ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

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NCHA Knockout Pneumonia Campaign - Webinar 6

September 6, 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

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	**ASPIRE +: The Implementation Model to Drive Results**	• **ASPIRE + operational dashboard**
October 4	In-Person Workshop Preparation	• Workshop prep slides
November 2	Knockout Pneumonia Readmissions in-person session	• 7 day action plan • 30 day action plan
December 6	Action Plan Implementation Report-Out and Next Steps	• Workshop participants

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!

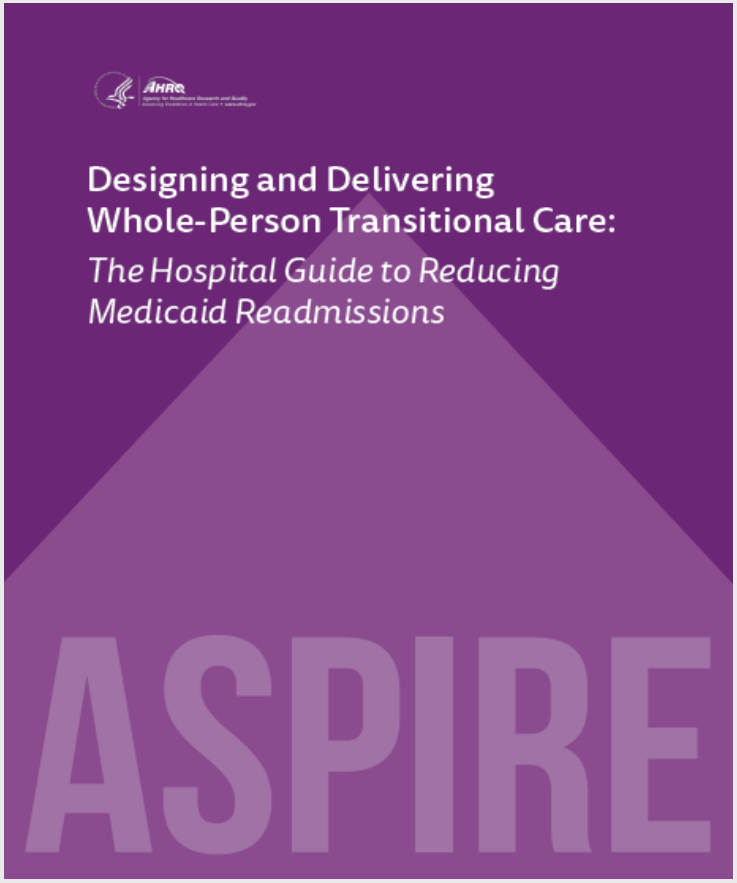
Tentative Agenda

- 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



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 · Virginia Hospital & Healthcare Association — An alliance of hospitals and health delivery systems

MHA Massachusetts Health & Hospital Association · Massachusetts Health Policy Commission · NCHA · Partnership for Patients — New York State Partnership for Patients

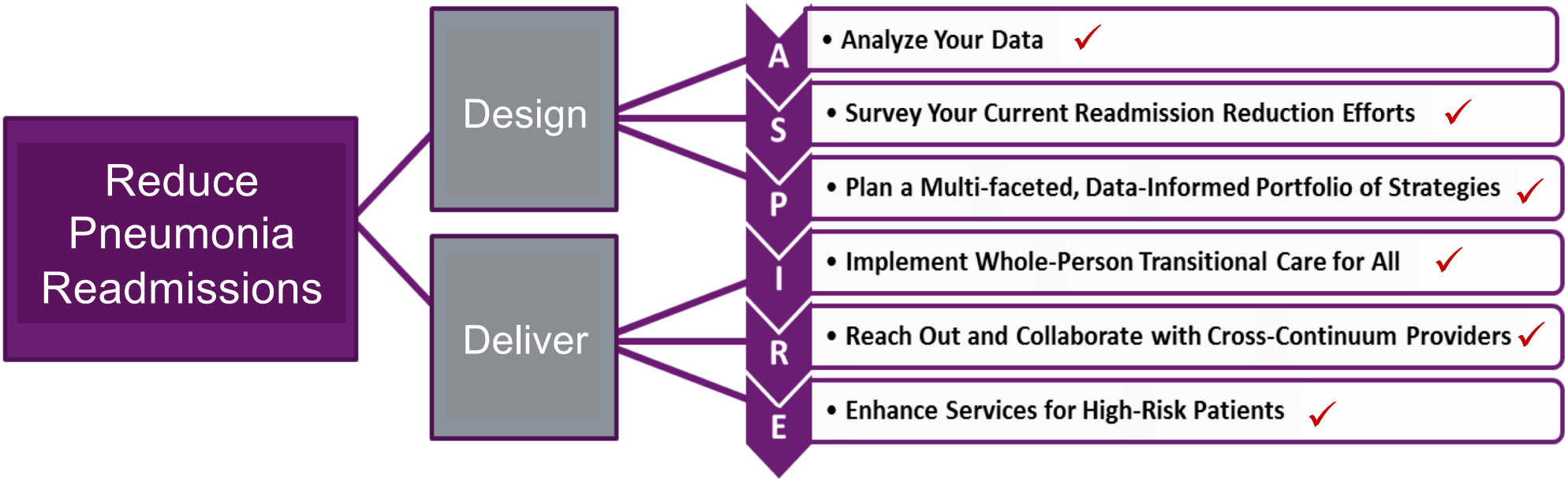
IHC Iowa Healthcare Collaborative — A Partnership for Quality, Patient Safety & Value · New Jersey Hospital Association NJHA · GHA Georgia Hospital Association

ASPIRE

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

COLLABORATIVE HEALTHCARE STRATEGIES

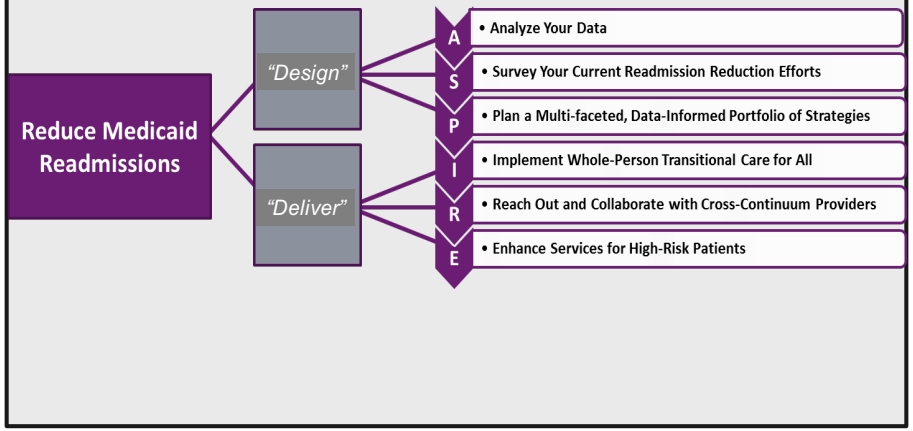
ASPIRE Framework



ASPIRE + The Implementation Model

ASPIRE Part 1: "Design" → ASPIRE Part 2 : "Deliver" → ASPIRE+ Part 3: "Implement"

Design Elements



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% (.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%

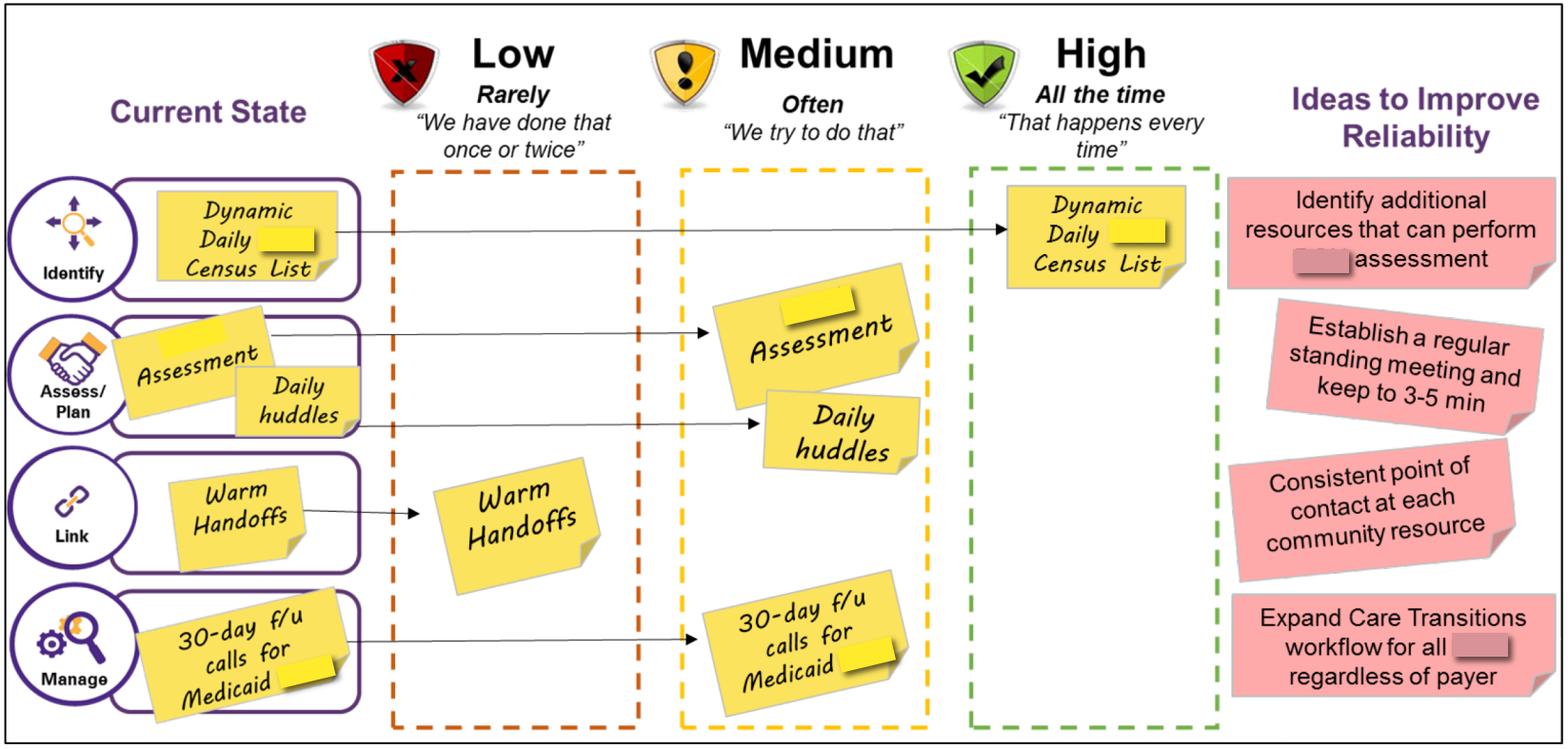
- We can change ***what*** we do, and ***how*** we do it
  - This is the very purpose of continuous process improvement

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

Operational Dashboard	This month	Last month
Total # target population discharges		
Total # (%)target population discharges “served” in-house		
Total # (%) target population discharges “served” post-discharge		

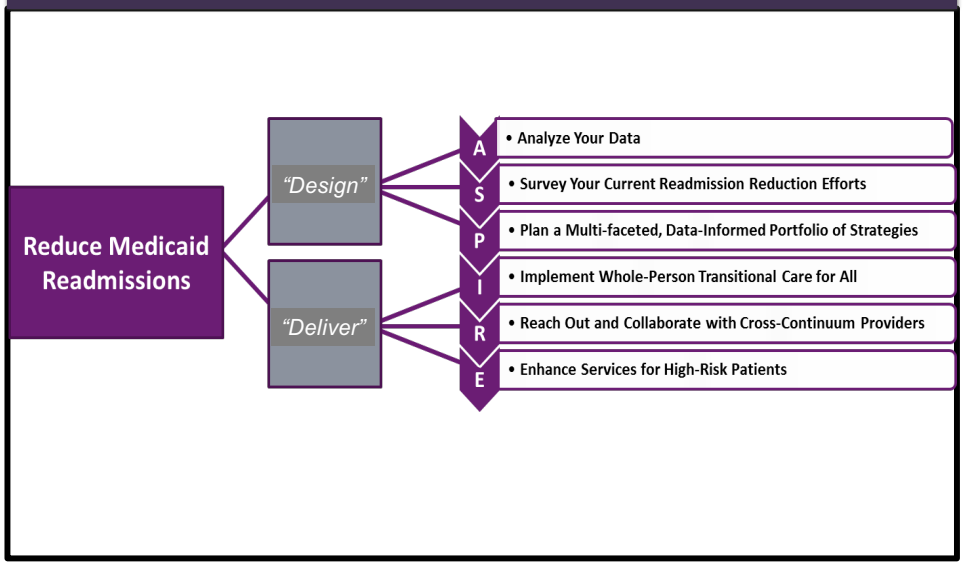
Improve or Innovate to Achieve High Reliability



ASPIRE +

Design and Execution → Results

Design Elements



Implementation Elements

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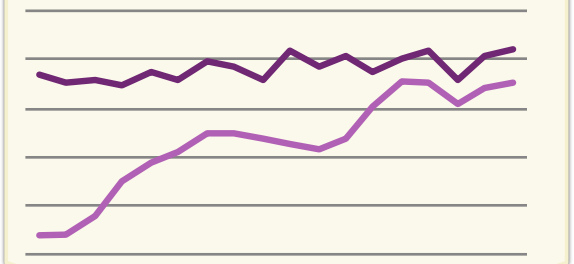
"+" = Execution

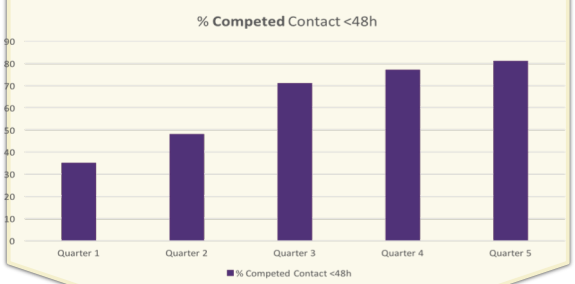
Effective Execution Drives Results

Close the Gap



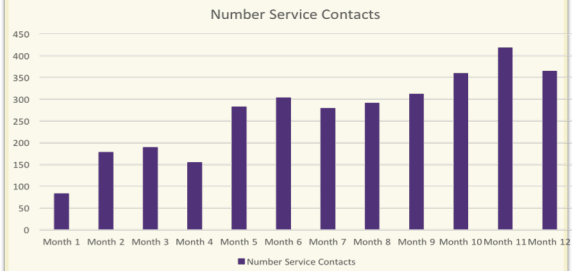
Patients "Served" vs. Total Target Population

Drive Up Completion



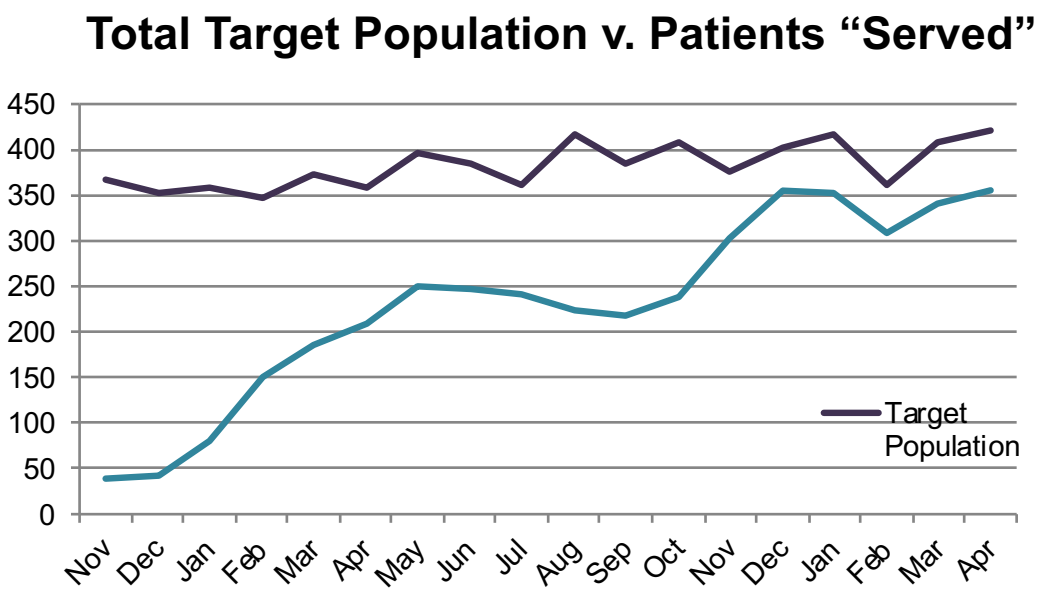
Attempts Don't Count in Readmissions!

Increase Contacts



Drive Up Patient-Facing Contacts with Same FTEs

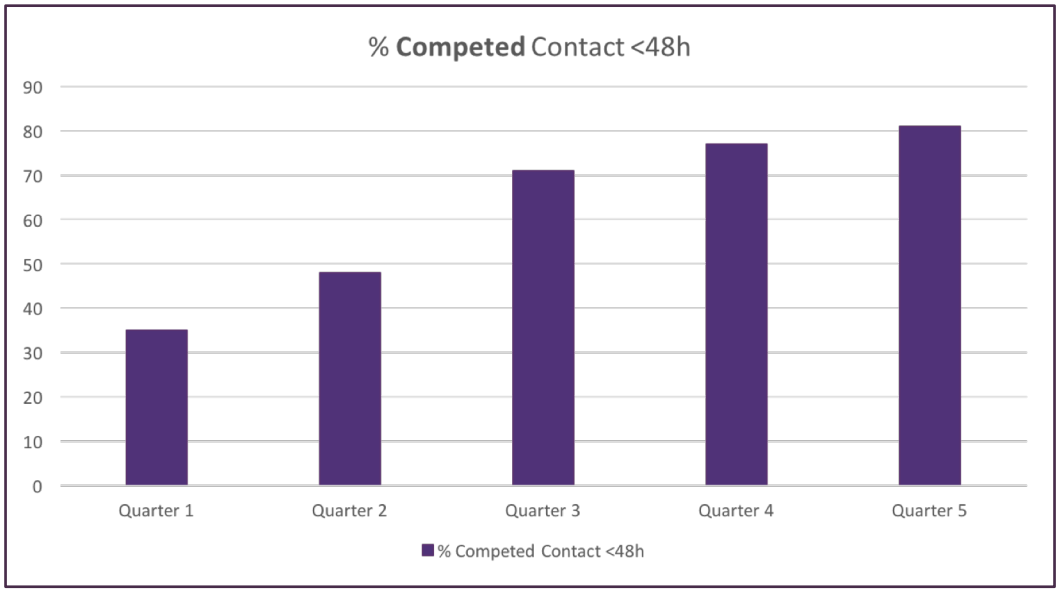
Close the Gap Between “Target” and ”Served”



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:

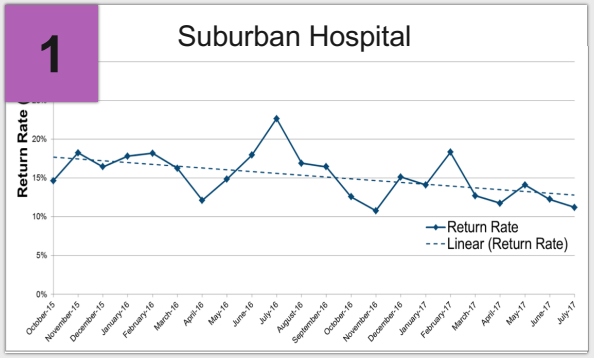
- "It's my job to check on you once you go home"
- Use texting
- Any relevant contact
- Call their cell prior to discharge to confirm #

Increase Service to Patients

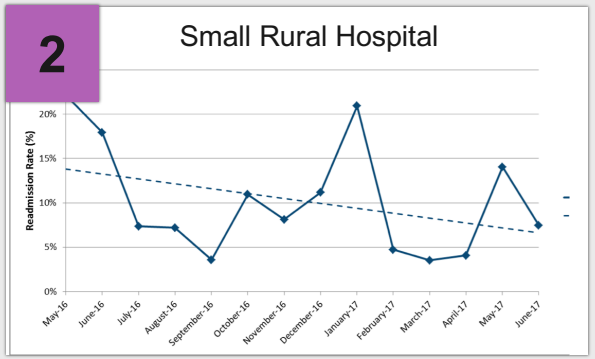
Key lessons:

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

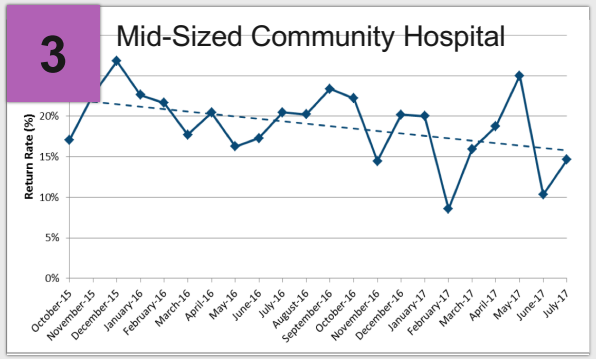
ASPIRE + Results



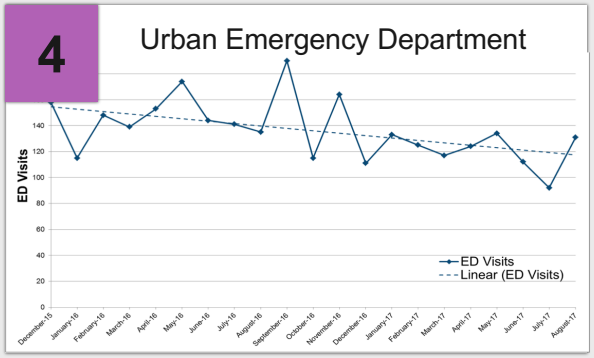
"Return" Reduction 27%



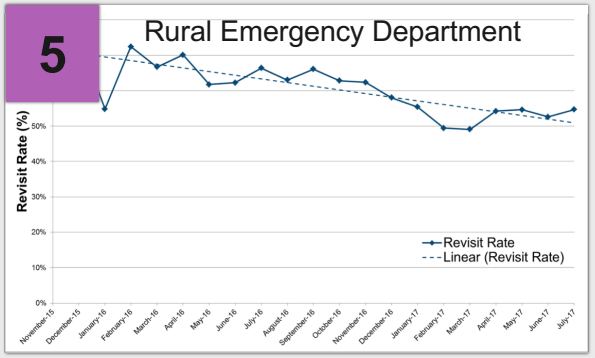
Readmission Reduction 58%



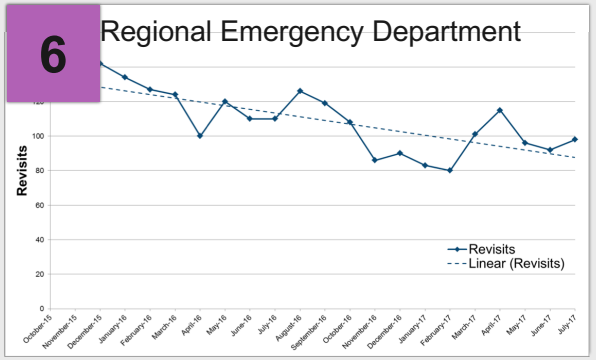
"Return" Reduction 29%



ED HU Visit Reduction 24%



ED HU Revisit Reduction 27%



ED BH Revisit Reduction 34%

http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/2017-chart-convening-morning-panel-slides-.pdf

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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