



ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

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NCHA Knockout Pneumonia Campaign - Webinar 3
May 3, 2018



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



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*

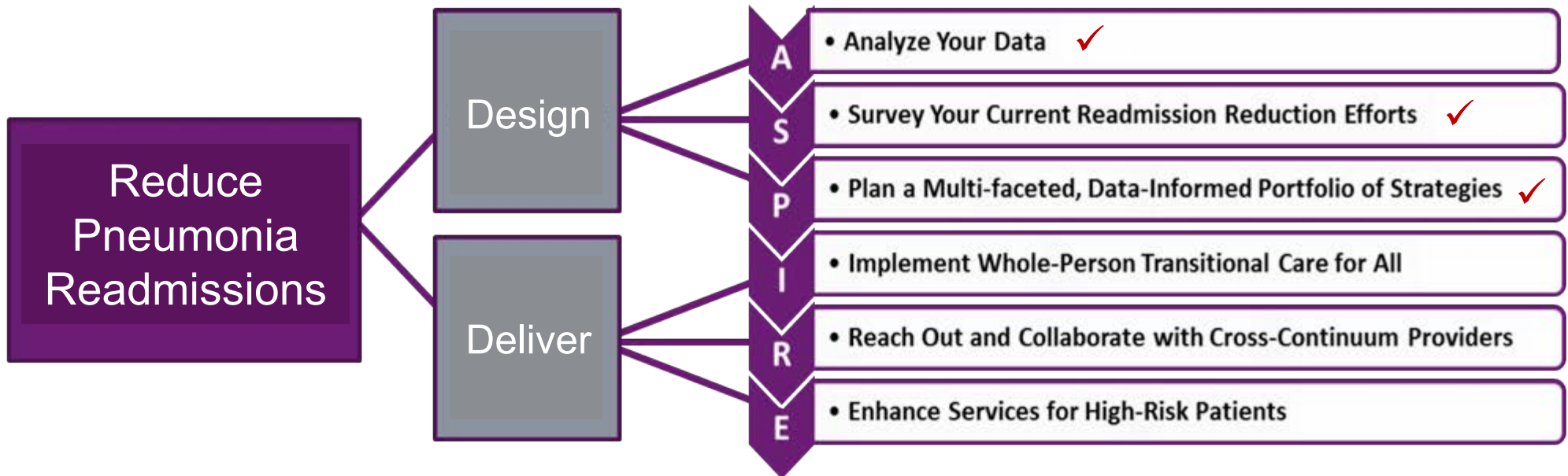
ASPIRE



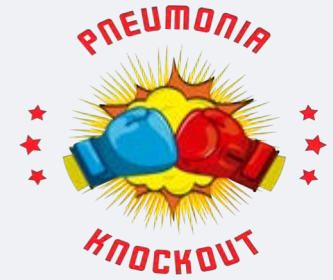
DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE:
THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS
<https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>



ASPIRE Framework



Knockout Pneumonia Readmissions Series



Webinar	ASPIRE to Knockout Pneumonia Readmissions	Resources
March 1	Know your data, understand root causes	<ul style="list-style-type: none"> ASPIRE Guide, Section 1 ASPIRE Tools 1 and 2
April 5	Align with related efforts and resources, identify gaps	<ul style="list-style-type: none"> ASPIRE Guide, Section 2 ASPIRE Tools 3, 4
May 3	Design a portfolio of strategies and operational dashboard	<ul style="list-style-type: none"> ASPIRE Guide, Section 3 ASPIRE Tools 5, 6, 7
June 7	Actively collaborate across the continuum	<ul style="list-style-type: none"> ASPIRE Guide, Section 4, 5 ASPIRE Tools 9, 11, 12
August 2	Deliver effective post-discharge transitional care	<ul style="list-style-type: none"> ASPIRE Guide, Section 6 ASPIRE Tool 13
September 6	Self-assessment and preparation for in-person session	<ul style="list-style-type: none"> Self-assessment tool Support request form
<i>October 16</i>	<i>Knockout Pneumonia Readmissions in-person session</i>	<ul style="list-style-type: none"> <i>30 day action plan</i> <i>90 day action plan</i>
November 1	Knockout Pneumonia Readmissions: Success Stories Part 1	<ul style="list-style-type: none"> We welcome volunteers
December 6	Knockout Pneumonia Readmissions: Success Stories Part 2	<ul style="list-style-type: none"> We welcome volunteers



Topics Programs Research Data Tools Funding & Grants News About

Home > Programs > Hospitals & Health Systems > Hospital Resources

Clinicians & Providers

Education & Training

Hospitals & Health Systems

- Hospital Resources
- Emergency Severity Index
- Guide to Patient and Family Engagement in Hospital Quality and Safety
- Hospital Guide to Reducing Medicaid Readmissions
- Improving the Emergency Department Discharge Process
- Improving Patient Safety Systems for Patients With Limited English Proficiency
- NICU Toolkit
- Preventing Falls in Hospitals
- Preventing Pressure Ulcers in Hospitals
- QI Toolkit for Hospitals
- Universal ICU Decolonization Protocol
- Long-term Care Resources
- National Center for

Designing and Delivering Whole-Person Transitional Care

Publication: 16-0047-EF
Previous Publication: 14-0050-EF

The Hospital Guide to Reducing Medicaid Readmissions

Reducing readmissions is a national priority for payers, providers, and policymakers seeking to improve health care and lower costs. Readmissions are a significant issue among patients with Medicaid. The Agency for Healthcare Research and Quality (AHRQ) commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. The guide has been field tested by individual hospitals and groups of hospital quality improvement collaboratives. Based on a series of coaching and feedback calls with hospitals, the second release of this guide has been updated to provide updated tools and clearer guidance on who should use the tools and what to do with the output of the tools. It also offers new tools that can be used in the day-to-day working environment of hospital-based teams and cross-setting partnerships.

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Prepared for the Agency for Healthcare Research and Quality under Contract No. HHS290201000034I.

Complete Files

RELATED PUBLICATIONS

Webinar 1: Introduction & Overview

Webinar Slides

Webinar 2: Analyze Data and Patient/Caregiver Perspectives

Webinar Slides

Webinar 3: Review & Update Readmission Reduction Efforts

Webinar Slides

Webinar 4: Implement Whole-Person Transitional Care for All

Webinar Slides

Webinar 5: Reach Out To Collaborate With Partners Across Settings

Webinar Slides

Webinar 6: Enhance Services for High-Risk Patients

Webinar Slides

ASPIRE Tools 5-6-7

Individual Tools

Tool Overview

- Tool 1: Data Analysis (Excel® File, 80 KB)
- Tool 2: Readmission Review (Word File, 68 KB)
- Tool 3: Hospital Inventory (Word File, 67 KB)
- Tool 4: Community Inventory (Word File, 73 KB)
- Tool 5: Portfolio Design (PowerPoint File, 354 KB)
- Tool 6: Operational Dashboard (PowerPoint File, 369.5 KB)
- Tool 7: Portfolio Presentation (PowerPoint File, 558 KB)
- Tool 8: Conditions of Participation Handout (Word File, 65.3 KB)
- Tool 9: Whole-Person Transitional Care Planning (Word File, 73 KB)
- Tool 10: Discharge Process Checklist (Word File, 76.75 KB)
- Tool 11: Community Resource Guide (Word File, 87 KB)
- Tool 12: Cross-Continuum Collaboration Tool (Word File, 73.3 KB)
- Tool 13: ED Care Plan (Word File, 71.25 KB)

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Page last reviewed June 2017

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



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



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



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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!

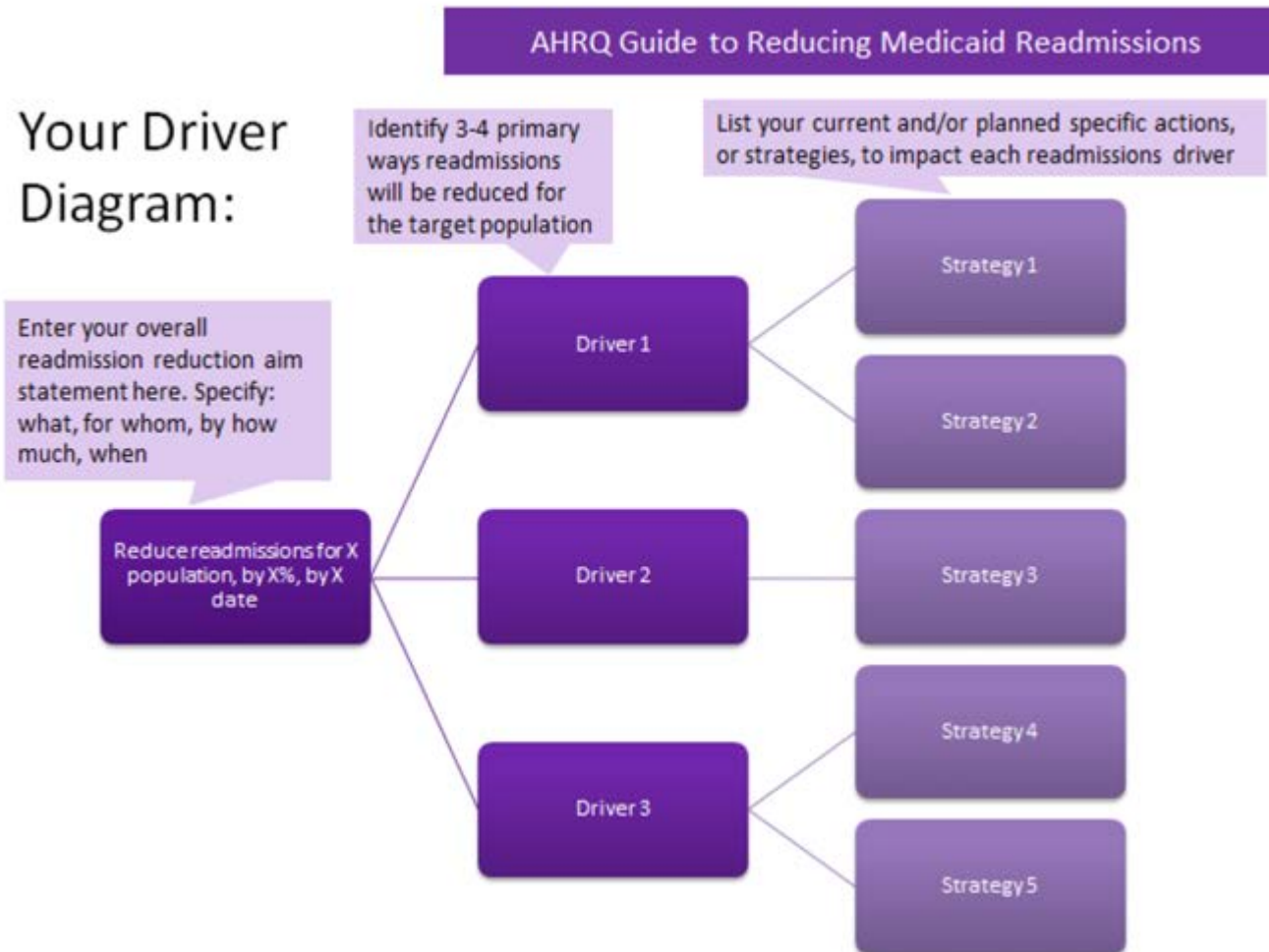


Create a Data-Informed Strategy

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

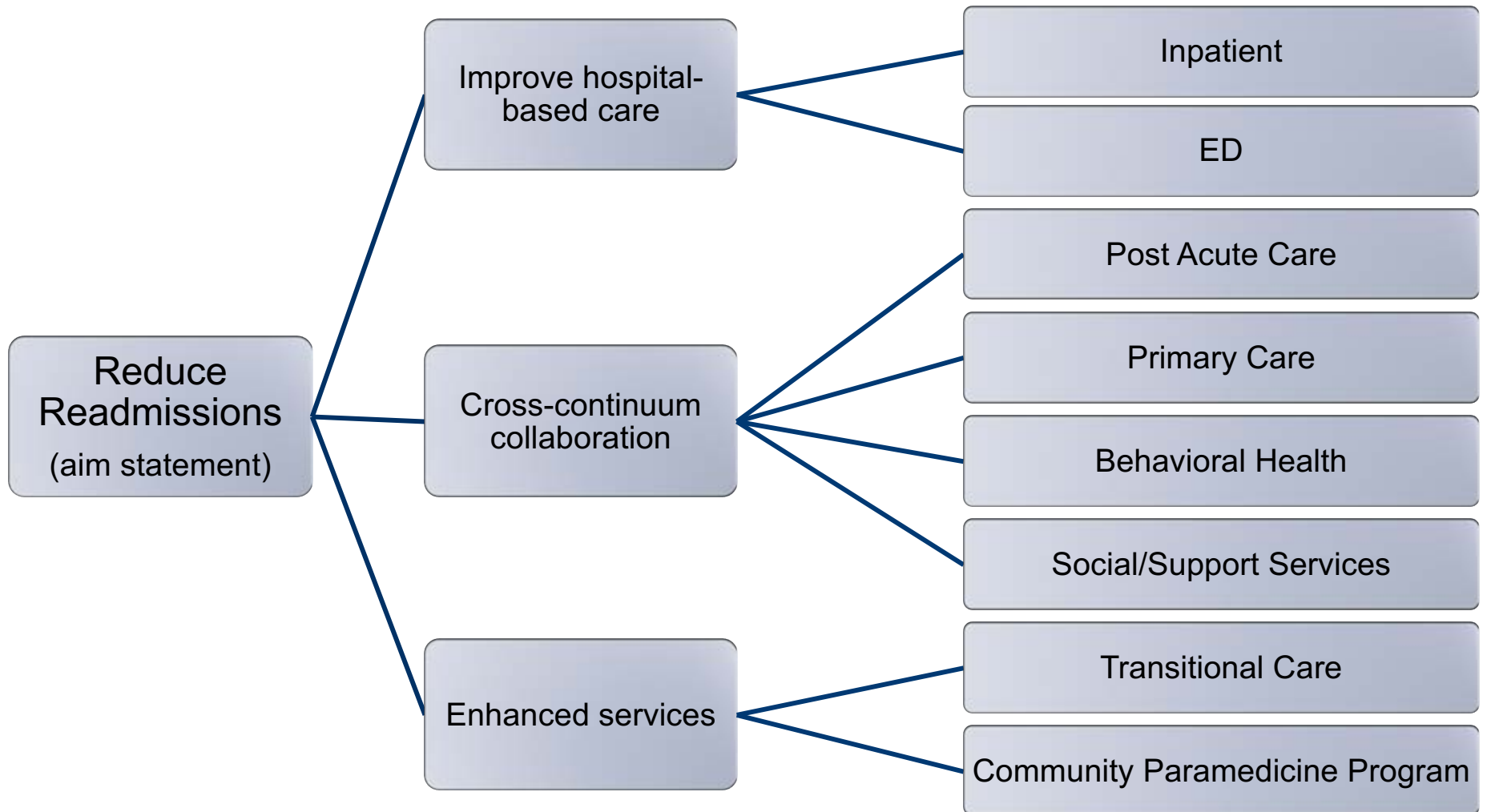


Driver Diagram Tool



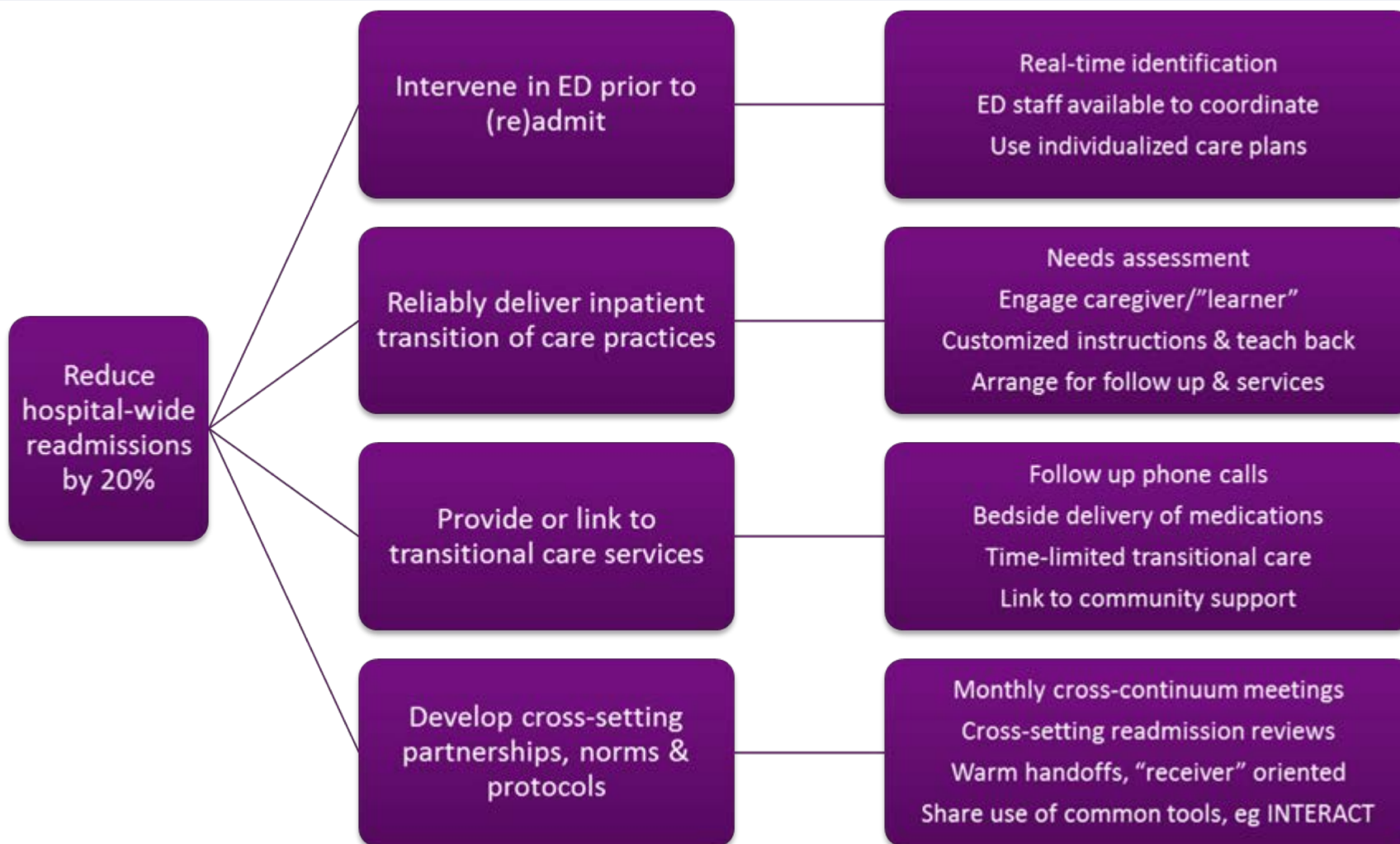
Linking Interventions to Strategy

What are we doing to reduce readmissions?



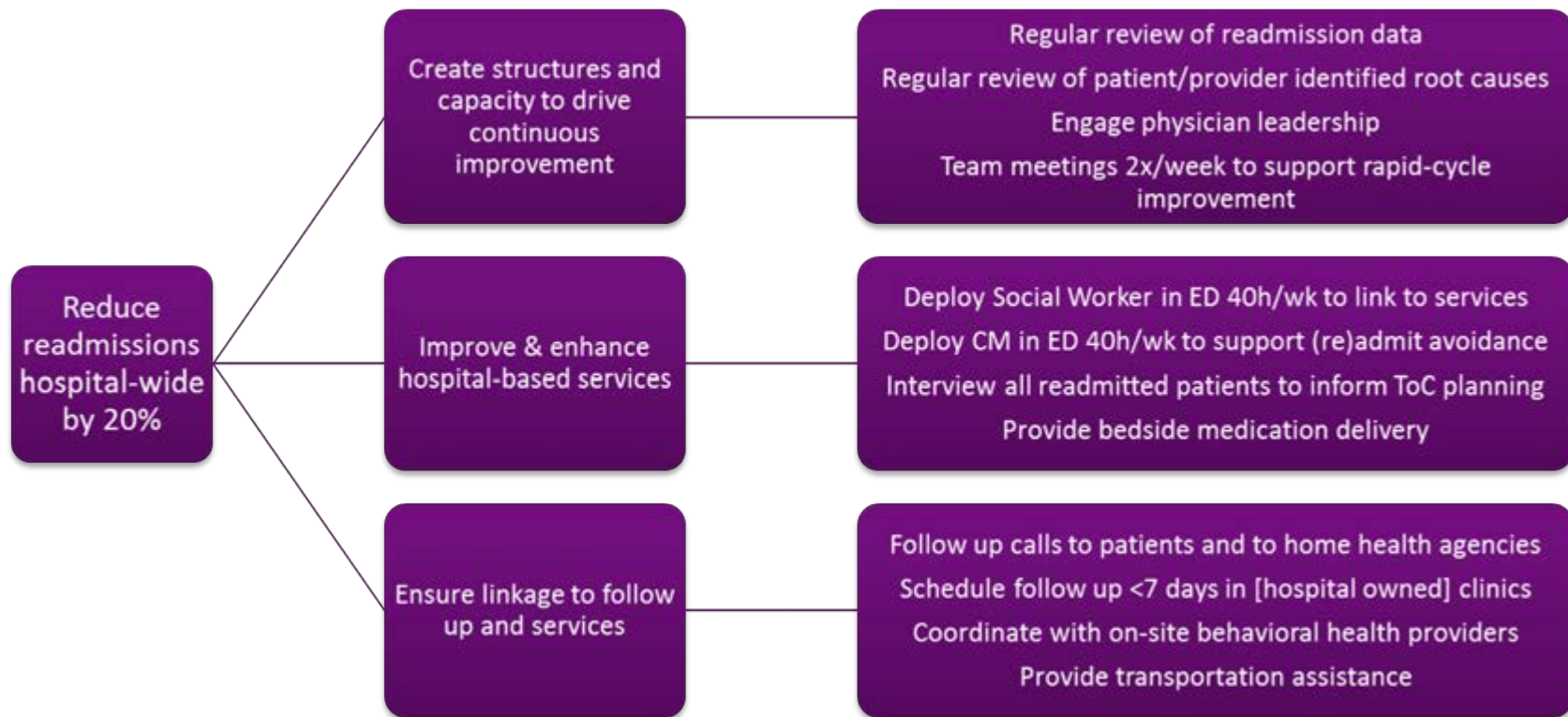
Example 1: Baltimore Hospital

Not pneumonia-specific

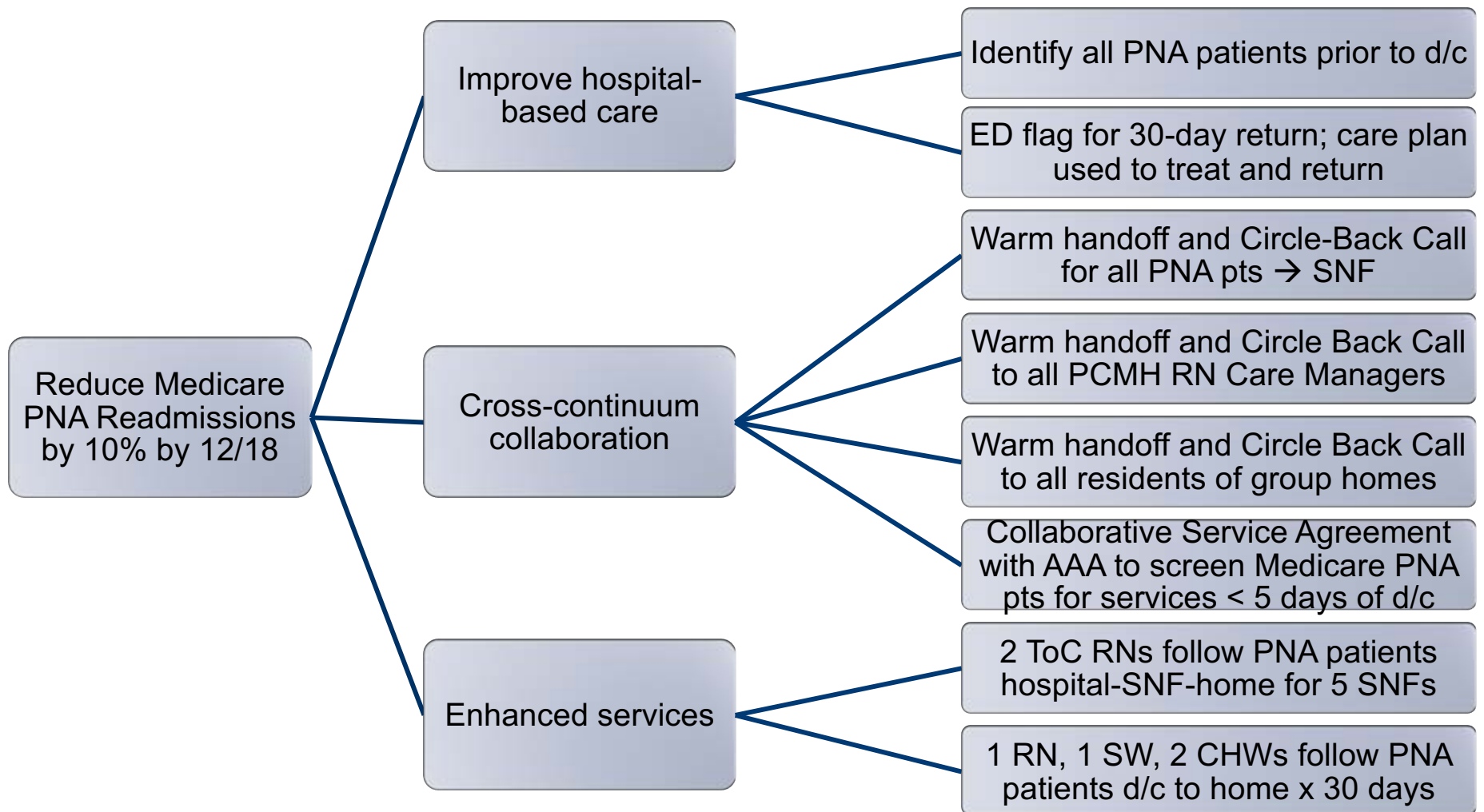


Example 2: Chicago Hospital

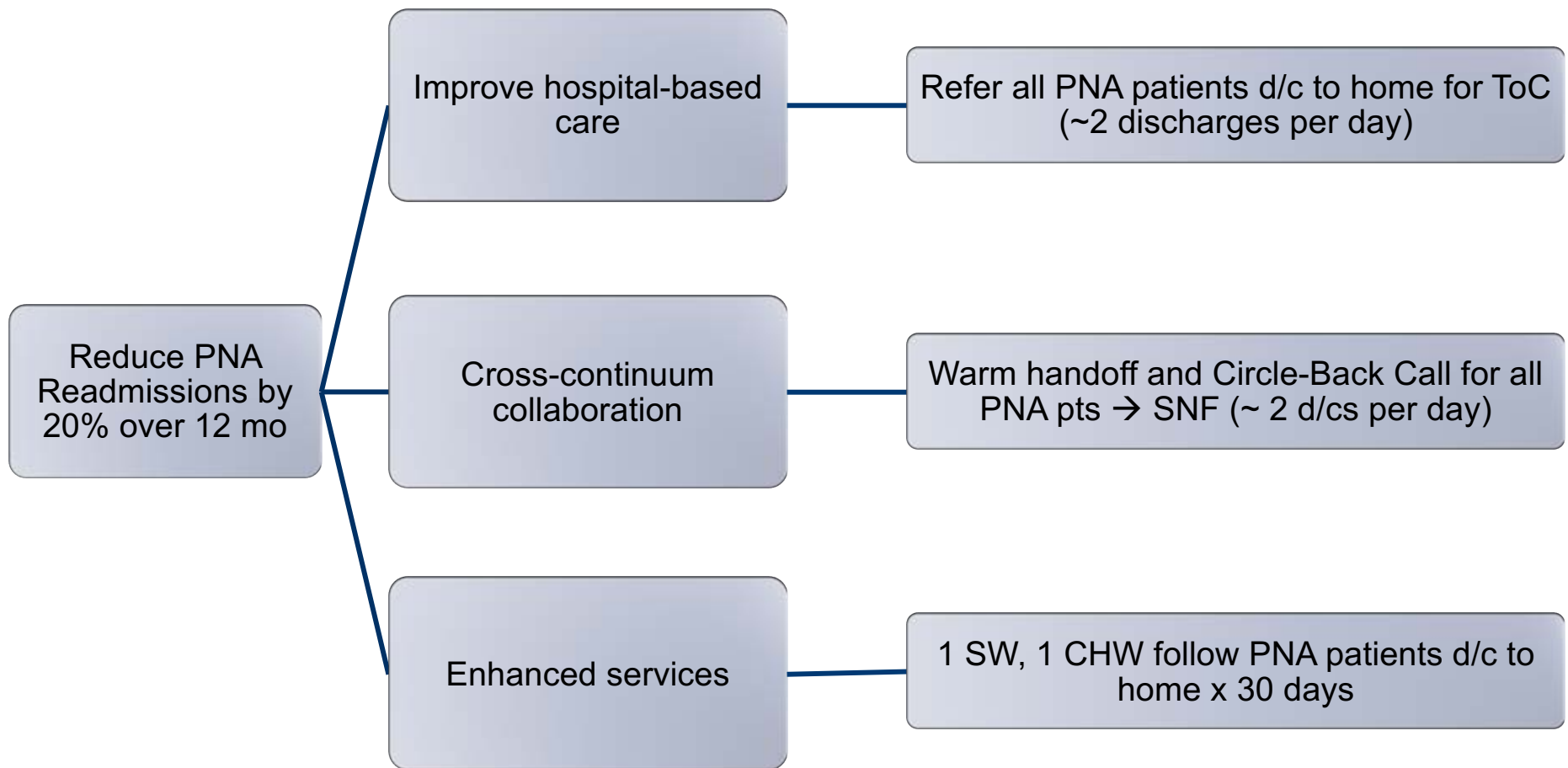
Not pneumonia-specific



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

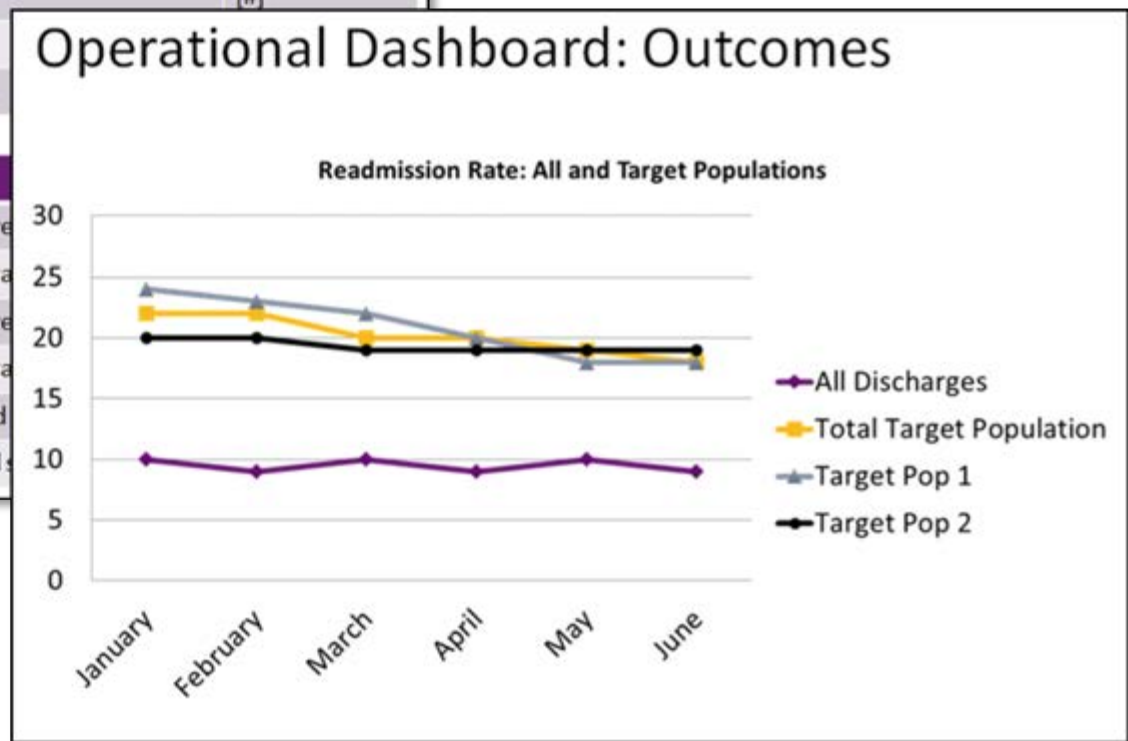


Establish an Operational Dashboard to Track Implementation and Outcomes (Tool 6)

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 received [intended services]
% of discharges in [target population 1] that received [intended services]
Number of discharges in [target population 2] that received [intended services]
% of discharges in [target population 2] that received [intended services]
Total target population discharges that received intended services
% of target population discharges that received intended services





Pneumonia Knockout Score Reducing Pneumonia Mortality and Readmissions

Goal: Reduce State Pneumonia (PNE) mortality rate by 7.5% in 2 years. Reduce State PNE readmissions by 5.4% to the national average.
Data: CMS measures reported on data.medicare.gov on 12/7/2016 period 7/1/2013 - 6/30/2016. Current report generated 10/1/2016 - 6/30/2017.

CMS 30 Day Pneumonia Mortality



CMS 30 Day Pneumonia Readmissions



State performance was stable 2012-2015. National rank changed in comparison to other states. State performance worsened in 2016. Performance improved slightly in 2017, but rank worsened.



State performance was stable 2012-2015. National rank changed in comparison to other states. State performance worsened in 2016. Performance improved slightly in 2017, but rank worsened.

Mortality Goal Impact



Based on CMS measure data and number of cases, NC had an estimated 8,417 pneumonia mortalities in 2017. The state would have an estimated 7,701 deaths if it were performing at the national average, and 7,120 deaths if it were performing in the top quartile nationally. Thus, if NC prevents between approximately 821 and 1,339 deaths, it should move from 49 out of 50 states to the national average in two years.

Readmission Goal Impact



Based on CMS measure data and number of cases, NC had an estimated 8,417 pneumonia readmissions in 2017. The state would have an estimated 7,800 readmissions if it were performing at the national average, and 7,120 readmissions if it were performing in the top quartile nationally. Thus, if NC prevents between approximately 821 and 1,339 readmissions, it should move from 49 out of 50 states to the national average in two years.



Pneumonia Knockout outcomes are based on CMS 30-day mortality and readmissions for Medicare patients. However, to understand and improve pneumonia care for all patients, it's important to have a broader sense of context. This report displays statewide claims data from NCHA's POS+ database, 10/1/2016 - 6/30/2017.

Self Pay Private/Commercial Other Medicare Medicaid

Inpatient Volume

Total Inpatient Discharges, NC



Total Inpatient Discharges, Hospital



Inpatient Discharges Pneumonia, NC

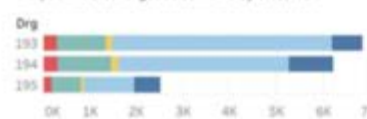


Inpatient Discharges Pneumonia, Hospital

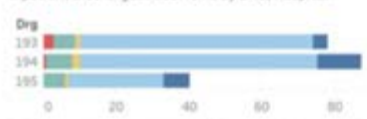


Severity

Inpatient Discharges Pneumonia by DRG, NC



Inpatient Discharges Pneumonia by DRG, Hospital



193 - Single Pneumonia and Pleurisy W MCC; 194 - W CC; 195 - W/D MCC
MCC - major complication or comorbidity; CC - complication or comorbidity

Emergency Department Volume

Total ED Visits, NC



Total ED Visits, Hospital



Total ED Visits Pneumonia, NC



Total ED Visits Pneumonia, Hospital



Length of Stay

Observed Average Length of Stay/Expected Length of Stay (NC Compared to National Benchmark)

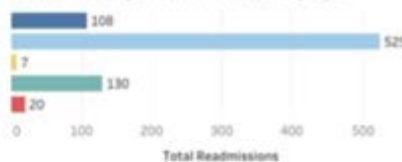


Observed Average Length of Stay/Expected Length of Stay (Hospital Compared to National Benchmark)



Readmissions

Pneumonia 30-day Readmissions, Hospital by Payer



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



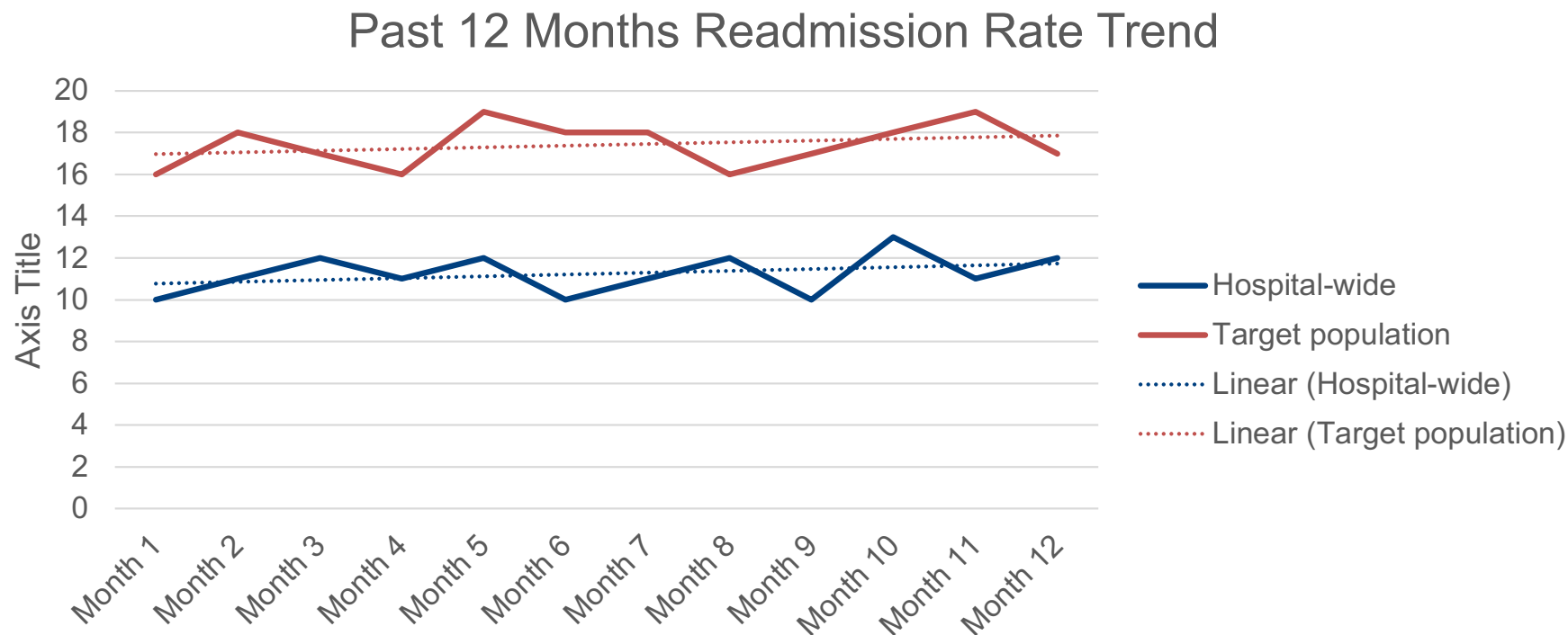
Part 1: Monthly Administrative Data

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

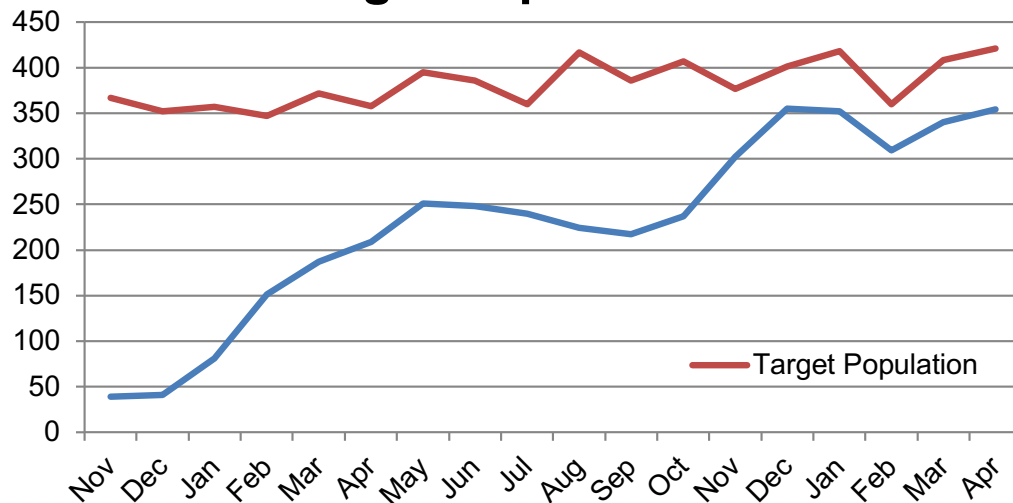
Overall and target population



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

Percent of Target Population Patients Served

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

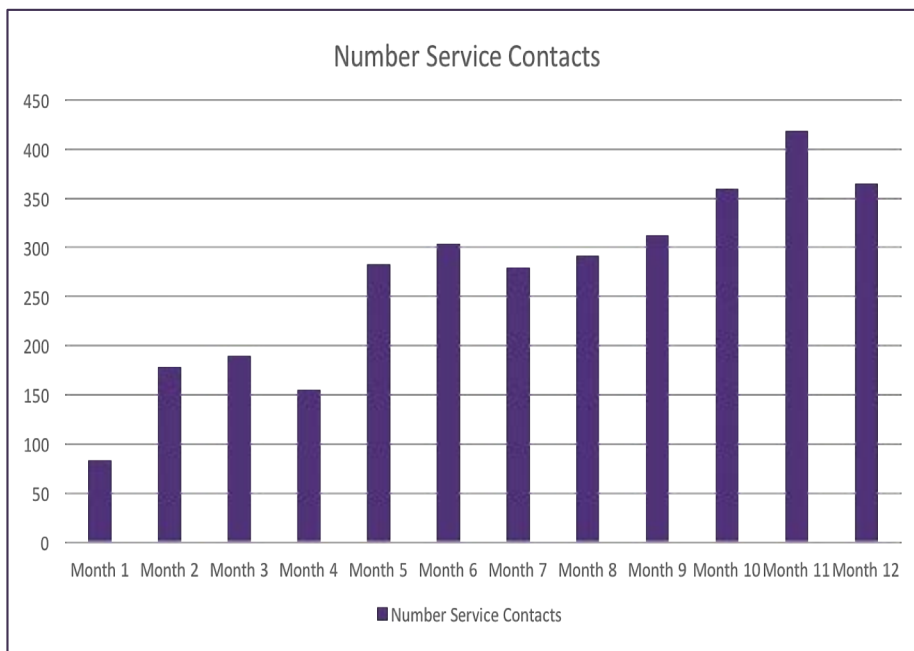


Key lessons:

- “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

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)

ASPIRE

[Hospital] Readmission Reduction
[Date]

Readmissions: Current State

- [Hospital's] current readmission rates:
 - Med
 - Med
 - Hos
- Why Update Our Readmission Reduction Strategy?
 - [insert rationale for quality, patient experience here]
 - Com read
 - Com come

[Hospital] Readmission Data Analysis

- Total discharges
- Readmission rate
- Top 3 diagnosis results
- % of all discharges with
- Readmission rate for all
- # of patients with an ac
- Readmission rate for th
- Other (your choice)

Insights From Readmitted Patient Interviews

- [use dir
- [provide
- [summa
- [highlig
- [avoid n
- "noncor

What Exists: Hospital and Community Inventory

- Hospital Based Efforts
 - Readmissio
 - Discharge
 - Outcomes
 - Medicatio
 - Includi
 - Schedule
 - Discharge
 - Learni
 - Discharge
- Community Based Efforts
 - Readmissio
 - Discharge
 - Outcomes
 - Medicatio
 - Includi
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 - Learni
 - Discharge

Readmission Reduction Goal and Target Population(s)

- [specify the h
- what will be
- for whom
- by how muc
- by when [e.g.
- [specify the t
- [e.g., Hospit
- [e.g., patien
- [e.g., patien
- [e.g., all pat

Readmission Reduction Goal and Target Population(s)

- Goal: [state go
- Current rate
- Current num
- Goal reduc
- Target popula
- Number of d
- Number of r
- Number of r
- Goal reduc

Your Driver Diagram

- Executive sponsor
- Champion
- Day-to-day lead
- Team members
 - Nursing
 - Care management
 - ED
 - Hospital medicine
 - Social work
 - Chaplain
 - Pharmacy
 - Data analyst
 - IT
 - Key 2-4 community

Readmission Reduction Team

- Executive sponsor
- Champion
- Day-to-day lead
- Team members
 - Nursing
 - Care management
 - ED
 - Hospital medicine
 - Social work
 - Chaplain
 - Pharmacy
 - Data analyst
 - IT
 - Key 2-4 community

Measures of Success

- Monthly implementation statistics
 - % of patients w
 - Specify service appointments
 - Aim to achieve
- Monthly readm
- Hospitalwide
- Specific target
- Aim to see a m
- Aim to achieve

Operational Dashboard: Volume and Implementation

Volume, per month

Number of (adult non-OB) discharges

Number of discharges in target

Number of discharges in target

Total number of discharges in t

% of all discharges that are targ

Implementation of Service 1

Number of discharges in target

% of discharges in target popul

Number of discharges in target

% of discharges in target popul

Total target population discharg

% of target population discharg

Operational Dashboard: Outcomes

Readmission Rate: All and Target Populations

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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