ASPIRE to Knockout Pneumonia Readmissions

Designing & Delivering Whole-Person Transitional Care

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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

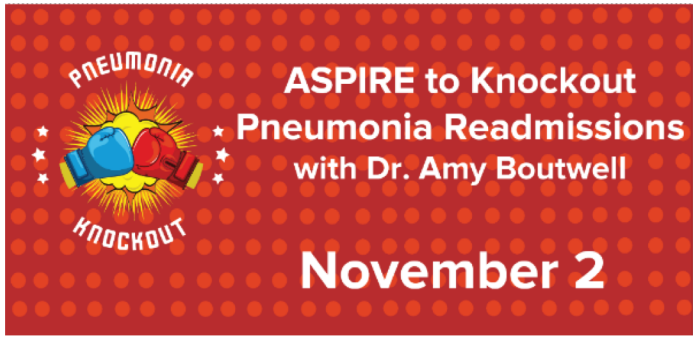
- We will focus on connecting concepts to ***action***
- We will focus on high-leverage ***strategies*** to reduce readmissions
- We will focus on ***implementation*** coaching

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

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!

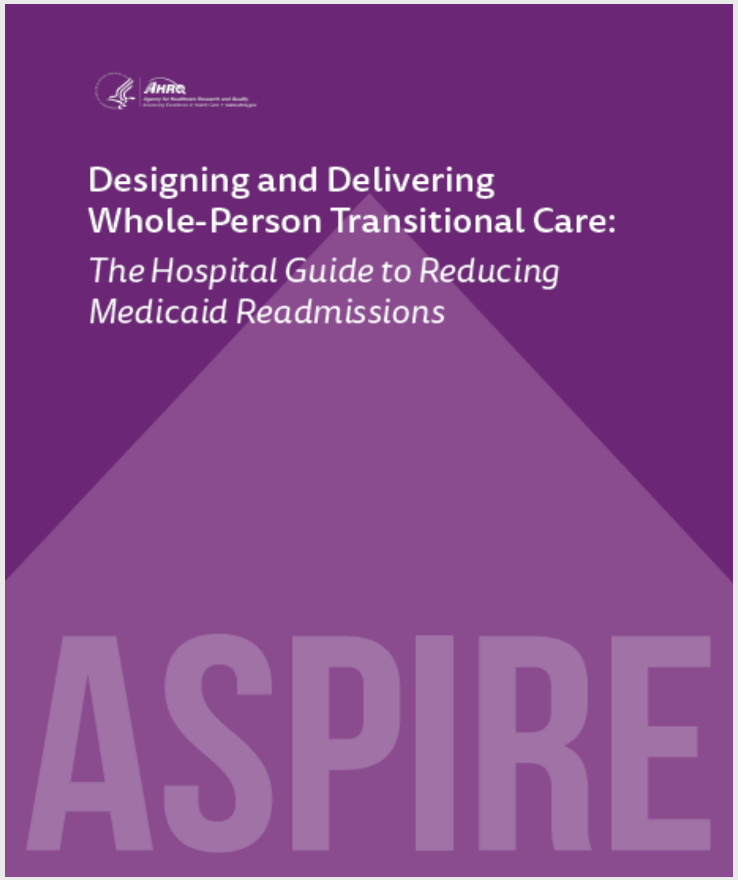
Tentative Agenda

- 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

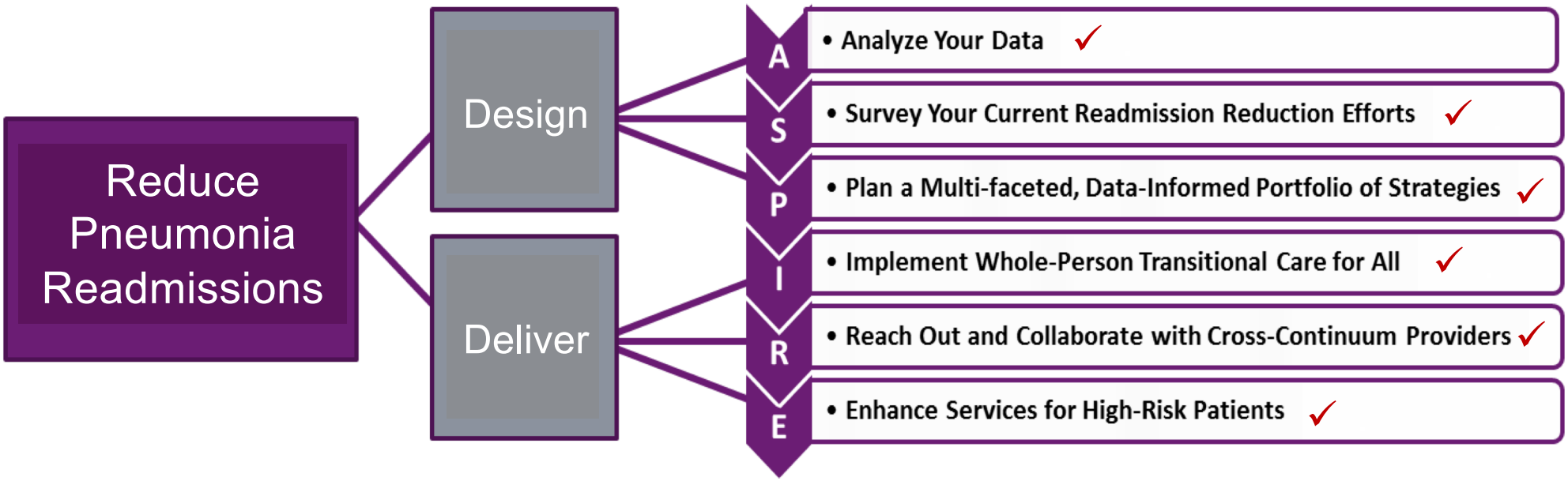
Partnership for Patients — Proud to be Partners in Better Care at Lower Costs. · vizient™ · SCHA South Carolina Hospital Association

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 · 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

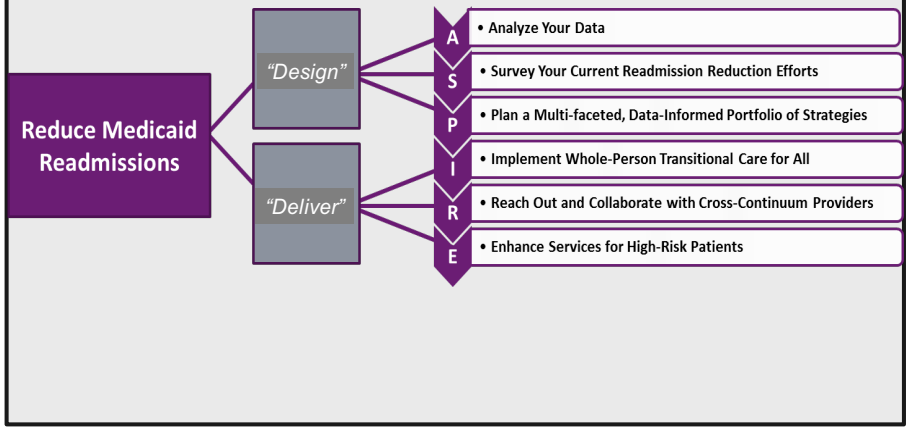
ASPIRE Framework



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. 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

What? (reduce readmissions)	•
For Whom? (which PNA patients)	•
By How Much? (relative to a baseline)	•
By When? (date, timeframe)	•

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

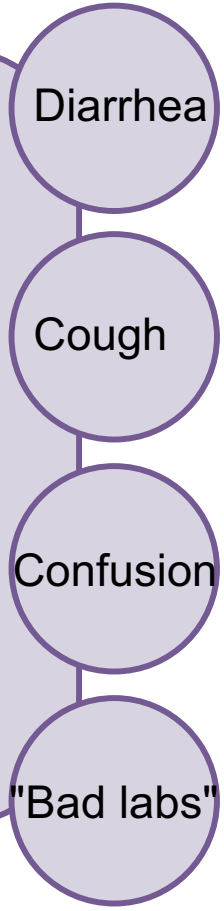
Interview 4: 65F d/c home, RA D4

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



*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

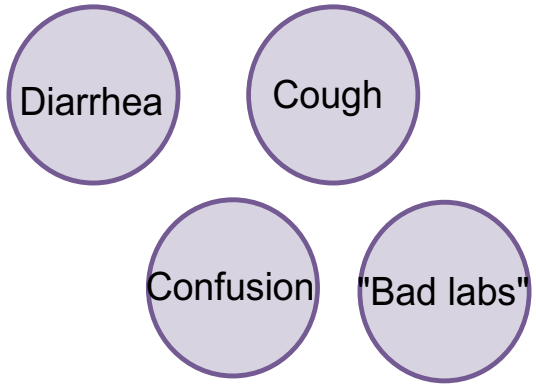
After Hospitalization

- ✓ 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

	# Discharges	# Readmissions	RA Rate
PNA, All	1000	200	20%
PNA, to Home	500 (50%)	80	16%
PNA, to Home Care	250 (25%)	60	**24%**
PNA, to SNF	250 (25%)	60	**24%**

During Hospitalization	During Transition	After Hospitalization
•	•	•
•	•	•
•	•	•



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?

Intervention: PNA to Home	Oct Week 1	Oct Week 2	Oct Week 3	Oct Week 4
# PNA patients	10 (100%)			
# d/c to home	5 (50% of total)			
# meds to bed	3 (60% of target)			
# appts <5 days	3 (60% of target)			
# d/c calls <48h	2 (40% of target)			
# with all above	1 (20% of target)			

Intervention: PNA to SNF	Oct Week 1	Oct Week 2	Oct Week 3	Oct Week 4
# PNA patients	10			
# d/c to SNF	3 (30% of total)			
# warm handoff	3 (100% of target)			
# “circle back” call	1 (30% of target)			

ACCELERATING PROGRESS

Identify 3 things to work on in October

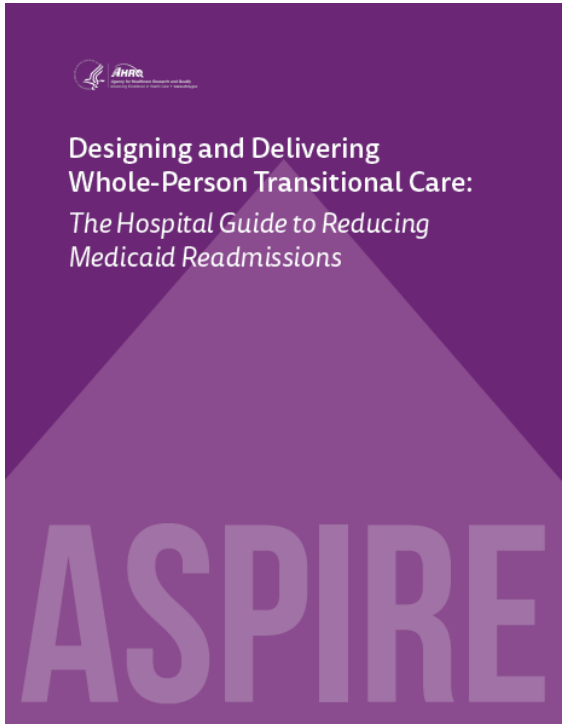
Tools

- 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

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

http://www.hret-hiin.org/Resources/readmissions/17/readmissions_whiteboard_series.shtml

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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