ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

Amy E. Boutwell, MD, MPP
NCHA Knockout Pneumonia Campaign - Webinar 7
October 4, 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

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

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

ASPIRE Framework

Reduce Pneumonia Readmissions

Design

Deliver

ASPIRE

• 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 + 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. Bring ASPIRE concepts to your pneumonia readmission work:
   - Data
   - Root Causes
   - Design
   - Deliver

2. Identify 3 ways to prepare to advance your readmission work by attending the November 2 workshop
CURRENT STATE

Data – Root Causes – Design – Deliver
### Readmission Reduction Aim Statement

<table>
<thead>
<tr>
<th>What? (reduce readmissions)</th>
<th></th>
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<tbody>
<tr>
<td>For Whom? (which PNA patients)</td>
<td></td>
</tr>
<tr>
<td>By How Much? (relative to a baseline)</td>
<td></td>
</tr>
<tr>
<td>By When? (date, timeframe)</td>
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Example 1: Reduce readmissions for all adult pneumonia patients by 10% over 2018
Example 2: Reduce Medicare PNA readmissions by 20% from 2017 baseline by end of 2018
Example 3: Reduce PNA readmissions for patients d/c to home by 20% from 1/1/18 to 12/31/18
Root Causes of Readmissions

The Readmission Interview

“I see you* were recently discharged about [x] days ago. I’d like to take about 2 or 3 minutes to focus in on the past [x] days and talk about what happened between the day you were discharged and the point at which you (or someone else) decided you needed to return to the hospital.”

Ask – Listen – Observe

Interview 1: 56F d/c home, RA D2
Interview 2: 82M d/c to SNF, RA D5
Interview 3: 43M d/c home, RA D11
Interview 4: 65F d/c home, RA D4
Interview 5: 72F d/c home, RA D10
Interview 6: 92M d/c home, RA D3
Interview 7: 91F d/c SNF, RA D2
Interview 8: 88M d/c SNF, RA D21

Diarrhea
Cough
Confusion
"Bad labs"

*you = the historian, a provider or care partner if the patient can not answer
### Interventions to Reduce Readmissions

#### During Hospitalization
- Identify on admission
- Flag as high risk
- Assess “whole-person”
- Identify care partner
- Daily updates
- Goals of care
- Teaching with teach back
- Contact PCP

#### During Transition
- Confirm phone #
- Confirm care partner #
- Let them know: call
- Ask if can text
- Meds to bed
- Ensure timely contact <48h
- Warm handoff, circle-back

#### After Hospitalization
- Point person to call
- Home visits
- Navigator, coach
- In-home support
- Frequent contact
- “Whole-person” needs
- Ensure stable recovery
Design: Based on Data, Informed by Root Causes

<table>
<thead>
<tr>
<th></th>
<th># Discharges</th>
<th># Readmissions</th>
<th>RA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNA, All</td>
<td>1000</td>
<td>200</td>
<td>20%</td>
</tr>
<tr>
<td>PNA, to Home</td>
<td>500 (50%)</td>
<td>80</td>
<td>16%</td>
</tr>
<tr>
<td>PNA, to Home Care</td>
<td>250 (25%)</td>
<td>60</td>
<td>24%</td>
</tr>
<tr>
<td>PNA, to SNF</td>
<td>250 (25%)</td>
<td>60</td>
<td>24%</td>
</tr>
</tbody>
</table>

During Hospitalization:
- 
- 
- 

During Transition:
- 
- 
- 

After Hospitalization:
- 
- 

Diarrhea
Cough
Confusion
"Bad labs"

Are you targeting your interventions to the right group of patients? Do your interventions address the root causes of readmissions for that group?
Deliver: Are you Delivering Interventions Consistently?

<table>
<thead>
<tr>
<th>Intervention: PNA to Home</th>
<th>Oct Week 1</th>
<th>Oct Week 2</th>
<th>Oct Week 3</th>
<th>Oct Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td># PNA patients</td>
<td>10 (100%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># d/c to home</td>
<td>5 (50% of total)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># meds to bed</td>
<td>3 (60% of target)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># appts &lt;5 days</td>
<td>3 (60% of target)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># d/c calls &lt;48h</td>
<td>2 (40% of target)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># with all above</td>
<td>1 (20% of target)</td>
<td></td>
<td></td>
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<table>
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<td># PNA patients</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># d/c to SNF</td>
<td>3 (30% of total)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># warm handoff</td>
<td>3 (100% of target)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># “circle back” call</td>
<td>1 (30% of target)</td>
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ACCELERATING PROGRESS

*Identify 3 things to work on in October*
Tools

• From today (in these slides)
  • Data, Readmission Interview, Interventions, Implementation Dashboard

• From ASPIRE (https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html)
  Tool 1: Data Analysis (all cause)
  Tool 2: Readmission Review (interview)
  Tool 3: Hospital Inventory (across departments, identify aligned efforts)
  Tool 4: Community Inventory (identify resources, supports to meet patient needs)
  Tool 5: Portfolio Design (“driver diagram” reflecting portfolio of strategies)
  Tool 6: Operational Dashboard (implementation of efforts, and trending outcomes)
  Tool 7: Portfolio Presentation (putting your strategy together in a ppt deck)
  Tool 8: Conditions of Participation Handout (current & proposed changes)
  Tool 9: Whole-Person Transitional Care Planning (identify & address issues/needs)
  Tool 10: Discharge Process Checklist (from CMS documents)
  Tool 11: Community Resource Guide (a build as you go tool for easy reference)
  Tool 12: Cross-Continuum Collaboration Tool (new partnerships with purpose)
  Tool 13: ED Care Plan (a tool for multi-visit patients)
Designing and Delivering Whole-Person Transitional Care
The AHRQ “ASPIRE” Guide

13 customizable tools
6 part webinar series
10 part “whiteboard video” series


Read the guide; listen to the webinars; watch the whiteboard videos
PREPARATION

What are 3 things you can do to make your participation in the November 2 working session a valuable experience?
RECOMMENDATIONS
Recommended for November Workshop

Recommended, not required; we expect teams are at different points along this spectrum

- Pull your data (# PNA discharges, readmissions, by dispo, etc)
- Interview 10 patients who have been readmitted
- Identify root causes of pneumonia readmissions
- List current readmission interventions; try using a driver diagram
- Measure week by week in October the % implementation of interventions
- Identify a community resource partner - and bring them with you!
- Come ready to accelerate your efforts to reduce pneumonia readmissions!
Thank you for your commitment to reducing readmissions

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