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

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NCHA Knockout Pneumonia Campaign - Webinar 5
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DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE:
THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

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COLLABORATIVE
HEALTHCARE STRATEGIES

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

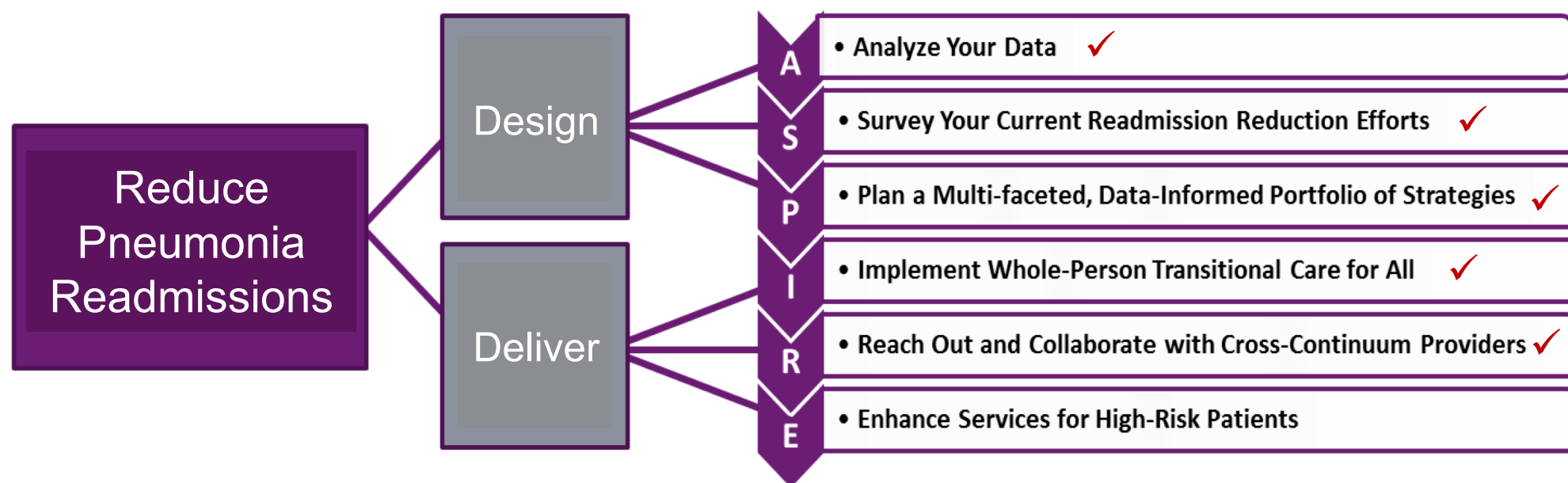- ➤ **Email us** with questions or issues to discuss on the next webinar

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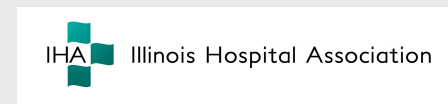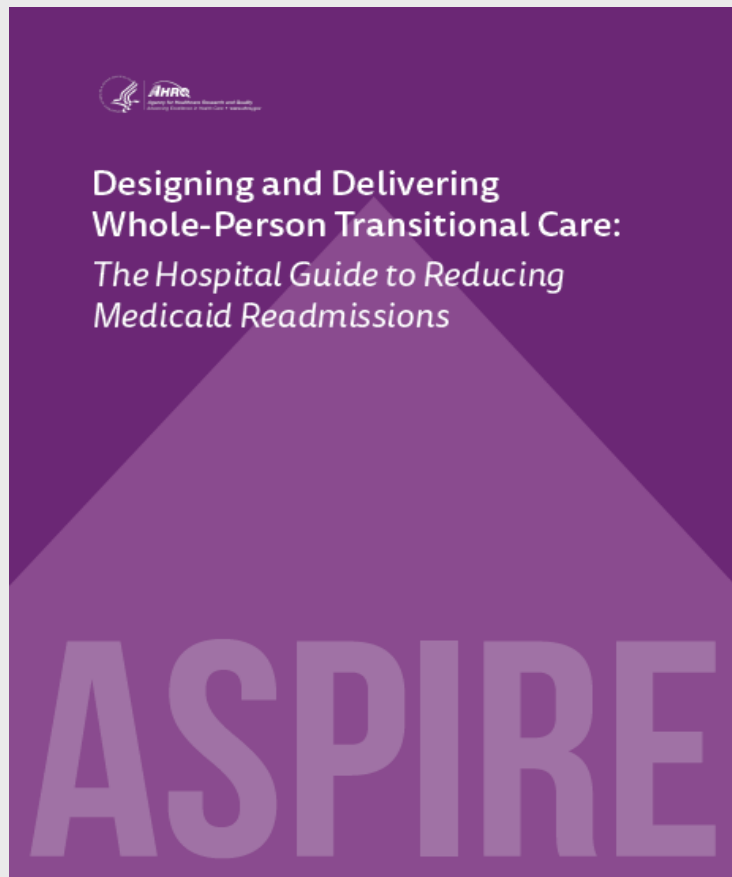
Designing and Delivering Whole-Person Transitional Care:
The Hospital Guide to Reducing Medicaid Readmissions

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ASPIRE Framework

Reduce Pneumonia Readmissions

Design

Deliver

A — • Analyze Your Data ✓

S — • Survey Your Current Readmission Reduction Efforts ✓

P — • Plan a Multi-faceted, Data-Informed Portfolio of Strategies ✓

I — • Implement Whole-Person Transitional Care for All ✓

R — • Reach Out and Collaborate with Cross-Continuum Providers ✓

E — • Enhance Services for High-Risk Patients

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Knockout Pneumonia Readmissions Series

Webinar	ASPIRE to Knockout Pneumonia Readmissions	Resources
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 8, 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
November 2	Knockout Pneumonia Readmissions in-person session	• 7 day action plan • 30 day action plan
November 15	Follow up coaching from in-person session	• Collaborative participants
December 6	Follow up coaching from in-person & lessons learned	• Collaborative participants

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Objectives for Today

- **Design** post-discharge services and supports that address the root causes of pneumonia readmissions

- **Deliver** effective post-discharge transitional care for pneumonia patients

- **Consider:** for which patients do we deliver pneumonia-specific transitional care, and for which patients do we deliver whole-person transitional care?
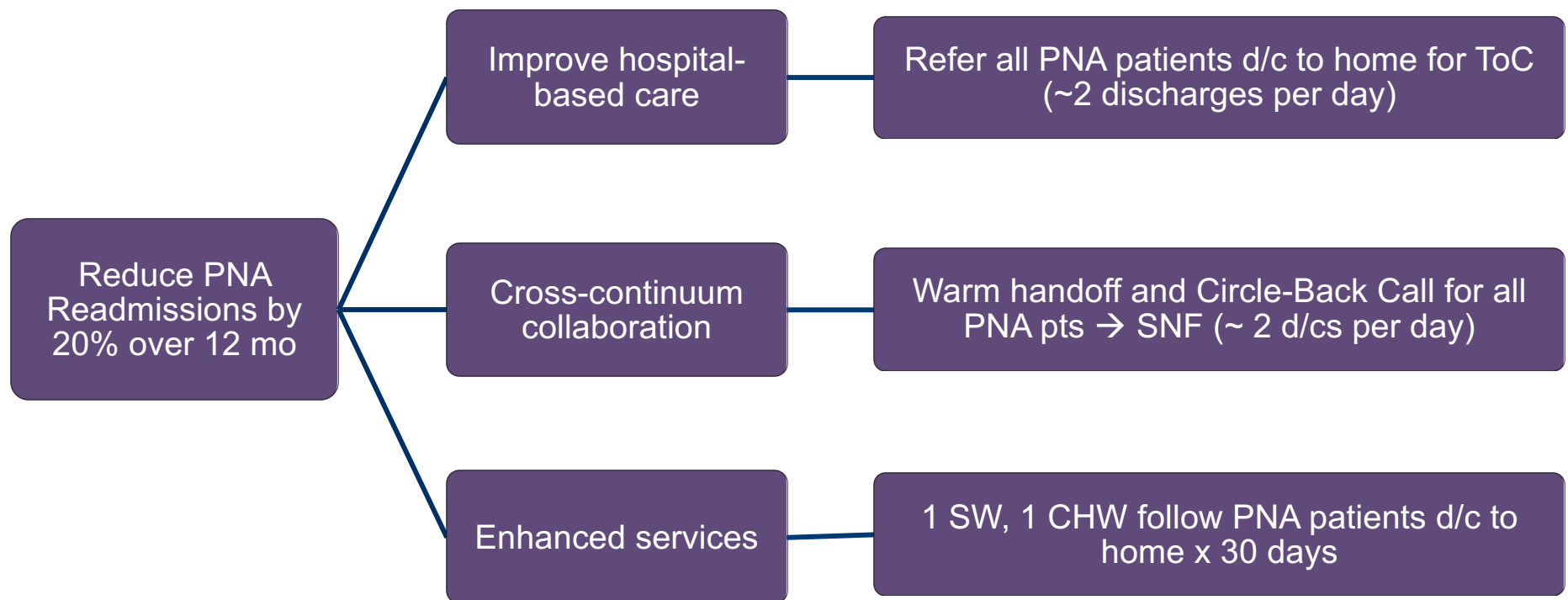
Take a Data-Informed Approach to Design

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 (services)?

What "would it take" to monitor for and address the issues that cause your pneumonia patients to return < 30 days?

Reducing PNA Readmissions Strategy - Example

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Reduce PNA
Readmissions by
20% over 12 mo
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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

DELIVER TRANSITIONAL CARE TO HIGH-RISK PATIENTS

Supports and services over 30 days

"I think that there's always going to be a group of folks that's always going to need somebody to help them. That's never going to change."

Transitional Care Social Worker

North Philadelphia

Enhanced Transitional Care Services

- Additional services and supports in the time following hospitalization;

- Services not provided to all patients as part of routine care;

- Offered to subgroups identified as "high risk" of readmission;

- Delivered prior to and after discharge, often for 30 days;

- Delivered by hospital staff or by contracted staff from other entities

High Risk Target Populations

- There may be several target populations at high risk of readmission identified by your data analyses, such as:

    - *Pneumonia patients discharged to home with home care;*

    - *Pneumonia patients discharged to residential/group home settings;*

    - *Pneumonia patients discharged to skilled nursing facilities;*

    - *Pneumonia patients with comorbid HF, COPD, AF, CVA, aspiration*

    - *Pneumonia patients with behavioral health comorbidities*

    - *Pneumonia patients who can't afford medications*

    - *Others….what pneumonia target populations have you identified?*

- One "standard" transitional care model would not likely meet the needs and address the root causes of readmissions for all these populations

- Design "enhanced services" to **meet the needs** of each target population

Transitional Care Services

"Our [navigators] are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills."

Director of Case Management

Baltimore-Area Hospital

"Whole-Person" Adaptations to Transitional Care

- Navigating

- Hand-holding

- Arranging for….

- Providing with….

- Harm reduction

- Meet "where they are"

- Patient priorities first

- Relationship-based

Social Work-based Transitional Care

"Bridge model"

- Social worker-provided 30-days of post-discharge support
- Engage with patients with clinical, behavioral health and social needs
- Assess for transitional care needs
- Expect needs will change over time
- Use motivational interviewing
- Identify services in place
- Assess eligibility for services
- Discuss finances in context of needs and priorities
- Link directly to services
- Brief short term therapeutic support
- Coordinate with clinical and social service providers
- Statistically significant all cause, all hospital readmission reduction by 20%

Boutwell, Johnson, Watkins. Analysis of a Social Work-Based Model of Transitional Care to Reduce Readmissions

In Practice: Social Work Transitional Care

Recognized as an AHRQ Service Delivery Innovation, and recently published as an evidence-based transitional care model in the Journal of the American Geriatrics Society, the Bridge Model is a social worker-led transitional care model. Social workers assess "whole-person" transitional care needs, and work with patients, their families, providers, and community service agencies to address post-hospital needs over a 30-day period. Developed at Rush University Medical Center, the Bridge model has been implemented for a target population that includes patients with social and behavioral health needs, including the following criteria: live alone, no source of emotional support, no support system in place, discharged with a social service referral, and a severe psychosocial need, among others.

The social worker calls the high-risk patient within two days of discharge, and first focuses on developing rapport with the patient or their caregiver. In more than 80 percent of cases, the social worker identifies problems to be addressed, with about three-fourths of these problems not becoming apparent until after discharge. The three most common problems are difficulty coping with change, caregiver stress, and problems managing medical care, including medications. Other common issues include trouble obtaining community services, communication breakdowns between providers, trouble managing a new treatment or diagnosis, and difficulty understanding the discharge plan.

A May 2016 external claims-based analysis demonstrated a statistically significant 20% reduction in all cause, any-hospital readmissions.

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

In Practice: Community Health Workers

Temple University Hospital started a community health worker (CHW) program to augment their efforts to reduce readmissions among heart failure and other high-risk patients. The hospital assigns a CHW to all patients with three or more readmissions in the past year. The CHWs meet with patients as early as possible during the hospitalization and try to meet with the patient multiple times before discharge. This connection while in the hospital makes it much easier to continue the relationship in the post-hospital setting. By design, CHWs meet with patients independently of doctors and nurses. CHWs have noted that patients feel more comfortable telling them about psychosocial and economic problems that may prevent them from adhering to their care plan, such as being unable to afford heat in their home or not understanding what the doctor said.

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

In practice: Interdisciplinary Transitional Care Team

A large safety net hospital in California has an 8-member interdisciplinary transitional care team:

- Pharmacist
- COPD RN
- CHF RN
- Social worker
- 2 Community Health Outreach Workers
- Program Manager
- Data Analyst

The team serves patients admitted with COPD, CHF, or HIV. They actively screen for marginal housing and substance use disorder. They describe their work as "actively support" patients – accompany, support, touch base, follow-up. They hold "drop in" visits in an outpatient conference room on site at the hospital, during which hours patients can connect with the team, have specific questions or needs addressed. Notably, all clinical members of the team do home visits. The team states their success is due to working as an interdependent, highly collaborative team.

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

Whole-Person Approach

Successful readmission reduction teams state:

- *"We look at the whole person, the big picture"*

- *"We always address goals and ask what the patient wants"*

- *"We meet the patient where they are"*

- *"First and foremost it's about a trusting relationship"*

- *"You can't talk to someone about their medications if there is no food in the fridge"*

- *"Our navigators are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills"*
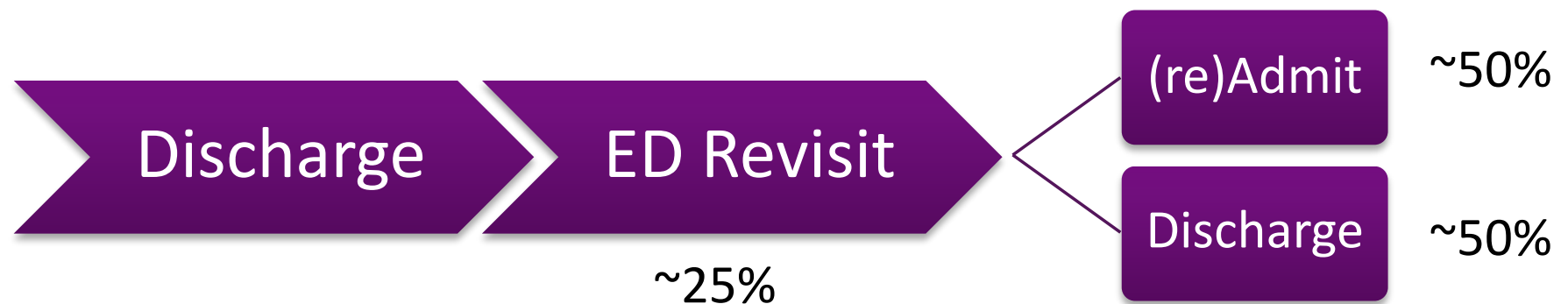
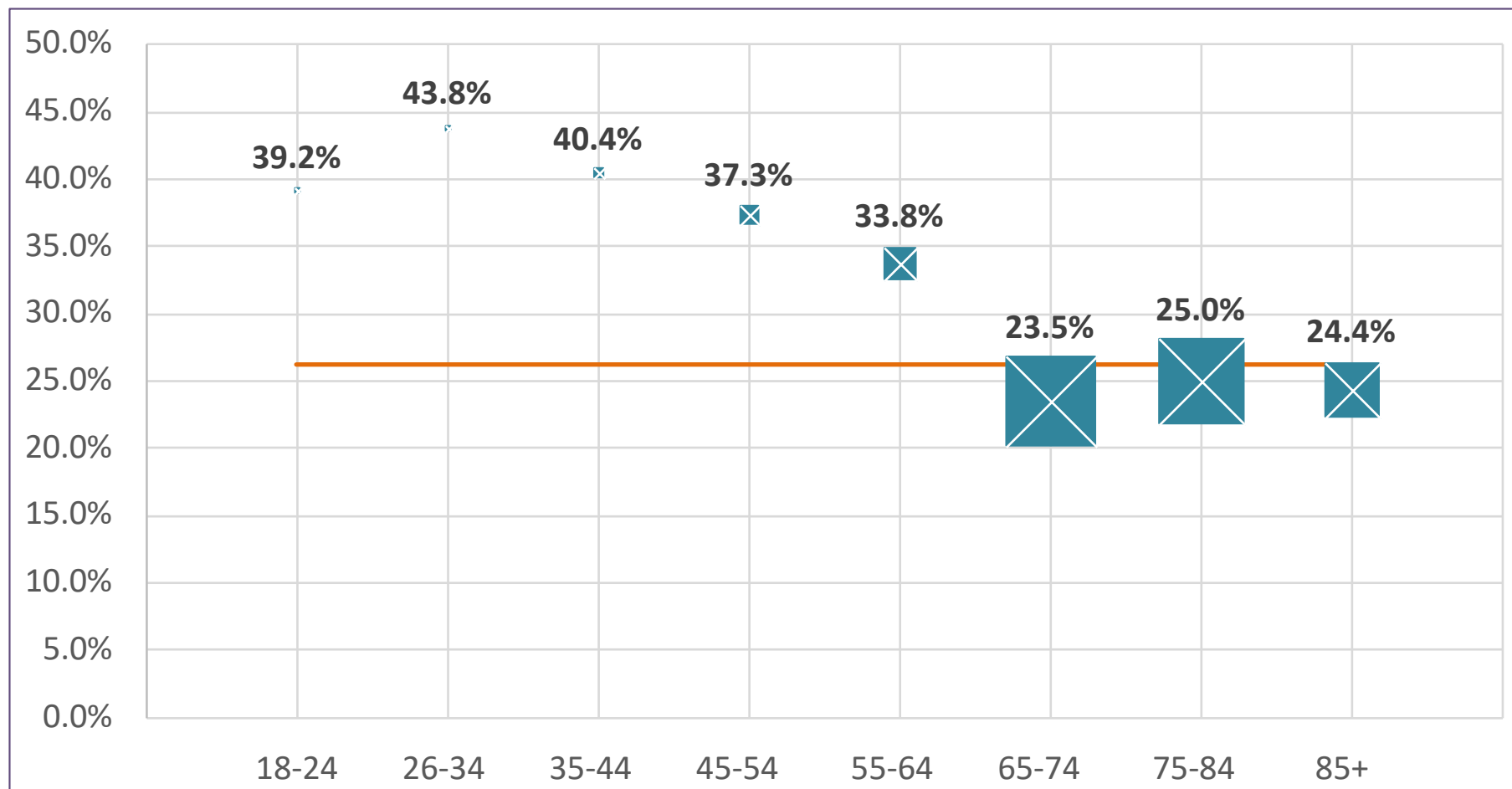- *"We do whatever it takes"*

RE-ENGAGE HIGH-RISK PATIENTS IN THE ED

Many patients return to the ED; that doesn't mean we need to readmit

Managing Over 30 Days: Be Ready for the ED Revisit

Discharge → ED Revisit

~25%

(re)Admit ~50%

Discharge ~50%

Virginia: Medicare ED Revisits after Discharge, by Age

Chart showing Medicare ED revisits after discharge by age group:

Age Group	ED Revisits
18-24	39.2%
26-34	43.8%
35-44	40.4%
45-54	37.3%
55-64	33.8%
65-74	23.5%
75-84	25.0%
85+	24.4%

Responding to the ED Revisit
Strategies of Bundles, ACOs, Readmission Teams, HU Teams

Identify
- Identify the (30-day, HU or HR) return in real-time with a visual cue

Notify
- ED providers see visual cue on tracker board/ on EMR banner
- Readmission prevention/bundle/accountable team notified

Respond
- "ED care alert" informs provider about available support options
- Accountable team responds virtually or in-person to facilitate d/c

Manage
- Utilize "care alert" to promote safe, consistent care plan
- Evaluate and reconnect to accountable team if no acute change
- Provide care in home or in alternate settings in ways that meet needs

In practice: High-risk Care Team Averts (Re)admits from ED

"Our patients look bad on their best day"

A highly successful high-risk, high-cost care management demonstration program leveraged the emergency department as an important opportunity to avert an admission or readmission. When a high-risk patient registered in the ED, a notification was sent to the care management team. The expectation was that the team would collaborate with the emergency department staff to identify whether a discharge, rather than (re)admission, was a safe and appropriate option.

In reflecting on their success factors, the program cited the care managers' and primary care physicians' longitudinal knowledge of their patients as critical to providing context to admission decisions, stating "our patients look bad on their best day," reflecting the importance of knowing a patient's "baseline" in order to accurate determine whether an acute change in clinical status has occurred. In addition, the fact that a high cost complex patient had a "team" willing to provide timely and close follow up allowed care to be delivered in the home or other lower-cost settings.

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

Recommendations

- Quantify: how many pneumonia discharges do you have?

- Understand: what are the root causes of readmissions?

- Consider: what would it take to address those root causes?

- Design: post-hospital supports and services that really address the root causes and needs of your pneumonia patients

- Deliver: whole-person transitional care, flexible, proactive

- Plan: for the ED return < 30 days and be ready to re-connect patient to services & supports, if acute care not needed

Thank you for your commitment to reducing readmissions

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