

# Letter from the NCHA

Dear Colleague:

The North Carolina Healthcare Association launched the Knockout Pneumonia Initiative in 2017 to support North Carolina hospitals and healthcare providers in our collective efforts to address pneumonia mortality and readmission rates in North Carolina.

Based on a thorough analysis of data, best practices, and in alignment with providers’ existing effort to improve care transitions and reduce readmissions, the NCHA engaged Dr. Amy Boutwell, developer of the Agency for Healthcare Research and Quality’s publication, “Designing and Delivering Whole-Person Transitional Care,” – otherwise known as the “ASPIRE” Guide.

Over the past several months, Dr. Boutwell has provided a robust curriculum of webinars walking participant through the concepts, tools and processes contained in the ASPIRE Guide – and has applied those concepts to our specific aim of reducing pneumonia readmissions.

This “Knockout Pneumonia Playbook” is intended to provide NCHA members and their post-acute and community based partners with a synthesis of the content provided through the in-depth educational sessions and highlight the key concepts and recommendations that have been made to help hospitals and cross-continuum partners achieve their readmission reduction goals.

Ever-mindful that readmission reduction teams are busy, we designed this “Playbook” to provide a 1-page concise summary of key points, effective practices, and recommendations. We encourage readmission reduction teams to use these 1-pagers to stimulate review and discussion as you work to develop and implement an effective “portfolio of strategies” to achieve your readmission reduction goals – and to Knockout Pneumonia Readmissions!

Thank you for your commitment to delivering high-quality and high-value patient care.

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# Table of Contents

Letter from the NCHA 1

Table of Contents 2

Call to Action: *Current State of Pneumonia Readmissions in NC* 3

ASPIRE Strategy 1: *Know Your Data, Understand Root Causes* 4

ASPIRE Strategy 2: *Identify Existing Resources* 5

ASPIRE Strategy 3: *Design a Portfolio of Strategies* 6

ASPIRE Strategy 4: *Actively Collaborate Across the Continuum* 7

ASPIRE Strategy 5: *Deliver Effective Transitional Care* 8

ASPIRE Strategy 6: *Effective Implementation to Drive Results* 9

Resources 10

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# Call to Action: *Current State of Pneumonia Readmissions in NC*

The opportunity to improve pneumonia care and reduce readmissions in North Carolina is clear:

* North Carolina ranks 49 out of 50 for pneumonia mortality rates
* More than half of NC hospitals have higher than average pneumonia readmission rates
* Pneumonia readmission rates increased 13% over 2016 (see graph, below)
* Pneumonia readmission rates are consistently higher than all cause rates (see graph, below)
* Pneumonia is among the top 10 diagnoses leading to the most readmissions in NC (see table)

 



*\* adult, non-OB, North Carolina 2016*

***For more information***

* Knockout Pneumonia Readmissions webinar 1, March 2018

# ASPIRE Strategy 1: *Know Your Data, Understand Root Causes*

Understand your hospital’s patterns of readmissions overall, and the pattern of readmissions for any given target population such as pneumonia. Specifically look not only at rate, but also at the number of readmissions. For any given target population of focus, quantify the number of discharges in that target population and the proportion of readmissions that your target population accounts for in relation to all readmissions to your hospital. All analyses are for adult, non-OB populations:

* What is your hospital’s all cause readmission rate?
* What is your hospital’s pneumonia readmission rate?
* How many readmissions occurred at your hospital last year?
* How many pneumonia readmissions occurred at your hospital last year?
* What percentage of all readmissions are pneumonia readmissions?
* How many pneumonia discharges do you have on average per day?

The best data analysis will only ever provide part of the information needed to reduce readmissions. Seek to understand root causes through a patient, caregiver and provider lens:

* Ask your readmitted patients and/or their caregivers to describe what happened between the day of discharge and the day of readmission.
* Listen for all of the factors - the clinical, non-clinical, social, behavioral, and logistical - that led to the patient returning to the hospital within 30 days of discharge.
* Use individual readmission interviews to identify themes.

***Recommendations***

* Analyze your own all payer, all cause data; use Tool 1 of the ASPIRE Guide
* Interview 10 readmitted patients; use Tool 2 of the ASPIRE Guide

***For more information***

* ASPIRE to Knockout Pneumonia Readmissions webinar 1, March 2018
* ASPIRE Guide Chapter 1, Tools 1 and 2, and webinar 2
* AHA/HRET HIIN Readmission Reduction Whiteboard video 2, 3

# ASPIRE Strategy 2: *Identify Existing Resources*

Many readmission reduction teams perceive limitations to their ability to effectively reduce readmissions because of lack of resources – in their hospital, or within their community. Readmission reduction teams do best when they shift their focus from what does not exist to a focus on identifying and leveraging the resources that do exist.

Within the hospital, consider:

* How do we identify patients at high risk of readmission? Is there a flag? A list?
* How do we define high risk of readmission? Is there a Tool? Score? Clinical definition?
* Are our target population patients (pneumonia) identified as high risk?
* What services already exist in to interview patients, families, and discuss social, behavioral needs, end of life or broad supports? Social work? Palliative care? Addiction services?
* What structures and process do we already have to provide navigation and support services to patients? Cancer navigators? Ortho bundle navigators? HF coaches? Volunteers?

Within the community, consider:

* Which agencies provide social and supportive services? County resources? Elder service councils? Family service agencies? Consider the YMCA, Salvation Army, 211, United Way, volunteer and faith based organizations.
* What are multi-service behavioral health clinics? Often these clinics have peers, advocates, social workers, recovery coaches, transportation support, group education, perhaps employment and benefit assistance. Do not hesitate to google search!
* Which practices are Patient-Centered Medical Homes (PCMH)? These practices will have care managers, provide post-hospital transitional care follow up, same-day access, etc. .
* Who is paying the bill for your high risk of readmission and/or multi-visit patients?

***Recommendations:***

* Survey the readmission reduction related efforts within your hospital; use ASPIRE Tool 3
* Survey the readmission reduction related efforts across the continuum; use ASPIRE Tool 4

***For more information:***

* ASPIRE to Knockout Pneumonia Readmissions webinar 2, April 2018
* ASPIRE Guide Chapter 2, Tools 3 and 4

# ASPIRE Strategy 3: *Design a Portfolio of Strategies*

Successful readmission reduction efforts employ a “portfolio of strategies” to reduce readmissions. It is common to see hospitals, health systems, and even communities with a variety of initiatives and programs – all operating in their own departments or service lines or silos.

As you conduct your survey of resources, pull together a picture of the portfolio of strategies that are currently in place to achieve readmission reduction (hospital-wide or for your specific target population). Use a driver diagram to articulate the strategy – not just the individual programs or projects or practice changes, but the logic of how those relate to achieving your readmission reduction goal. Consider:

* Do you have resources in place to track readmission data and identify root causes?
* Do you have efforts in place to improve transitional care for all patients?
* Do you have efforts in place to effectively collaborate with providers and agencies across the continuum?
* Do you have “enhanced transitional care” services for high risk populations?
* Are there gaps that should be addressed to strengthen your portfolio of strategies?

 

***Recommendations***

* Articulate your current portfolio of strategies using a driver diagram
* Analyze your strategy to ensure it is designed to get the results you want to achieve

***For more information***

* ASPIRE to Knockout Pneumonia Readmissions webinar 3, May 2018
* ASPIRE Guide Chapters 3 and Tools 5, 6 and 7

# ASPIRE Strategy 4: *Actively Collaborate Across the Continuum*

Effective collaboration for the purposes of reducing readmissions can take many forms. In all cases, partnership and relationship building and developing a shared understanding of our common patients, our care transition processes (or lack thereof), insights from our own data analyses, and a shared understanding and discussion of root causes is a foundation of effective cross-continuum collaboration.

Many cross-continuum teams stop at data analyses or even joint readmission reviews. Don’t stop there! Those are necessary but not sufficient to reduce readmissions. Move into testing processes and practices that actually improve day to day, and week to week care management over time and across settings.

Examples include:

* “Circle-back” phone call: hospital calls the “receiving provider” (SNF, for example) the day after transition to follow up on the transition and clarify any immediate questions or concerns
* Weekly virtual co-management rounds: review shared patients, discuss any issues, jointly problem solve by the parties committed to the shared outcome of avoiding readmission
* Hospital, ACO, bundle, or system-based navigators who follow and actively manage patient care, address needs, and serve as first point of contact over time and across settings
* ED processes to identify patients who return < 30 days and active process to identify safe and appropriate alternatives to (re)admission

Many readmission reduction teams are already working on one important cross-continuum collaboration: with skilled nursing facilities. Consider which other providers and agencies share in the care of your high-risk patient populations. In particular:

* Do you have collaborative relationships with behavioral health providers? community service agencies? payers? ACOs, PCMHs and community-based care management agencies?

***For more information***

* ASPIRE to Knockout Pneumonia Readmissions webinar 4, June 2018
* HQI’s “Circle Back” video: <https://www.youtube.com/watch?v=SG28aJhs63s>
* ASPIRE Guide Chapter 4, 5 and Tools 8, 9, 11, 12
* AHA/HRET Readmission Reduction Whiteboard video 10

# ASPIRE Strategy 5: *Deliver Effective Transitional Care*

Transitional care is care that is provided to high risk patients because they are at high risk of readmission. The purpose of transitional care is to mitigate the chance of readmission. Transitional care services are:

* Additional services and supports in the time following hospitalization;
* Services not provided to all patients as part of routine care;
* Offered to subgroups identified as “high risk” of readmission;
* Delivered prior to and after discharge, often for 30 days;
* Delivered by hospital staff or by contracted staff from other entities

It is important to design transitional care services to address the root causes of readmissions in your high risk population or population. More often than not, even when focused on a disease-specific target population, transitional care providers find success when they identify and address “whole-person” needs – as opposed to narrowly focusing on the primary medical issue.

Many successful readmission reduction teams – whether focused on “high risk,” or disease-specific target populations – attribute their success to the following approaches:

* *“We look at the whole person, the big picture”*
* *“We always address goals and ask what the patient wants”*
* *“We meet the patient where they are”*
* *“First and foremost it’s about a trusting relationship”*
* *“You can’t talk to someone about their medications if there is no food in the fridge”*
* *“Our navigators are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills”*
* *“We do whatever it takes”*

***For more information***

* ASPIRE to Knockout Pneumonia Readmissions webinar 5, August 2018
* ASPIRE Guide Chapter 6
* AHA/HRET HIIN Readmission Reduction Whiteboard video 7

# ASPIRE Strategy 6: *Effective Implementation to Drive Results*

You are busy every day trying to implement improved care for your patients. You may be wondering: What are we doing? For which patients? How consistently are we doing it? What are the results? For the target population? For patients who received the service?

An operational dashboard can help you know what services are being delivered, to which patients, with what results? An operational dashboard might contain the following elements:

* All discharges in the target population(s)
* Number of discharges who received the service/process
* % of target population discharges that received the service/process
* Readmission rates of the target population

Before you conclude that a given service/process is not effective to reduce readmissions:

* Quantify the total number of discharges in the target population: How many patients have we defined as being at risk of readmission? Are we effectively identifying all target population patients? Are we effectively engaging them in care? Are we delivering intended services once identified and engaged?
* Drive to a high level of implementation of services for the target population. The services can’t reduce readmissions if they are not being delivered to high risk patients!

***Recommendations***

* Create an “operational dashboard” to track the implementation of your various strategies
* Track the % of target population patients who receive the intended service(s)
* Improve and innovate to drive up the % of target population patients “served”
* Track the readmission rate for all patients, target population(s), and patients “served”
* Track, trend, display, share monthly performance and outcome data visibly; use as a tool
* Start with the information you have, and build a comprehensive dashboard over time

***For more information***

* ASPIRE to Knockout Pneumonia Readmissions webinar 6, September 2018
* AHA/HRET HIIN Readmission Reduction Whiteboard video 10

# Resources

Please see the [Knockout Pnuemonia webpage](https://www.ncha.org/pneumonia-knockout-campaign/) to access the full curriculum of recorded webinars:

1. ASPIRE to Reduce Pneumonia Readmissions March 2018
2. Align with Existing Resources, Identify Gaps April 2018
3. Design a Portfolio of Strategies and Operational Dashboard May 2018
4. Actively Collaborate Across the Continuum June 2018
5. Deliver Effective Transitional Care August 2018
6. ASPIRE +: Implementation to Drive Results September 2018
7. Preparing for the In-Person Workshop October 2018

Please see the AHRQ webpage to access the full curriculum of the [ASPIRE Guide](https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html):

* ASPIRE Guide
* ASPIRE Toolkit
* ASPIRE Webinars
1. Introduction & Overview
2. Analyze Data and Caregiver Perspectives
3. Review & Update Readmission Reduction Efforts
4. Implement Whole-Person Transitional Care for All
5. Reach Out to Collaborate with Partners Across Settings
6. Enhance Services for High-Risk Patients

Please see the AHA/HRET HIIN [“Readmission Reduction Whiteboard Video Series”](http://www.hret-hiin.org/Resources/readmissions/17/readmissions_whiteboard_series.shtml)

1. Introduction
2. Know Your Data
3. Understand the Root Causes
4. Improve Transitions for All Patients
5. Develop a Customized Transitional Care Plan for All Patients
6. Effectively Communicating with Patients and their Caregivers
7. Engaging the ED in Readmission Reduction Efforts
8. Deliver Enhanced Services Based on Need
9. Improving Care for High Utilizers
10. Collaborating with Clinical and Non-Clinical Community Providers and Services
11. Measure What You Implement