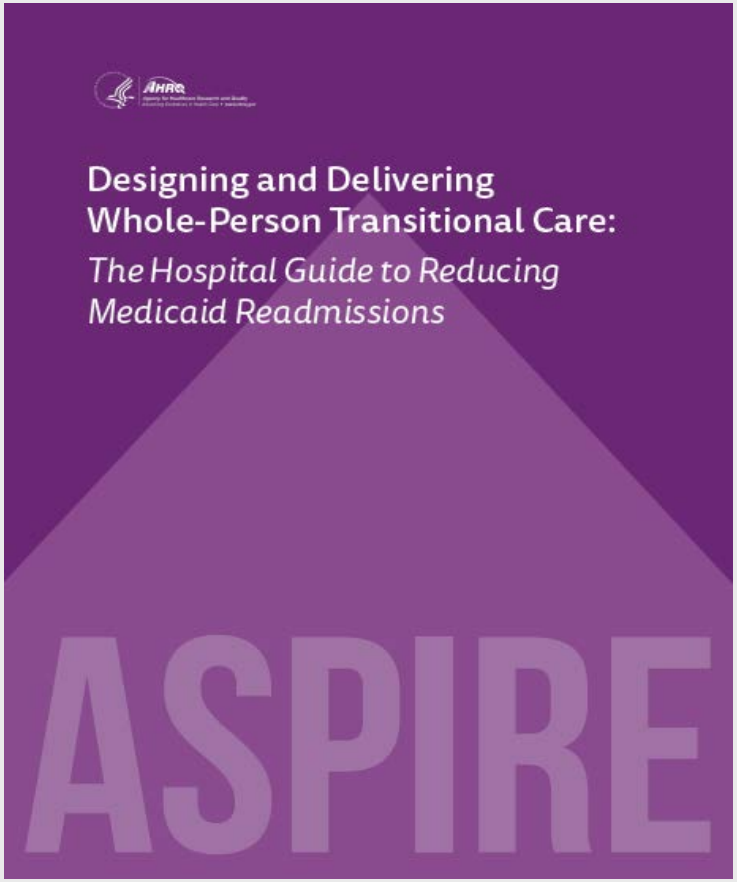
This series is to support your work to reduce pneumonia readmissions

- 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

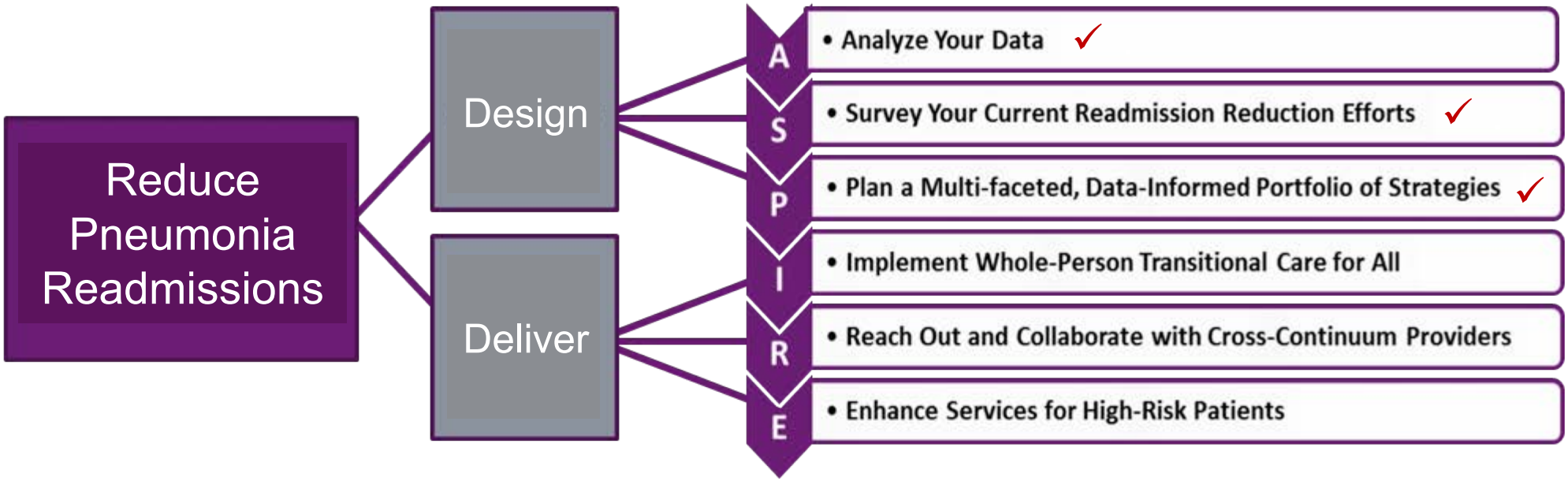
- ***Come with*** questions, challenges, cases, data, ideas for improvement
- ***Invite*** your cross-continuum partners to attend
- ***Email us*** with questions or issues to discuss on the next webinar

# ASPIRE to Reduce Readmissions



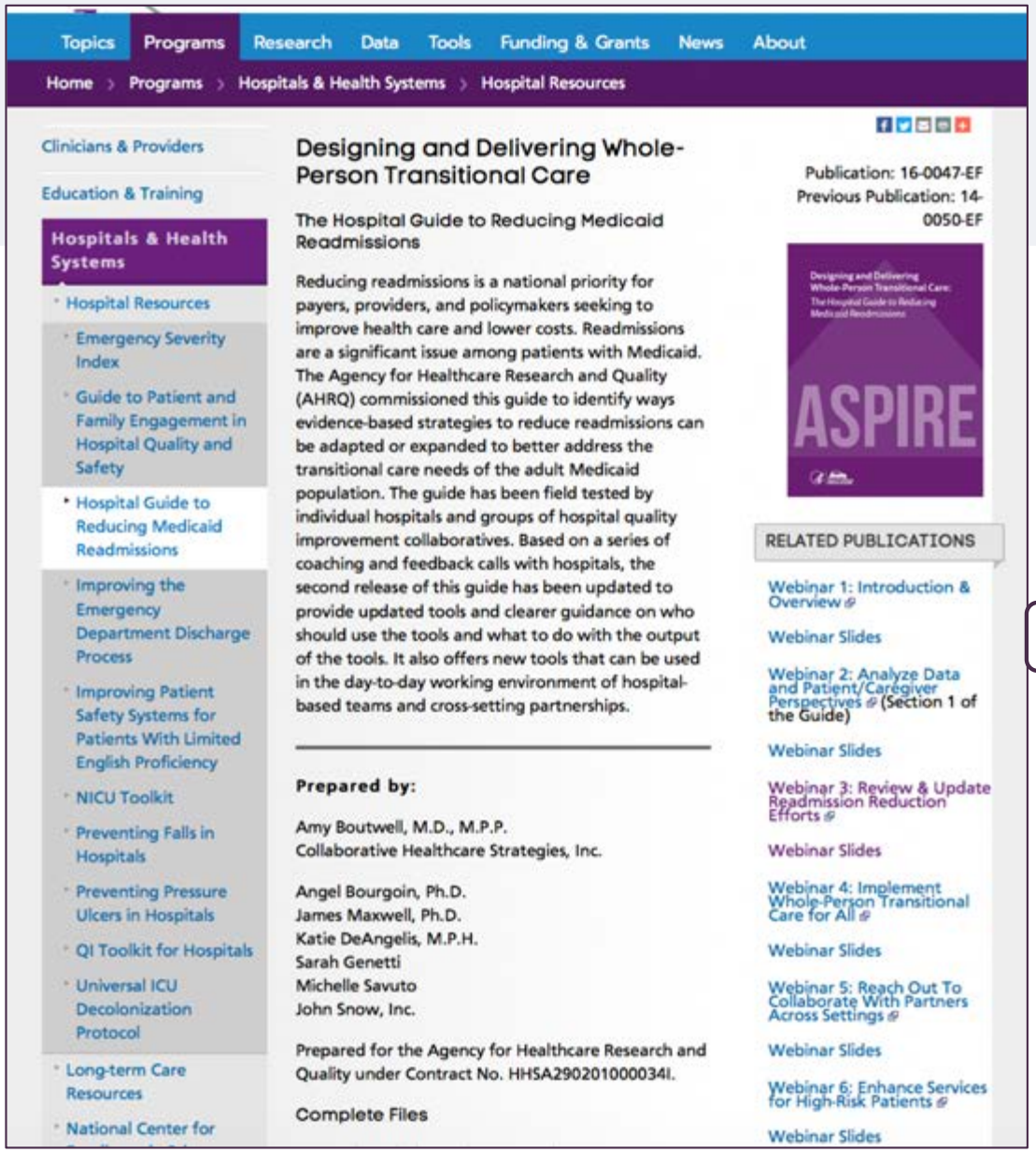

AHRQ · PREMIER · American Hospital Association · Maryland Hospital Association · Partnership for Patients (Proud to be Partners in Better Care at Lower Costs.) · vizient · SCHA South Carolina Hospital Association · IHA Illinois Hospital Association · MHA Massachusetts Health & Hospital Association · Virginia Hospital & Healthcare Association (An alliance of hospitals and health delivery systems) · Massachusetts Health Policy Commission · NCHA · 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

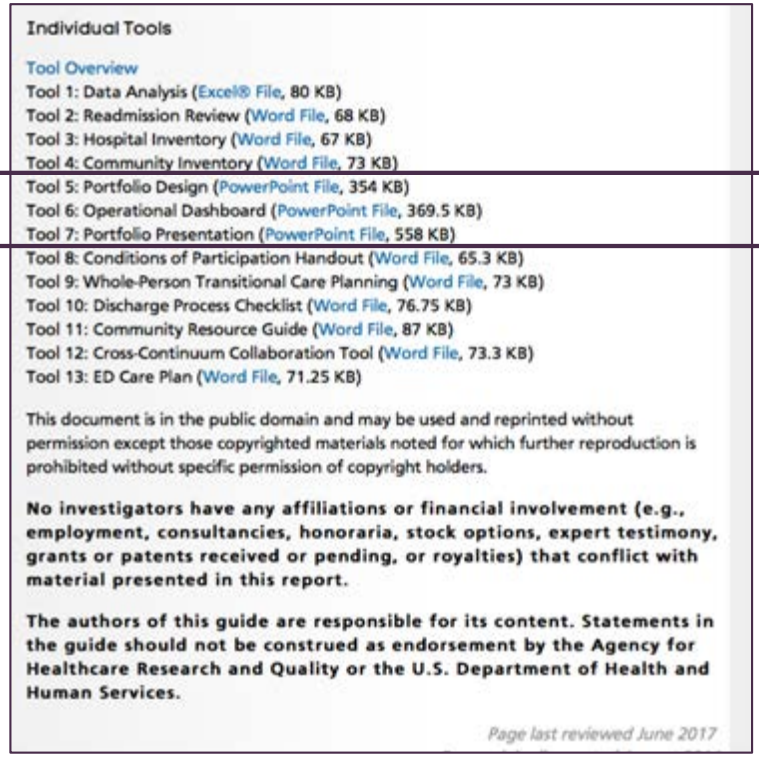


# Knockout Pneumonia Readmissions Series

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




## ASPIRE Tools 5-6-7




https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

# Objectives for this Session

- ***Design a portfolio of strategies*** to effectively reduce pneumonia readmissions
- ***Develop an operational dashboard*** to support implementation and drive continuous improvement to get results

## *Consider:*

1. *What is your pneumonia readmission reduction aim?*
2. *What intervention(s) are you delivering?*
3. *Do you know what % of your PNA patients receive the intervention(s)?*

## *Write down or chat in:*

1. *What is your pneumonia readmission reduction aim?*

# *Write down or chat in:*

*What is your pneumonia readmission reduction aim?*

- *What-for whom-by how much- by when?*
- *Reduce **PNA** readmissions for **Medicare** patients by 10% by end of 2018*
- *Reduce **PNA** readmissions for all patients discharged to **home** by 15%*
- *Reduce **PNA** readmissions for patients discharged to **SNF** by 20% in 1 year*
- *Reduce readmissions for **"high risk" PNA** patients by 10% by end of 2018*
- *Reduce AMI, HF, COPD, **PNA** readmissions for **Medicare** pts by 20%*
- *Reduce **all cause** (adult, non-OB) readmissions by 10%, from 10% to 9%*

**BOLDED** term is your target population; this is your denominator
An aim statement specifies which patients are you targeting?
Success depends on ***effectively*** and ***reliably*** serving your target population

## *Write down or chat in:*

*2. What intervention(s) are you delivering?*

# *Write down or chat in:*

*What intervention(s) are you delivering?*

- ***Identify** pneumonia patients upon admission / daily*
- ***Assess** readmission risks using the BOOST 8P tool*
- ***Identify** the care plan partner; **include** in discharge planning*
- ***Schedule** follow up appointments for 3-5 days post discharge*
- ***Provide** medications to bedside prior to discharge*
- ***Conduct** post discharge phone calls <48 hours of discharge*
- *Warm handoff with **"circle back"** for all SNF transitions*
- ***Provide** transitional care with in-home, telephonic contact x 30 days*
- ***Provide** transitional care, following patients across SNF to home x 30 days*

**BOLDED** term is your intervention; this should be measured

Success depends on **effective** interventions: will your intervention(s) reduce readmissions?

## *Write down or chat in:*

3. *Do you know what % of your PNA patients receive the intervention(s)?*

## *Write down or chat in:*

*Do you know what % of your PNA patients receive the intervention(s)?*

- *% PNA patients identified during the hospitalization: 92%*
- *% PNA patients received transitional risk assessment: 80%*
- *% PNA patients d/c to home w appointment made prior to d/c: 40%*
- *% PNA patients d/c to SNF with warm handoff & circle back call: 60%*
- *% PNA patients referred for transitional care: 70%*
- *% PNA patients who received 30 day completed ToC episode: 30%*

Success depends on ***effectively*** and ***reliably*** serving your target population

Are you consistently (reliably) delivering what you intend to deliver to your target population?

# *Design a multifaceted portfolio of strategies*

# Take a Data-Informed Approach

1. What is our aim?
2. What does our data show?
3. Who should we focus on?
4. What should we do?

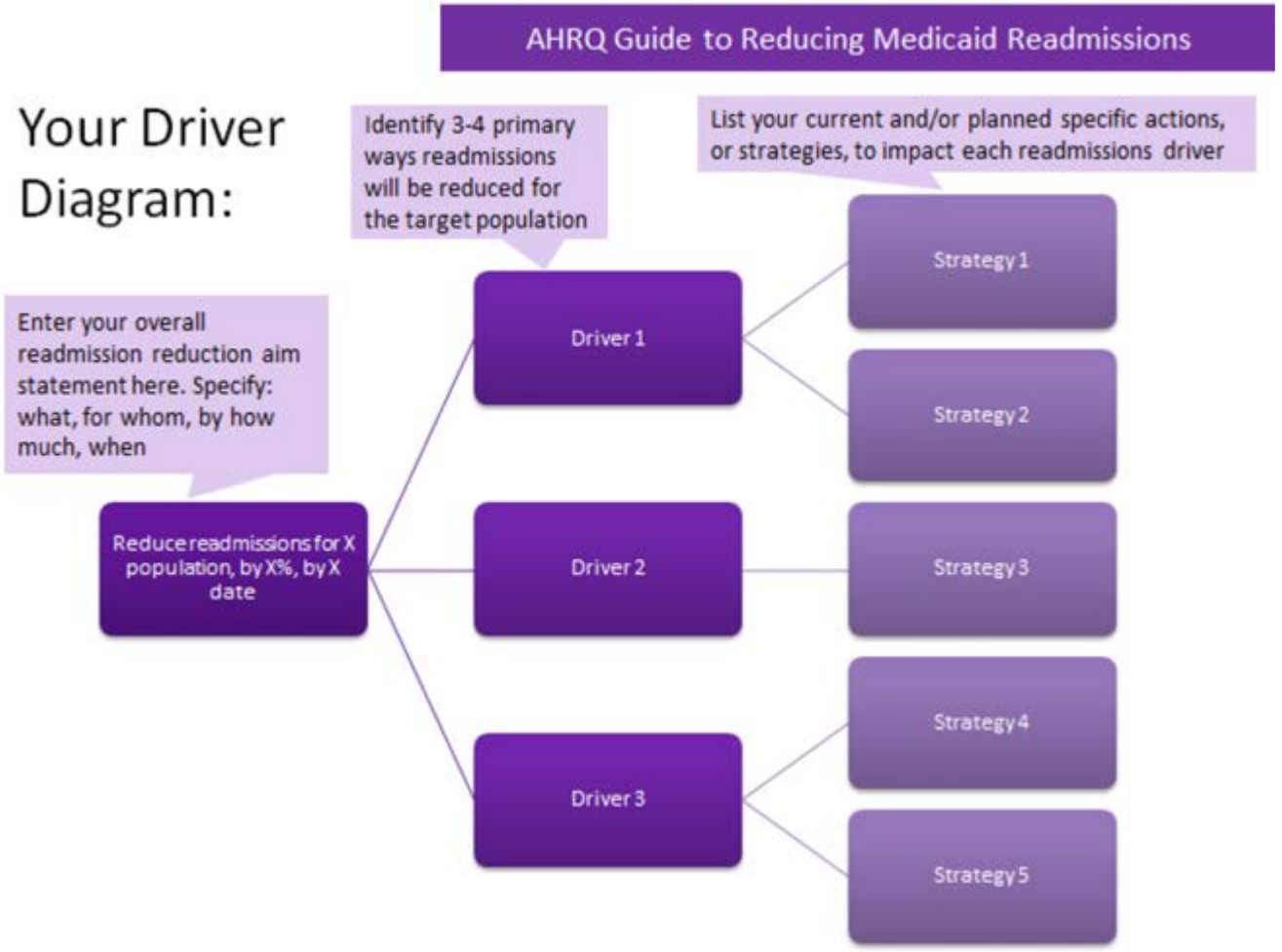
Many teams start in the ***reverse*** order!

# Create a Data-Informed Strategy

1. Specify the goal and target population
   - The goal should be data-informed and specify what will be achieved for whom, by how much, and by when

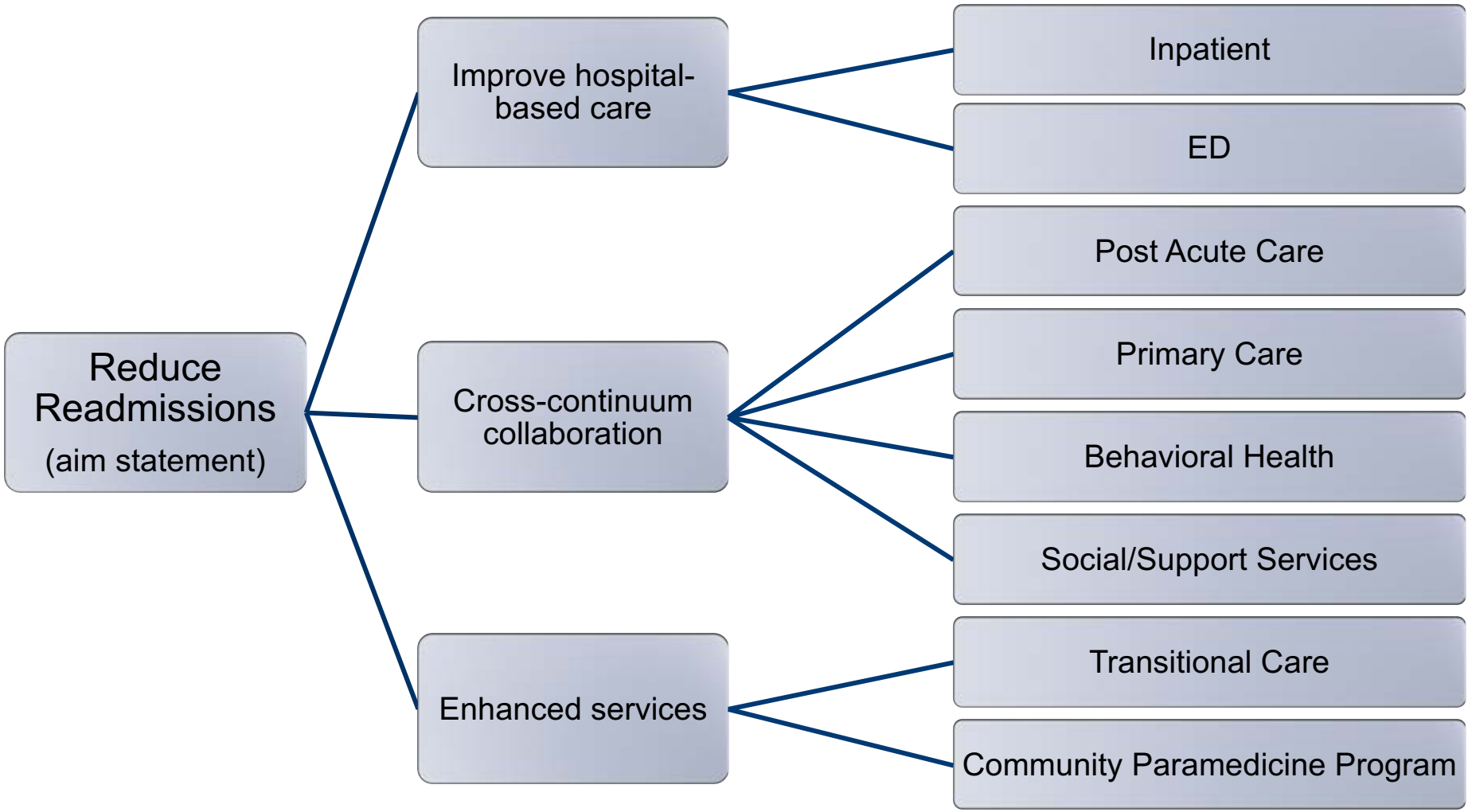
2. Identify 3-4 primary ways by which the aim will be achieved.
   - Consider: improving hospital-based transitional care processes, collaborations with cross-setting partners, and delivering enhanced services
   - There may be others depending on your target population and resources available

# Driver Diagram Tool



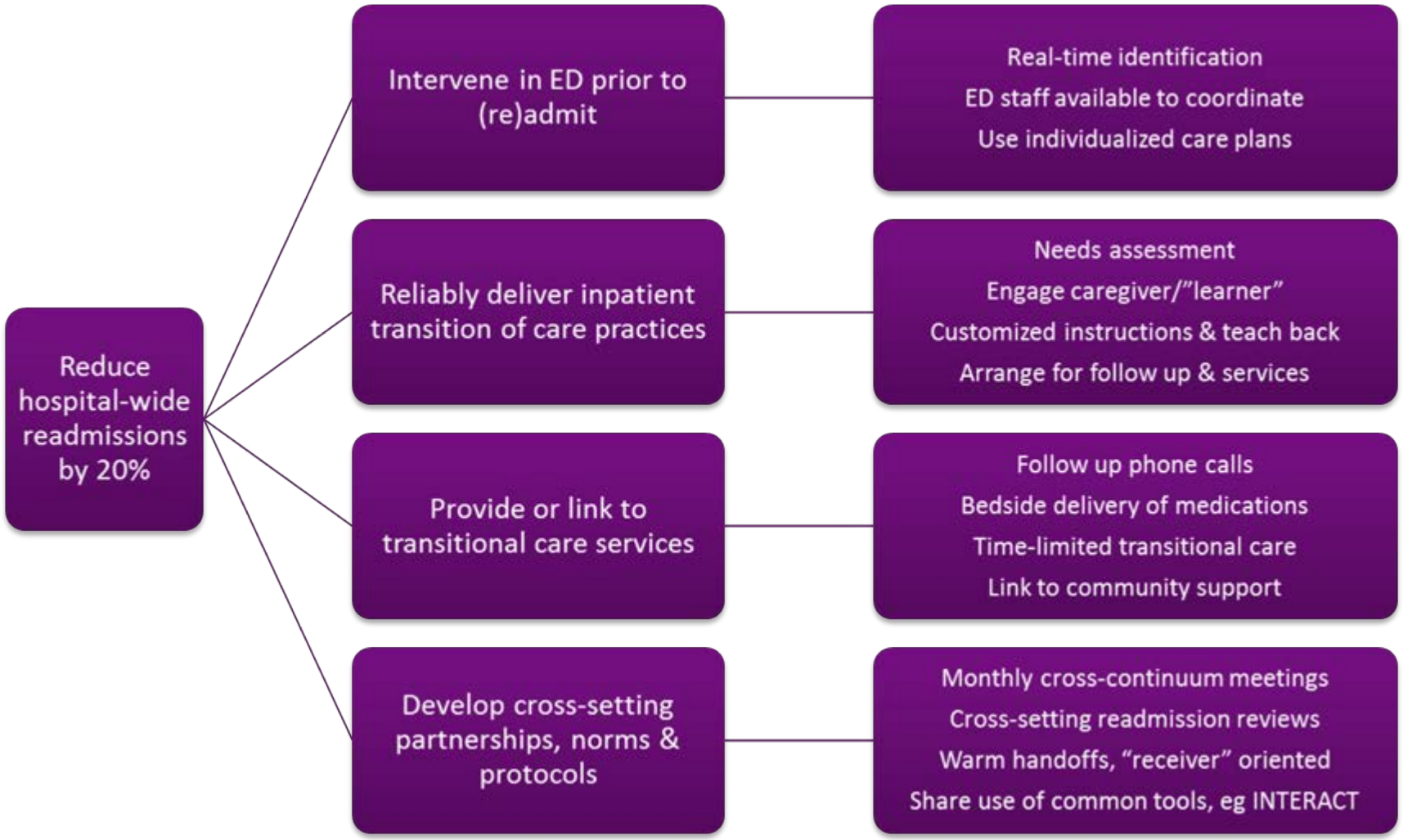
# Linking Interventions to Strategy

*What are we doing to reduce readmissions?*



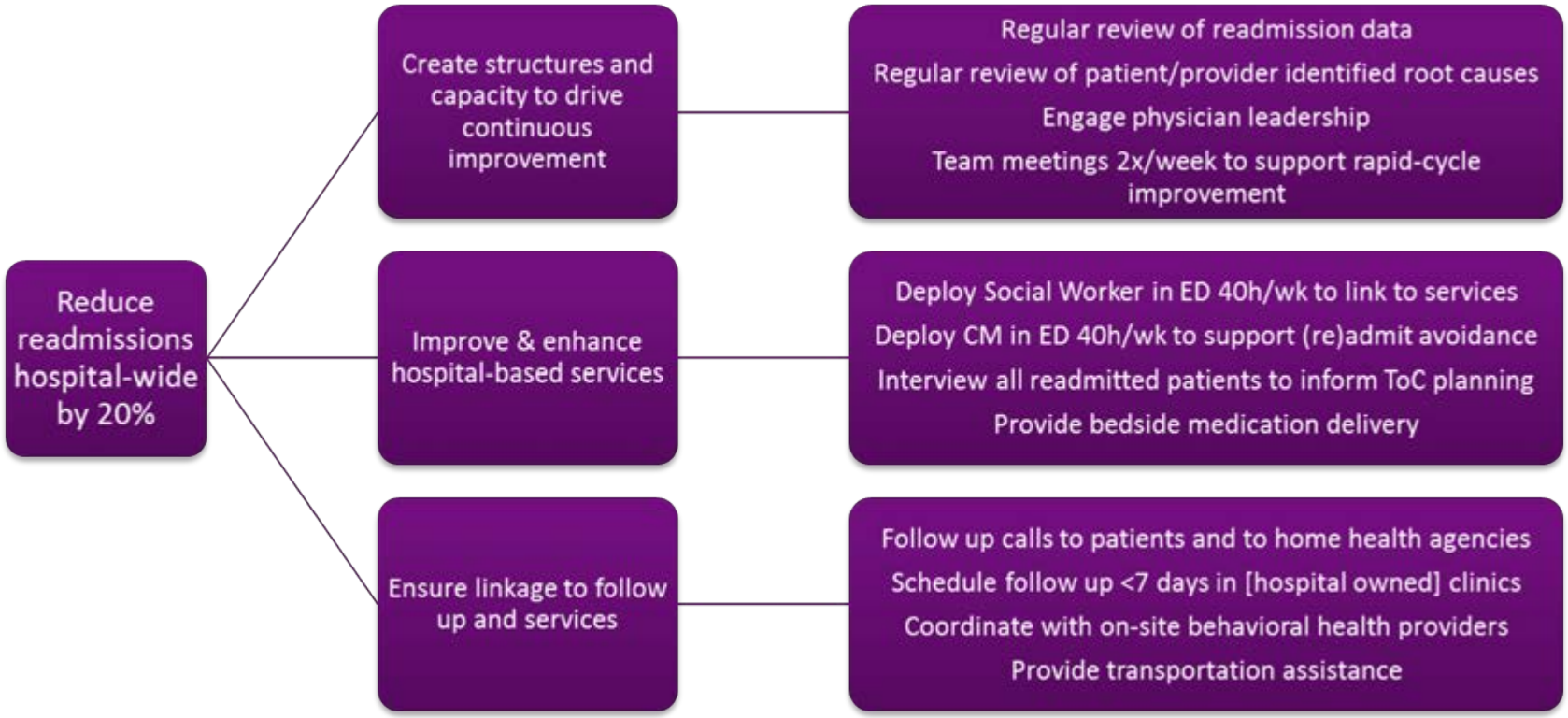
# Example 1: Baltimore Hospital

*Not pneumonia-specific*

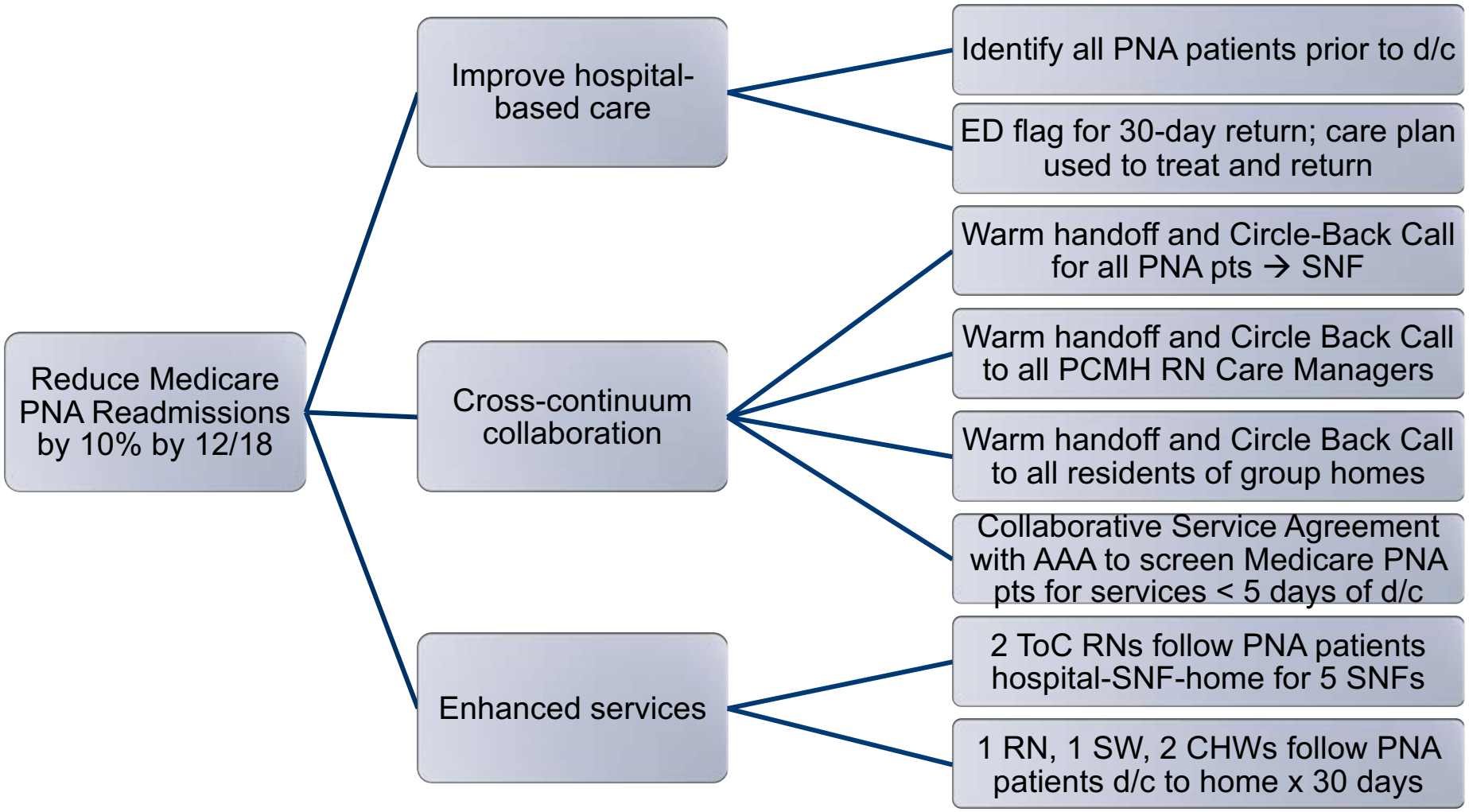


# Example 2: Chicago Hospital

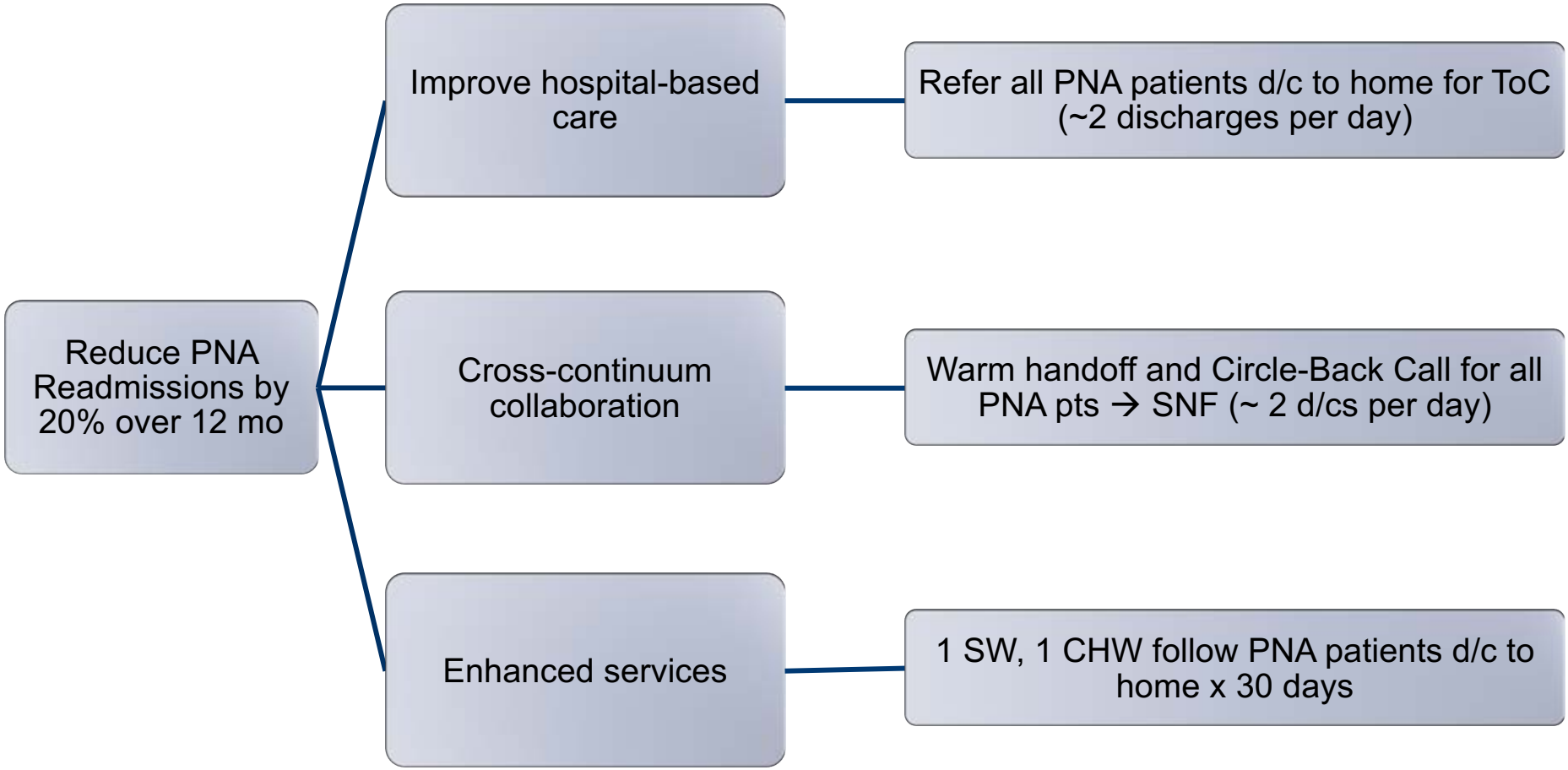
*Not pneumonia-specific*



# Pneumonia Example 1



# Pneumonia Example 2



# Analyze Your Strategy: Is it Complete?

- Are all readmission reduction related activities captured?
- Will this strategy address the root causes of readmissions for your target population?
- Are your strategies deployed for all patients in your target population? If no, why not?
- What strategies have not been prioritized? Why?
- Do you have confidence that these interventions, if delivered to your patients, would reduce readmissions by 10-25%?
- Are the following data-informed or high-leverage elements included? If not, why not?
  - Dual-eligible, Medicaid, or poverty
  - Behavioral health comorbidities
  - Social support needs (isolation, transportation, personal care)
  - High utilizers
  - High risk comorbidities (sepsis, dialysis, aspiration, sickle cell, etc)
  - Discharges to post-acute care settings
  - Rurality
  - Collaborations with: MCOs, BH providers, clinics, social services, housing services

# *Develop an operational dashboard*

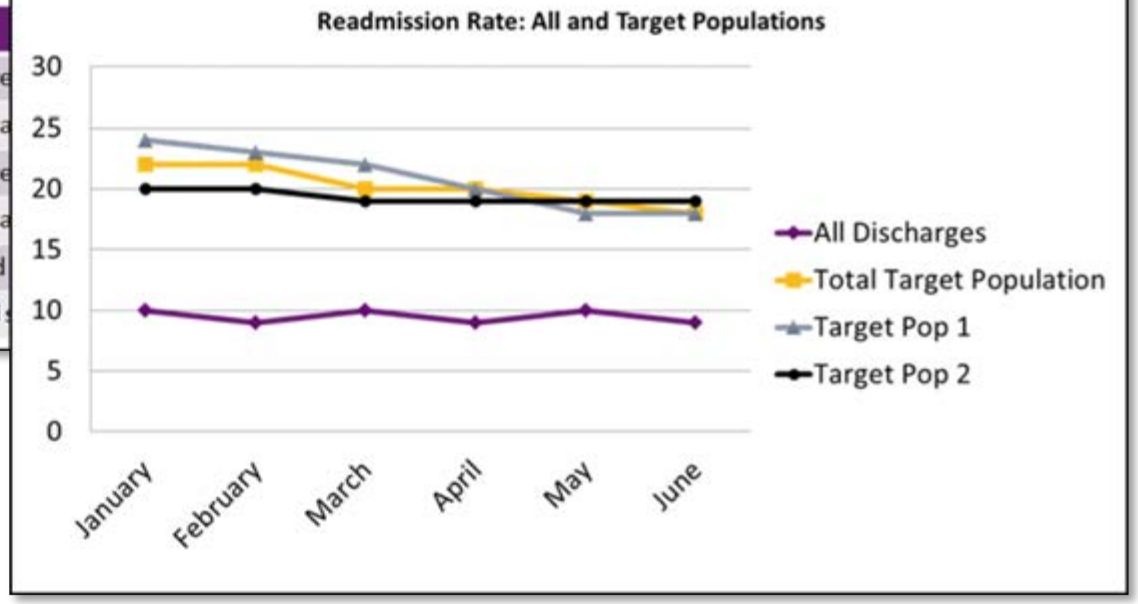
# Establish an Operational Dashboard to Track Implementation and Outcomes (Tool 6)

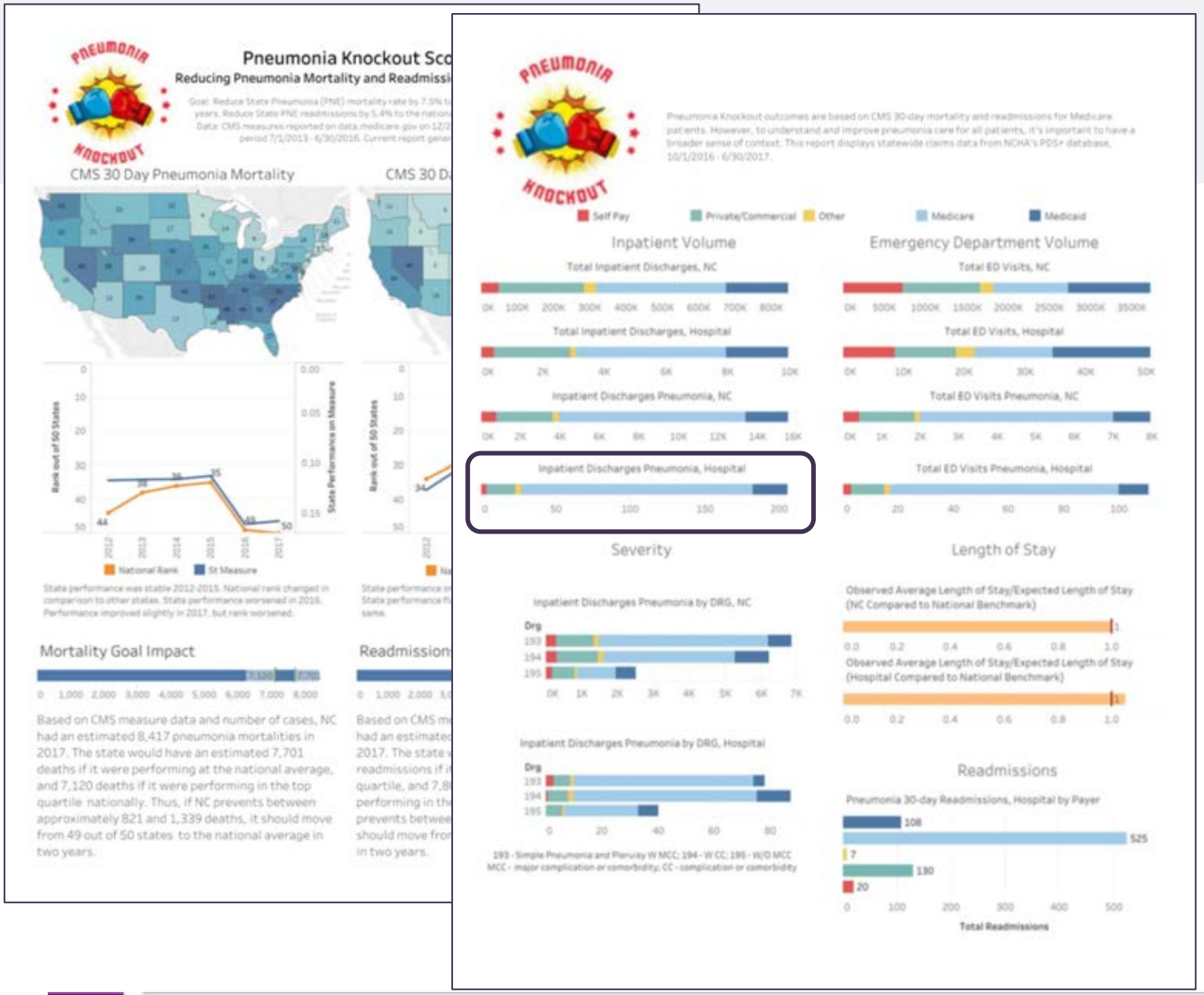
## Operational Dashboard: Volume and Implementation

| Volume, past month | Number or % |
|---|---|
| Number of (adult non-OB) discharges | [#] |
| Number of discharges in target population 1 | [#] |
| Number of discharges in target population 2 | [#] |
| Total number of discharges in target populations | |
| % of all discharges that are target population discharges | |

| Implementation of Service Delivery |
|---|
| Number of discharges in[ target population 1] that receive |
| % of discharges in [target population 1] that received [stra |
| Number of discharges in[ target population 2] that receive |
| % of discharges in [target population 2] that received [stra |
| Total target population discharges that received intended |
| % of target population discharges that received intended s |

## Operational Dashboard: Outcomes






**USE YOUR DATA**

Find PNA d/c per yr:
=200 d/c per year

Estimate d/c per day:
= 200/ 365 (days/yr)

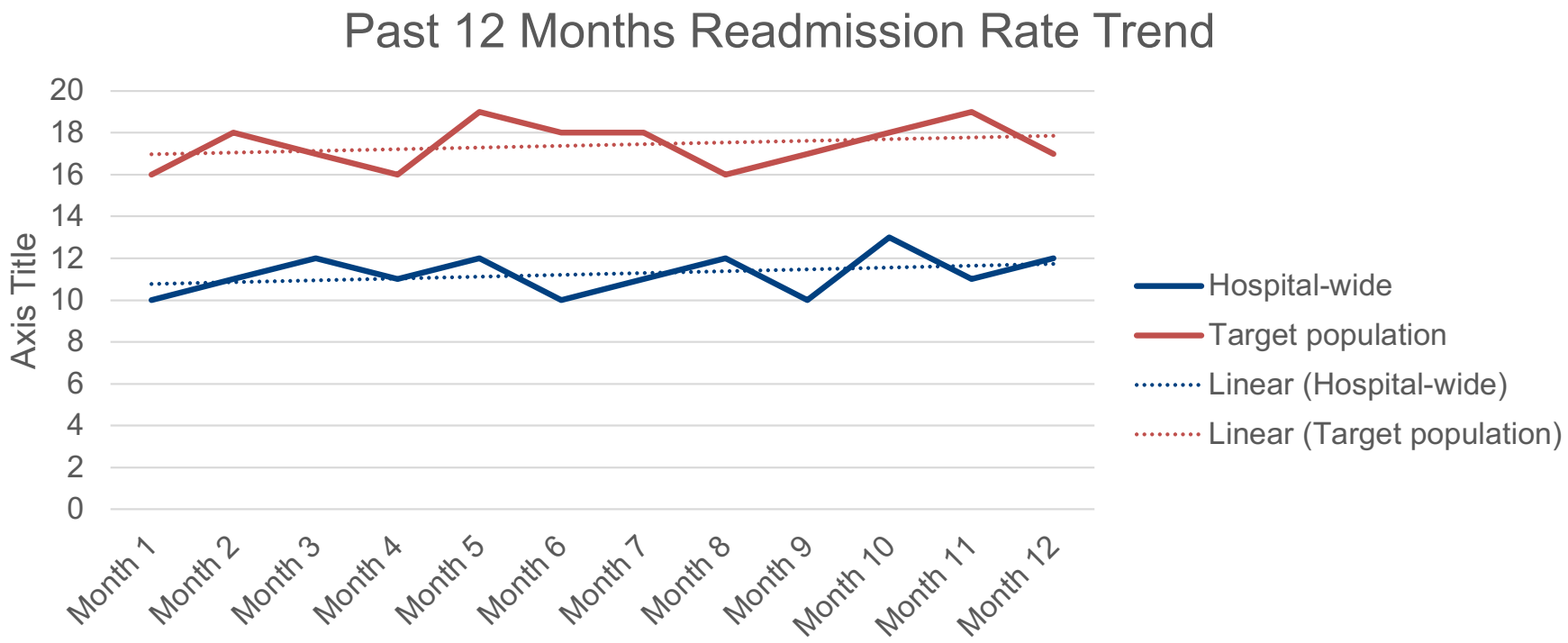
**~<1 PNA d/c per day**
**~3-4 PNA d/c per week**

# Part 1: Monthly Administrative Data

| Monthly measurement | All | Medicare |
|---|---|---|
| A. Total number of pneumonia discharges | | |
| B. Total number of readmissions following discharges (A) | | |
| C. Pneumonia readmission rate (B/A) | | |
| D. Total number of pneumonia discharges to SNF | | |
| E. Total number of pneumonia discharges to home care | | |
| F. Total number of pneumonia discharges to home | | |
| G. Total number of pneumonia discharges in “target population” (if stratifying by high risk) | | |
| H. Total number of “target population” readmissions | | |
| I. Readmission rate, “target population” (H/G) | | |
| J. % of all PNA discharges in “target population” (G/A) | | |

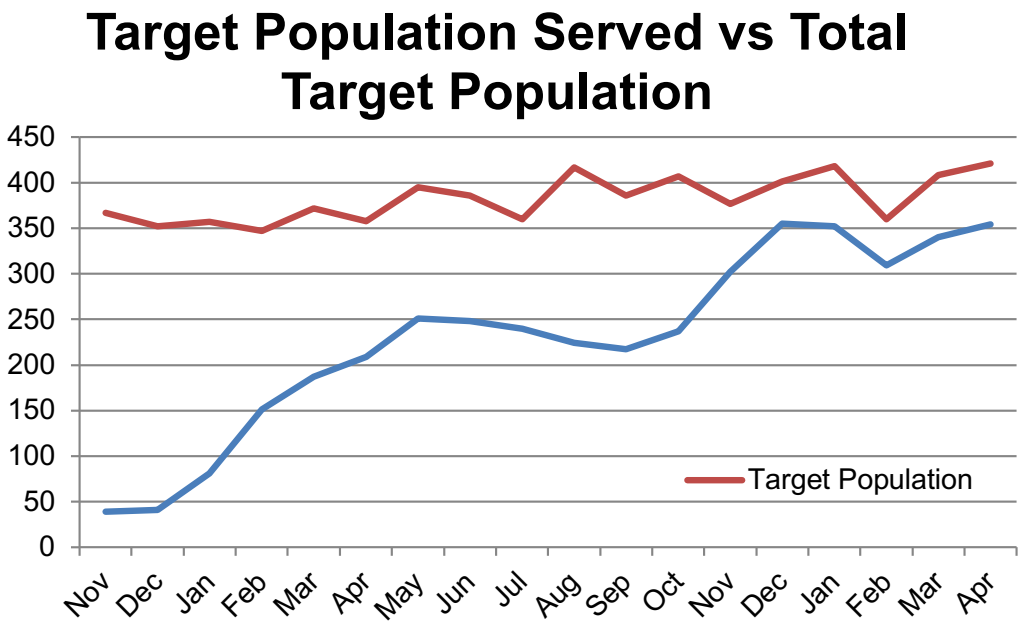
# Part 1: Data Trend Over Time

*Overall and target population*




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

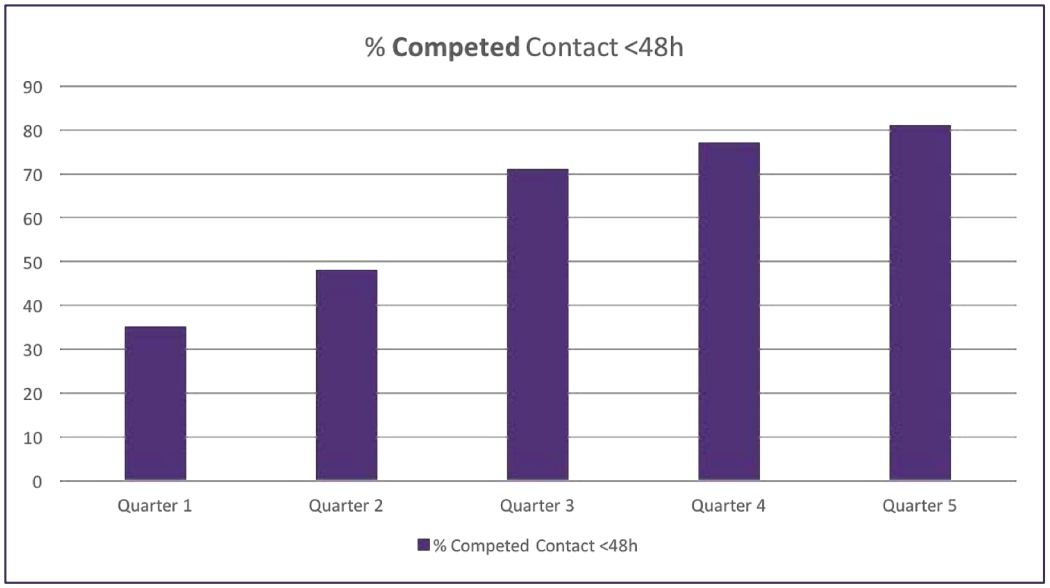
# Percent of Target Population Patients Served




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

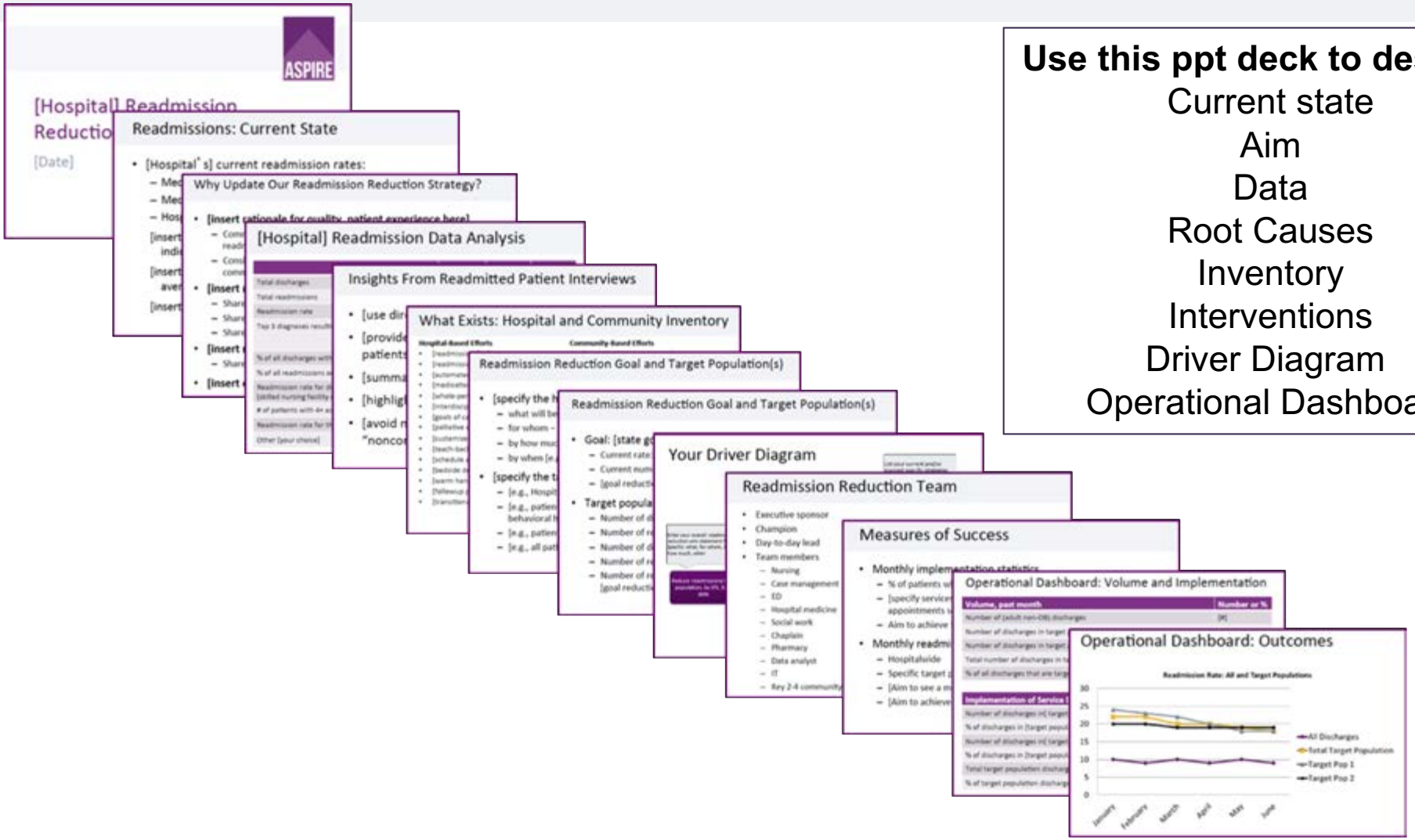
# Part 2: Operational Dashboard

*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*

# Portfolio Presentation Tool (ASPIRE Tool 7)




**Use this ppt deck to describe**

Current state
Aim
Data
Root Causes
Inventory
Interventions
Driver Diagram
Operational Dashboard

# Recommendations

1. ***Design*** a multi-faceted portfolio of strategies to reduce readmissions – use a driver diagram to organize and display your *theory of change*

2. ***Ensure*** your readmission reduction strategy addresses the root causes of readmissions for your patients with pneumonia

3. ***Develop*** an operational dashboard to track the implementation of your readmission reductions strategies - start with your pneumonia patients

4. ***Review*** your implementation on a weekly and monthly basis – continually modifying your workflow and methods until you reach high reliability

5. ***Share*** your pneumonia readmission reduction strategy, using Tool 7


*Thank you for your commitment to reducing readmissions*

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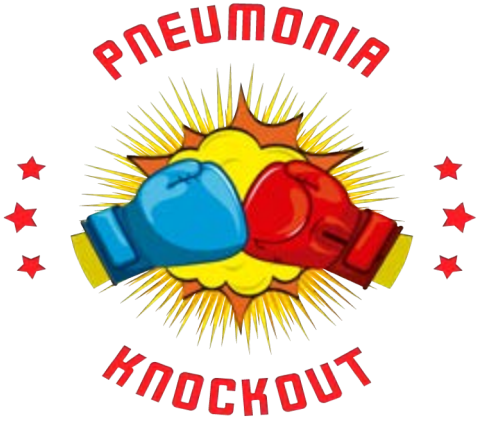
# Contact Us

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