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

Amy E. Boutwell, MD, MPP
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

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
Knockout Pneumonia Readmissions Series

<table>
<thead>
<tr>
<th>Webinar</th>
<th>ASPIRE to Knockout Pneumonia Readmissions</th>
<th>Resources</th>
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</table>
| 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 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                                                |
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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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

Your Driver Diagram:

AHRQ Guide to Reducing Medicaid Readmissions

Identify 3-4 primary ways readmissions will be reduced for the target population

List your current and/or planned specific actions, or strategies, to impact each readmissions driver

Enter your overall readmission reduction aim statement here. Specify: what, for whom, by how much, when

Reduce readmissions for X population, by X%, by X date

Driver 1

Driver 2

Driver 3

Strategy 1

Strategy 2

Strategy 3

Strategy 4

Strategy 5
Linking Interventions to Strategy

What are we doing to reduce readmissions?

Reduce Readmissions (aim statement)

- Improve hospital-based care
  - Inpatient
  - ED
  - Post Acute Care
- Cross-continuum collaboration
  - Primary Care
  - Behavioral Health
- Enhanced services
  - Social/Support Services
  - Transitional Care
  - Community Paramedicine Program
Example 1: Baltimore Hospital
*Not pneumonia-specific*

- Reduce hospital-wide readmissions by 20%
- Intervene in ED prior to (re)admit
- Reliably deliver inpatient transition of care practices
- Provide or link to transitional care services
- Develop cross-setting partnerships, norms & protocols
- Real-time identification
  - ED staff available to coordinate
  - Use individualized care plans
- Needs assessment
  - Engage caregiver/“learner”
  - Customized instructions & teach back
  - Arrange for follow up & services
- Follow up phone calls
  - Bedside delivery of medications
  - Time-limited transitional care
  - Link to community support
- Monthly cross-continuum meetings
  - Cross-setting readmission reviews
  - Warm handoffs, “receiver” oriented
  - Share use of common tools, eg INTERACT
Example 2: Chicago Hospital

Not pneumonia-specific

- Reduce readmissions hospital-wide by 20%
- Create structures and capacity to drive continuous improvement
- Improve & enhance hospital-based services
- Ensure linkage to follow up and services
- Regular review of readmission data
  - Regular review of patient/provider identified root causes
  - Engage physician leadership
  - Team meetings 2x/week to support rapid-cycle improvement
- Deploy Social Worker in ED 40h/wk to link to services
  - Deploy CM in ED 40h/wk to support (re)admit avoidance
  - Interview all readmitted patients to inform ToC planning
  - Provide bedside medication delivery
- Follow up calls to patients and to home health agencies
  - Schedule follow up <7 days in [hospital owned] clinics
  - Coordinate with on-site behavioral health providers
  - Provide transportation assistance
Pneumonia Example 1

Reduce Medicare PNA Readmissions by 10% by 12/18

Improve hospital-based care
- Identify all PNA patients prior to d/c
- ED flag for 30-day return; care plan used to treat and return
- 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
- 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

Cross-continuum collaboration

Enhanced services

Collaborative Healthcare Strategies
Pneumonia Example 2

Reduce PNA Readmissions by 20% over 12 mo

- Improve hospital-based care
  - Refer all PNA patients d/c to home for ToC (~2 discharges per day)

- Cross-continuum collaboration
  - Warm handoff and Circle-Back Call for all PNA pts → SNF (~2 d/cs per day)

- Enhanced services
  - 1 SW, 1 CHW follow PNA patients d/c to home x 30 days
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

<table>
<thead>
<tr>
<th>Volume, past month</th>
<th>Number or %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of (adult non-OB) discharges</td>
<td>[#]</td>
</tr>
<tr>
<td>Number of discharges in target population 1</td>
<td>[#]</td>
</tr>
<tr>
<td>Number of discharges in target population 2</td>
<td>[#]</td>
</tr>
<tr>
<td>Total number of discharges in target populations</td>
<td></td>
</tr>
<tr>
<td>% of all discharges that are target population discharges</td>
<td></td>
</tr>
</tbody>
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### Operational Dashboard: Outcomes

**Readmission Rate: All and Target Populations**

- All Discharges
- Total Target Population
- Target Pop 1
- Target Pop 2

![Graph showing readmission rates for different populations over time.]
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
<table>
<thead>
<tr>
<th>Monthly measurement</th>
<th>All</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Total number of pneumonia discharges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Total number of readmissions following discharges (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Pneumonia readmission rate (B/A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Total number of pneumonia discharges to SNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Total number of pneumonia discharges to home care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Total number of pneumonia discharges to home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Total number of pneumonia discharges in “target population” (if stratifying by high risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Total number of “target population” readmissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Readmission rate, “target population” (H/G)</td>
<td></td>
<td></td>
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<tr>
<td>J. % of all PNA discharges in “target population” (G/A)</td>
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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?*

<table>
<thead>
<tr>
<th></th>
<th>This month</th>
<th>Last month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # target population discharges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges “served” in-house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges “served” post-discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges with timely contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges ”completed bundle”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other [specific to your program]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other [specific to your program]</td>
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*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 reduction 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

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