ASPIRE to Knockout Pneumonia Readmissions

Knockout Pneumonia Readmissions Workshop
November 2, 2018
Working Session Agenda

• Welcome
  – Objectives, structure of day
  – Your burning issues

• Knocking out readmissions is possible!
  – Examples from ASPIRE implementation sites

• 8-part working session
  – Motivation, goals
  – Data
  – Target pop
  – Root causes
  – Interventions
  – Implementation
  – Operational dashboard
  – Measurement

• Action plan development, report out
Structure of the Workshop

- Facilitated, interactive discussion

- Ground rules
  - *Our time is precious; we are here to do important work today*
  - *Be present and participate*
  - *Please step out of the room to email or text*
  - *We are here to generate concrete meaningful next steps*
  - *We will focus on what we can do, rather than what we can’t do*
YOUR BURNING ISSUES

What would you like to discuss/address today?
WHAT WORKS

Success is possible!
ASPIRE +
Design and Execution → Results

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

- 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
“+” = Execution
Only 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
Bay Area Readmission Reduction Collaborative

https://www.youtube.com/watch?v=ftAzr3aXyQM
“Circle Back” call with SNFs

https://www.youtube.com/watch?v=SG28aJhs63s
“Coaching” - Mrs. MacDonald

https://www.youtube.com/watch?v=5uS6hBh1Qtg
“Interdisciplinary Transitional Care” – Mr. Anderson

https://www.youtube.com/watch?v=QfKgsfgXkik
“MVP Care” – Mr. Eison

https://www.youtube.com/watch?v=t80ikD-UG94
Hospitals with Hospital-Wide Results

• Know their data –
  – Analyze, trend, track, display, share, post

• Broad concept of “readmission risk”
  – Whole-person needs, not just medical

• Multifaceted strategy
  – Hospital, cross-continuum, post-hospital

• Use technology to make this better, quicker, automated
  – Automated notifications, implementation tracking, dashboards
Rural Hospital: All Payer Heart Failure

- ED CM flags all HF admits
- List to HF ToC RN
- 1-2 new patients / day
- Brief visit in-hospital
- Phone calls x 30 days
- Transportation
- Medication – affordability
- Care seeking patterns

Team:
- ED CM, 1 RN
- Finance/ Quality Analyst

All Payer Heart Failure Readmissions
Rural Hospital, Broad High Risk: All cardiac, pulmonary, BH

• Daily review of inpatient census
• High risk: all cardiac, pulmonary or behavioral health condition
• ~50% of inpatients “high risk”
• Only 4-6 people per day
• Brief meet & greet in-hospital
• 48h follow up call
• Home visit “just to see if we can help with anything you might need”
• SW and RN did visit together
• Identified needs, mobilized services

Team:
• 1 RN, 1 SW
• 56% reduction in readmissions
Population Design: All Discharges to Post-Acute Care

Team

- RN Manager
- Analyst
- 4 RN
- 1 SW
- 1 NP

Success factors

- Building relationships with SNF staff
- Warm handoff; circle-back
- SNF co-management
- Readmission prevention plans
Hospital-Wide Readmission Reduction Design:
Targeted Highest Risk All Medicaid, Medicare <65, Behavioral Health

Volume (discharges, patients)

- **Discharges/mo**: 350
- **“Served”/mo**: 300
- **Percentage**: 85%

Success factors

- Year 1 no progress; took time to learn
- Effective engagement, timely contact
- ED Care Plans with cross agency input
- Home visits
Key Actions

1. *Know* your data
2. *Understand* root causes
3. *Develop* a portfolio of strategies
4. *Improve* hospital-based transitional care for all
5. *Collaborate* with cross setting providers & payers
6. *Provide* enhanced services for high risk patients
7. *Track* implementation to *drive* key processes
ASPIRE +

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%
The AHRQ Hospital Guide to Reducing Medicaid Readmissions

Target Population & Hospital-Wide

Target Pop: 25% Reduction
Hospital-Wide: 15% Reduction
BUILDING A SUCCESSFUL PROGRAM

8-part working session
Reducing Readmissions Workshop
Design and Deliver Whole-Person Transitional Care

To Design and Deliver a Successful Readmission Reduction Program:

1. Motivation, goal (why are we doing this and what is success?)
2. Data (what are the patterns of readmissions at our hospital?)
3. Target Population (how will we focus our efforts?)
4. Root Causes (why do our target population patients return?)
5. Interventions (what will we do to address root causes?):
6. Implementation (how will we deliver those interventions?):
7. Operational Dashboard (how consistently are we delivering?):
8. Measurement (what is the impact on readmissions?)
1. Motivation, Goal

*Why are we doing this and what is success?*

Why are you (your organization) working to reduce readmissions?

What is your readmission reduction goal? (fill in elements of goal, below)

- What?
- For whom?
- By how much?
- By when?
2. Data

*Who is high risk? and how many high risk patients are there?*

<table>
<thead>
<tr>
<th>EXAMPLE</th>
<th>All</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of adult, non-OB discharges</td>
<td>1000</td>
<td>500</td>
<td>250</td>
</tr>
<tr>
<td>Total number of readmissions</td>
<td>150</td>
<td>80</td>
<td>50</td>
</tr>
<tr>
<td>Readmission rate</td>
<td>15%</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Readmission rate, d/c to SNF or Home Care</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission rate, d/c to home</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top diagnoses leading to most readmissions</td>
<td>Sepsis HF COPD</td>
<td>Sepsis HF COPD</td>
<td>Sickle PNA DKA</td>
</tr>
<tr>
<td>Total # discharges, target population (HF d/c to home)</td>
<td>50</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Total # readmissions, current target population</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Readmission rate, current target population</td>
<td>20%</td>
<td>17.5%</td>
<td>30%</td>
</tr>
</tbody>
</table>
### Discharge Diagnoses Leading to Most Readmissions

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Comm.</th>
<th>Unins.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARF (1384)</td>
<td>Sickle Cell (478)</td>
<td>Chemo (290)</td>
<td>Pancreatitis (187)</td>
<td>Sepsis (1859)</td>
</tr>
<tr>
<td>Sepsis (1366)</td>
<td>Sepsis (175)</td>
<td>CVA (276)</td>
<td>Chemo (157)</td>
<td>ARF (1800)</td>
</tr>
<tr>
<td>PNA (1336)</td>
<td>Chemo (175)</td>
<td>Arthritis (260)</td>
<td>DKA (136)</td>
<td>PNA (1750)</td>
</tr>
<tr>
<td>COPD (1211)</td>
<td>COPD (173)</td>
<td>Sepsis (222)</td>
<td>CVA (125)</td>
<td>CVA (1622)</td>
</tr>
<tr>
<td>CVA (1140)</td>
<td>DKA (156)</td>
<td>PNA (188)</td>
<td>COPD (109)</td>
<td>COPD (1608)</td>
</tr>
<tr>
<td>UTI (1038)</td>
<td>PNA (145)</td>
<td>ARF (182)</td>
<td>ARF (97)</td>
<td>UTI (1608)</td>
</tr>
<tr>
<td>Afib (851)</td>
<td>ARF (137)</td>
<td>CAD (181)</td>
<td>Sepsis (96)</td>
<td>HF (1115)</td>
</tr>
<tr>
<td>HF (822)</td>
<td>HF (129)</td>
<td>Pancreatitis (153)</td>
<td>PNA (81)</td>
<td>CAD (1092)</td>
</tr>
<tr>
<td>CAD (746)</td>
<td>Pancreatitis (127)</td>
<td>Afib (152)</td>
<td>ETOH w/d (76)</td>
<td>Afib (1092)</td>
</tr>
</tbody>
</table>

*Source: Boutwell in collaboration with South Carolina Hospital Association*
Readmissions by Age

Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010


-- Indicates too few cases to report.
Readmission rates among all patients discharged to post-acute care are high

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
Readmission Rates for People with BH conditions

40% of adult hospitalized patients had at least 1 behavioral health condition

Patients with any BH condition had a 77% higher readmission rate

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
Timing of Readmissions

Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
2. Data

What are our readmission rate trends over time?

- Do you track and trend readmission rates monthly?
- Is the trend getting better? Worse? Same?
3. Target Population
Who are we focusing efforts on and why?

• What is your target population?

• Does your target population align with your goal and your data?

• Can you identify your target population in day to day workflow?

• How many discharges per day are in your target population?

• What is the readmission rate of your target population?

• Is the readmission rate of your target population > the hospital rate?
4. Root causes

Why, why, why, why, why do our patients return to the hospital < 30days?

- What are the root causes of readmissions for your target population?

- How do you identify root causes of readmissions?

- Can you think of a readmitted patient story? What was the root cause? (ask “why” 5 times)
“I see you were discharged a [few days, weeks] ago. Can I ask you* to remember back to the day you were discharged? How did you feel when you left the hospital? Tell me about how thing went [over the next few days]. Did you have any problems or questions or challenges with anything? Did you have any interaction with any health care providers, or anyone who checked in on you? At what point did you – or someone else – decide you needed to return to the hospital? Looking back over the past [few days, weeks], is there anything that you think could have been done to help you after you left the hospital the first time?”

*You = patient and/or care partner. Engage any informant who was involved in the care following the first discharge
5. Interventions

What are we doing to reduce readmissions?

- Improve hospital-based care
- Cross-continuum collaboration
- Enhanced services

- Inpatient
- ED
- Post Acute Care
- Primary Care
- Behavioral Health
- Social/Support
- Transitional Care
- Navigation
5. Interventions

Do our interventions address the root causes of readmissions?

- Do your readmission reduction efforts address root causes of readmissions?

- What do your patients “really need” in order to reduce readmissions?

- How can you adapt your efforts to more effectively address root causes?

- Can you strengthen collaborations with community agencies/payers?
6. Implementation

*How do we deliver the services we intend to deliver? Who does what, when?*

- Identify
- Notify
- Assess
- Link
- Manage

**Diagram:**
- Patient Presents
- Identify
- Manage
- Link
- Assess/Plan

**Source:**
ASPIRE
DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE: THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS
Percent of Target Population Patients Served

Target Population Served vs Total Target Population

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

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 #
Intensify Patient-Facing Service Delivery: Work Smarter

Key lessons:
- Brief in-hospital visit
- Prioritize community visits
- Batch SNF visits
- Batch home visits
- Batch documentation
7. Operational Dashboard

*How consistently do we deliver what we intend to deliver?*

<table>
<thead>
<tr>
<th>Metric</th>
<th>This month</th>
<th>Last month</th>
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<tbody>
<tr>
<td>Total # target population discharges</td>
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<tr>
<td>Total # (%) target population discharges “served” in-house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges “served” post-discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges with timely contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # (%) target population discharges ”completed bundle”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other [specific to your program]</td>
<td></td>
<td></td>
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<tr>
<td>Other [specific to your program]</td>
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*Use implementation data to increase the % completed service delivery*
8. Measurement

What is the impact on readmissions?

![Readmission Rate Trend](chart)

- Hospital-wide
- Target population
- Linear (Hospital-wide)
- Linear (Target population)
Summary

- Employ a data-informed approach to designing efforts
- Design efforts targeted at root causes of readmissions
- Develop a portfolio of strategies to achieve hospital-wide results
- Adapt strategies to serve whole-person needs
- Deliver interventions to a high percentage of the target population
- Measure implementation to drive to higher levels of performance
Prioritize

Low impact on readmissions

High impact on readmissions

Hard to Do

Easy to Do
### Action Plan: Next 7 days

“I will go back next week and do this”

<table>
<thead>
<tr>
<th>Action steps</th>
<th>By Whom?</th>
<th>By When?</th>
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<tbody>
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**Stakeholders (who needs to be engaged):**

**Expected benefit (on results):**

**Measurement plan (how will you know if you did it and the impact):**
# Action Plan: Next 30 days

“We can do this in the next couple weeks”

<table>
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<th>By Whom?</th>
<th>By When?</th>
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Stakeholders (who needs to be engaged):

Expected benefit (on results):

Measurement plan (how will you know if you did it and the impact):
Action Plan: Next 90 days
“This is important to have in place by February”

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Stakeholders (who needs to be engaged):

Expected benefit (on results):

Measurement plan (how will you know if you did it and the impact):
Thank you for your commitment to reducing readmissions

Amy E. Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Developer, MVP Method of Improving Care for Multi-Visit Patients
Developer, AHRQ Hospital Guide to Reducing Medicaid Readmissions
Developer, IHI STAAR (State Action on Avoidable Readmissions) Initiative