ASPIRE to Knockout Pneumonia Readmissions
Designing & Delivering Whole-Person Transitional Care

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NCHA Knockout Pneumonia Campaign - Webinar 8
December 6, 2018
## Knockout Pneumonia Readmissions Series

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| 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                                                  |
ASPIRE Framework

Reduce Pneumonia Readmissions

Design

- 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

Deliver
Objectives for Today

1. Learn what you are doing as a result of the Knockout Pneumonia Readmission webinar series & workshop to reduce readmissions

2. Get ideas from each other about feasible, meaningful next steps

3. Celebrate a great year together!
IN PERSON WORKING SESSION

Linking Priorities to Design; Learning from Successes; Action Plans
Knockout PNA Readmissions Playbook

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Resources

Please see the Knockout Pneumonia webpage 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:
• 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 Patients
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”
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
Knockout PNA Readmissions Playbook

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 to readmissions. For all population and the population of readmissions to your hospital:

- What is your focus?
- What is your focus?
- How many readmissions?
- How many patients?
- How many patients?
- What percentage?
- How many patients?

The best data analysts understand root cause.

- Ask your readmissions leadership and the community.
- What are the top issues?
- Use individual referral.

Recommendations:
- Analyze the focus
- Interview 10 readmissions.

For more information:
- ASPIRE to Knockout Readmissions
- ASPIRE Guide Chapter 2, Tools 1.4

For more information:
- AHA/NET Institute

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 the best time when they shift their focus to resources that do exit.

Within the hospital, consider:

- How do we identify patients at high risk of readmission?
- How do we define high risk of readmission?
- Are our readmission population?
- What services are available to improve care for the patient?

Within the community, consider:

- Which agencies provide social services?
- Which agencies provide health services?
- Which agencies provide services?

Recommendations:
- Survey the readmission reduction team.
- Survey the readmission reduction team.

For more information:
- ASPIRE to Knockout Readmissions
- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

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 communities with a variety of initiatives and programs as of their own departments or service lines or sites.

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?

For more information:
- ASPIRE to Knockout Readmissions
- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

For more information:
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- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

ASPIRE Strategy 4: Actively Collaborate Across the Continuum

Effective collaboration for partnership and relational our care transition process understanding and discussion.

Many cross-systems are necessary but only those that actually improve day-to-day care.

Examples include:
- “Circle back” phone call transition to follow up
- Weekly virtual call with the team
- Hospital, ACO, referral address needs, and more
- ED processes to identify appropriate alternative

Recommendations:
- Survey the readmission reduction team.
- Survey the readmission reduction team.

For more information:
- ASPIRE to Knockout Readmissions
- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

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:

- Additional services
- Services not provided
- Offered to patients
- Delivered to patients
- Delivered by hospital

It is important to define the population at risk for readmission, the population, transition – as opposed to a medicine.

Many successful readmission programs require:
- “We look at the patient.”
- “We believe in the patient.”
- “We meet the patient.”
- “We meet the patient.”
- “We make the patient.”
- “We make the patient.”

Recommendations:
- Survey the readmission reduction team.
- Survey the readmission reduction team.

For more information:
- ASPIRE to Knockout Readmissions
- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

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 result? An operational dashboard might contain the following elements:

- All discharges in the target population
- Number of discharges who received the service/program
- &% of target population discharges that received the service/program
- Readmission rates of the target population

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

- Quantify the total number of readmissions 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 received the intended service (or)
- 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 visibility, use as a tool
- Start with the information you have, and build a comprehensive dashboard over time

DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE: THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

COLLABORATIVE HEALTHCARE SOLUTIONS

For more information:
- ASPIRE to Knockout Pneumonia Readmissions webinar 5, May 2018
- ASPIRE Guide Chapter 2, Tools 1.4
- AHA/NET Institute

For more information:
- ASPIRE to Knockout Pneumonia Readmissions webinar 6, September 2018
- AHA/NET Institute Readmission Reduction Whitepaper 10
LINKING PRIORITIES TO DESIGN

Motivation → Goal → Target Population → Intervention
Workshop Participants’ Burning Issues

• Root causes of readmission
• SNF readmissions
• Resources for transitional care
• Hospital and home care partnerships
• Readmissions and length of stay
• Post discharge appointments
• Accurate, dynamic medication list
Organizations’ Motivations to Reduce Readmissions

- Penalties
  - Disease specific
- VBP
  - HCAHPS, Efficiency (Medicare Spend Per Beneficiary)
- HCAHPS
  - Experience = communication & understanding
- Star Ratings
  - Readmissions, Experience
- Commercial (Blue, United) plan incentives
- Throughput, capacity
  - Free up beds, reduce diversion
Organizations’ Aim Statements

- Reduce all cause, all payer PNA readmissions by 7.5% in FY19
- Reduce all cause readmissions from 0.9 to 0.8 by EOY 2018
- Reduce all cause readmissions to 11% by 6/30/19
Organizations’ Target Populations

- COPD, HF, PNA, AMI
- Sepsis
- UTI
- Sickle cell
- Uninsured
- High risk score (cerner, epic, jvion, lace)
- Multi-visit patient
Design

✓ Does your organization’s motivation to reduce readmissions align with your organization’s readmission reduction aim statement?

✓ Does your target population criteria align with your readmission reduction aim statement?
LEARNING FROM SUCCESSES

What does success look like? What are universal success factors?
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
Lessons from Success - Video 1

- “We learned it’s not the medical, it’s the social”
- Teach-back, reassess
- High touch, close contact
- Follow up calls, visits at home, appointments
- Home visit with the RN & SW
- Collaborate with SNF
- Case conference with the next team
- ”We now have a lot of players at the table”
- “It’s all about relationships”
- https://www.youtube.com/watch?v=ftAzr3aXyQM
Lessons from Success – Video 2

Mrs. MacDonald, hospitalized with pneumonia

• “When I got home, I was overwhelmed”
• “I didn’t think……then I realized”
• Coach came twice to my home
• Not rushed, explained everything
• “Best of all….it was free”

• https://www.youtube.com/watch?v=5uS6hBh1Qtg
Lessons from Success – Video 3

Thaddeus Eison, multi-visit patient

- 30M homeless, addiction, CVA, CHF, OSA, PPM/AICD, DJD
- “Talk about lonely”
- “The only person who cared about me….she gone”
- “I don’t know how to deal with the hurt”
- ”I don’t know which way to turn”
- Recovery coach: “we will help you”
- ”Now I have a plethora of choices”
- “Sometimes you need to give power and allow others to help you”
- “I think you will be some kind of proud of me”
- “I’m grateful”
- https://www.youtube.com/watch?v=5uS6hBh1Qtg
“Circle Back”

- RN-RN verbal handoff
- ToC RN calls back 1 day after transfer
- Asks a set of 6 questions
  - Do you have everything you need to take excellent care of the patient?”
- Consistent point of contact between hospital – SNF
  - “It’s nice to have someone follow up”
  - Allows for as-needed problem solving
- Follow up on all issues
  - Provides real time feedback to staff
  - “26% of the time there was an issue….not it is 8%”
  - Shows we are getting better at the transition
- [https://www.youtube.com/watch?v=0wCZc3hkPdY](https://www.youtube.com/watch?v=0wCZc3hkPdY)
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
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%
ASPIRE

The AHRQ Hospital Guide to Reducing Medicaid Readmissions

Target Population & Hospital-Wide

Target Pop: 25% Reduction
Hospital-Wide: 15% Reduction
ACTION PLANS

Feasible, Meaningful and Within Our Sphere of Influence
Participants’ High Impact Improvement Ideas

• Broaden concept of “high risk”
  • Develop criteria, based on data
• Identify all SNF patients as high risk
• Conduct readmission interviews
• Establish a pathway to serve high risk patients
• Extend transitional care services into the home
Participants’ Action Steps

7 days

• Look at our own data
• Update our readmission A3
• Ask volunteers to conduct readmission interviews
• Look into where we can post an ED care plan

30+ days

• Analyze data to identify the populations with high readmission rates
  • Share with UR committee
• Start to draft ED care plans
• Develop high risk patient pathway(s)
DISCUSSION

What are you doing? For which patients? How can you continue to improve service delivery to get better results?
FINAL WORDS

Measure what you implement
Articulate your transitional care process

- Identify
- Notify
- Assess
- Link
- Manage
Maintain an Operational Dashboard

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<tr>
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<th>This month</th>
<th>Last month</th>
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<tr>
<td>Total # target population discharges</td>
<td></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>
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<tr>
<td>Other [specific to your program]</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*
Trend Monthly for the Hospital and Target Population

Readmission Rate Trend

- Hospital-wide
- Target population
- Linear (Hospital-wide)
- Linear (Target population)
Thank you for your commitment to reducing readmissions!

It’s been a pleasure to work with you!

Amy E. Boutwell, MD, MPP
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Advisor, NCHA Knockout Pneumonia Readmissions Campaign
Developer, AHRQ ”ASPIRE” Guide to Reducing Readmissions
Developer, the MVP Method of Improving Care For High Utilizers

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