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
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<th>ASPIRE to Knockout Pneumonia Readmissions</th>
<th>Resources</th>
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<td>March 1</td>
<td>Know your data, understand root causes</td>
<td>• ASPIRE Guide, Section 1&lt;br&gt; • ASPIRE Tools 1 and 2</td>
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<td>April 5</td>
<td>Align with related efforts and resources, identify gaps</td>
<td>• ASPIRE Guide, Section 2&lt;br&gt; • ASPIRE Tools 3, 4</td>
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<td>May 3</td>
<td>Design a portfolio of strategies and operational dashboard</td>
<td>• ASPIRE Guide, Section 3&lt;br&gt; • ASPIRE Tools 5, 6, 7</td>
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<td>June 7</td>
<td>Actively collaborate across the continuum</td>
<td>• ASPIRE Guide, Section 4, 5&lt;br&gt; • ASPIRE Tools 8, 9, 11, 12</td>
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<td>August 2</td>
<td>Deliver effective post-discharge transitional care</td>
<td>• ASPIRE Guide, Section 6&lt;br&gt; • ASPIRE Tool 13</td>
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<td>September 6</td>
<td><strong>ASPIRE +: The Implementation Model to Drive Results</strong></td>
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<td>October 4</td>
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<td>November 2</td>
<td>Knockout Pneumonia Readmissions in-person session</td>
<td>• 7 day action plan&lt;br&gt; • 30 day action plan</td>
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<td>December 6</td>
<td>Action Plan Implementation Report-Out and Next Steps</td>
<td>• Workshop participants</td>
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Aspiring to Knockout Pneumonia Readmissions

November 2, 2018
8:30am – 3:00pm

Novant Health Conference Center
3333 Silas Creek Parkway
Winston Salem

Space is limited, only 75 spots available, spots will be filled on a first come first served basis!

Register Here!

Tentative Agenda

• 7:45am Registration, Breakfast, Networking
• 8:30am-12pm Aspiring to Knockout Pneumonia Readmissions Workshop
  • 12-1pm Networking Lunch
• 1-3pm Aspiring to Knockout Pneumonia Readmissions Workshop Continued

Target Audience

Readmission Champions, Members of Hospital Based Readmission Teams including Quality, Nursing, Social Workers, & Population Health Professionals
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

ASPIRE

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

COLLABORATIVE HEALTHCARE STRATEGIES
ASPIRE + The Implementation Model

ASPIRE Part 1: “Design”

ASPIRE Part 2: “Deliver”

ASPIRE+ Part 3: “Implement”

Design Elements

- Reduce Medicaid Readmissions
- “Design”
- “Deliver”

Implementation Elements

- Data and root cause analysis
- Real-time identification
- Timely engagement
- Whole-person approach
- Service across settings and over time
- Collaboration across the continuum
- Implementation and outcomes measurement
Objectives for Today

1. Describe the elements of the ASPIRE+ operational dashboard

2. Articulate 3 ways you can better implement your pneumonia readmission reduction strategies to Knockout Pneumonia Readmissions
ASPIRE +: “Implement”

Design + Deliver + **Effectively Implement** → Outcomes

- Design: data-informed, root causes
- Deliver: multi-faceted portfolio of strategies
- Implement: deliver what you intend to deliver for the patients you targeted
High Reliability = Effective Implementation

- An intervention can not work unless it is delivered to the patient

- A population based program can not have impact unless the intervention is delivered to a majority of the population a majority of the time

- Many (unsuccessful) programs only focus on results for the patients served

- We need to focus as much on the patients we did not serve, and keep modifying our approach to drive up the % served
Why is Effective Implementation Important?

- Population A has 100 patients (discharges) per month
  - Population A has a readmission rate of 15%
  - Population A has 0.15 x 100 = 15 readmissions
  - Goal: reduce readmissions by 20%
  - 20% fewer readmissions = .2 x 150 = 3 fewer readmissions

- Program A targets Population A
  - Program A identifies 50% of target pop, approaches 80% identified; 50% accept
  - Program A actually serves 20 patients (discharges) per month
  - Program A serves patients with a readmission rate of 15% (0.15 x 20 = 3)
  - Goal of Program A is to reduce readmissions by 20%
  - Program A is successful in reducing readmissions for the patients they serve!
  - Math: 3 readmissions x .20 = 0.6 fewer readmissions (<1/mo)

- Impact of Program A on Population A
  - 0.6 fewer readmissions / 15 readmissions = 4% readmission reduction
Was Program A Effective?

• No. We aimed for a 20% reduction and we got a 4% reduction

• Does that mean the intervention was ineffective?
  • No. The program was effective for the patients served
  • The problem is not that the patients are “too complex”
  • The problem is not that we don’t know “what works”
  • The problem is the gap between “targeted” and ”served”
  • This gap can be closed
  • When the gap is closed, the population-level results improve
Opportunities Abound for Improving Implementation

• Currently, Program A
  • Identifies 50% of target population (.5 x 1000 = 500)
  • Approaches 80% of identified patients (.8 x 500 = 400)
  • 50% of approached patients accept service (.5 x 400 = 200)
  • Reduces readmissions by 20%

• We can change **what** we do, and **how** we do it
  • This is the very purpose of continuous process improvement
Reliable Implementation Drives Results

- Reliable implementation requires implementation measurement and PDSA

- Improve reliability by automating, dedicating staff, clear roles, batching, making the new (more effective) way the easy way

- Consider each key step in the intervention according to how reliably it is delivered to every target population patient, every time they present

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<tr>
<th>Operational Dashboard</th>
<th>This month</th>
<th>Last month</th>
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<tr>
<td>Total # target population discharges</td>
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<tr>
<td>Total # (%) target population discharges “served” in-house</td>
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<tr>
<td>Total # (%) target population discharges “served” post-discharge</td>
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Improve or Innovate to Achieve High Reliability
Design and Execution → Results

**Design Elements**

- **Design**
  - Reduce Medicaid Readmissions

- **Deliver**
  - "Design"
  - 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

**Implementation Elements**

- Data and root cause analysis
- Real-time identification
- Timely engagement
- Whole-person approach
- Service across settings and over time
- Collaboration across the continuum
- Implementation and outcomes measurement
“+” = Execution

Effective Execution Drives Results

Close the Gap

Patients “Served” vs. Total Target Population

Drive Up Completion

Attempts Don’t Count in Readmissions!

Increase Contacts

Drive Up Patient-Facing Contacts with Same FTEs
Close the Gap Between “Target” and ”Served”

Key lessons:
- Reliably identify target pop
- Face to face in-hospital
- Scripting
- Engagement skills
- Opt-out approach
- Continuation of your care
- Avoid “special program”
Prioritize Completed Timely Post-Hospital Contact

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 #
Increase Service to Patients

Key lessons:

- Brief in-hospital visit
- Prioritize community visits
- Batch SNF visits
- Batch home visits
- Batch case conferencing
- Batch documentation
ASPIRE + Results

1. Suburban Hospital
   - "Return" Reduction 27%

2. Small Rural Hospital
   - Readmission Reduction 58%

3. Mid-Sized Community Hospital
   - "Return" Reduction 29%

4. Urban Emergency Department
   - ED HU Visit Reduction 24%

5. Rural Emergency Department
   - ED HU Revisit Reduction 27%

6. Regional Emergency Department
   - ED BH Revisit Reduction 34%

Recommendations

1. Be sure you know how many discharges per month are in your target population

2. Measure how many (and what %) of your target population are “served” by your Knockout Pneumonia Readmission intervention(s)

3. Apply continuous improvement and innovation to increase the % of patients “served” by your intervention

4. Use the ASPIRE+ execution model to increase:
   - % of patients served
   - % completed timely contact
   - # patient-facing transitional care services delivered

5. Trend the readmission rate for your target population every month
New Program Announcement

Is your hospital in the AHA/HRET or Vizient HIIN?

• Have you noticed that your Knockout PNA Readmissions efforts do not effectively work for multi-visit patients?

• A different approach is needed – the MVP Method

• Join the MVP learning network! Informational webinars:
  • AHA/HRET HIIN September 7 from 12-1 ET
  • Vizient HIIN September 11 from 12-1 ET

• Email Dr. Boutwell for webinar registration information
  amy@collaborativehealthcarestrategies.com
Thank you for your commitment to reducing readmissions

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Author, AHRQ "ASPIRE" Guide to Reducing Readmissions
Developer, the MVP Method of Improving Care For High Utilizers

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