ASPIRE to Reduce Readmissions

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Objectives

• Explain the value of a data-informed, whole-person approach to reducing readmissions

• Identify the components of the ASPIRE framework

• Formulate a strategy to apply the ASPIRE framework to strengthen your readmission reduction efforts
Agenda

• *This is possible!*

• Key steps to *design* and effective strategy

• Key practices to *deliver* effective care

• Measure, innovate to *execute* to get results

What is your readmission reduction goal?
Who do you consider at risk of readmission?

During this session, consider:

• Do you know your data?
• Do you seek to understand root causes of utilization?
• Do you take a disease-specific or “whole-person” approach?
• Do you actively collaborate with staff in other organizations?
• Do you deliver services in ways that meet patients’ needs?
Hospitals with Hospital-Wide Results

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

- Broad concept of “readmission risk”
  - Way beyond case finding for diagnoses

- Multifaceted strategy
  - Improve standard care, collaborate across settings, enhanced care

- Use technology to make this better, quicker, automated
  - Automated notifications, implementation tracking, dashboards

Designing and Delivering Whole-Person Transitional Care: 
*The ASPIRE Guide*

- 13 customizable tools
- 6-part webinar series

The ASPIRE Framework

Reduce All Cause Readmissions

“Design”

“Deliver”

ASPIRE Field Work Hospitals

- 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

All Cause, All Payer 30-day Readmissions

ASPIRE Field Work Hospitals
Design

Your own data, root cause analysis, community resources

Take a Data-Informed Approach

1. What is our aim?
2. What does our data show?
3. Who should we focus on?
4. What services should we deliver?

Many teams start in the reverse order!
Readmission Rates by Payer & Discharge Setting

High rates: all adult non-OB Medicaid

High rates: all discharges to post-acute care

Discharge Diagnoses ➞ Most Readmissions

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Method: DRG, age>18, exclude OB

Source: Boutwell in collaboration with South Carolina Hospital Association
Readmissions and Any Behavioral Health Diagnosis

Among all adult, non-OB discharges:

- **40%** 1+behavioral health diagnosis
- **77%** higher readmission rates

Heart Failure Readmission Rate by Age, Payer

High rates across ages; highest for Medicaid

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Source: Boutwell in collaboration with the Massachusetts Center for Health Information and Analysis 2016
“Multi-Visit Patients” (MVPs)

- 4+ hospitalizations/year
- 7% - 25% - 60%
- Average admits 6 v. 1.3
- Average LOS 6.1 v. 4.5
- Readmission rate 38% v. 8%

Boutwell with Massachusetts Center for Health Information and Analysis 2016
Jiang et al. AHRQ HCUP Statistical Brief #184 Nov 2014

Understand Root Causes: the “story behind the cc”

- 77F hospitalized for a dialysis catheter and developed sepsis returns to the hospital 8 days following discharge with shortness of breath.

- 86M with cancer hospitalized for constipation and abdominal pain returns to the hospital 1 day after discharge with abdominal pain.

- 45F with HIV hospitalized for pneumonia discharged to home returns to the hospital 8 days later with persistent cough.

- 32M with a lifetime of uncontrolled diabetes presents to the ED or hospital every day with chest, flank, abdominal pain.
• Interviewed 60 patients who returned to ED <9 days of visit
  • Average age 43 (19-75)
  • Majority had a PCP,
  • Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
  • Most reported no problem filling medications
  • 19/60 thought they didn’t get prescribed the medications they needed (pain)
  • 24/60 expressed concerns about clinical evaluation and diagnosis

• Primary reason: fear and uncertainty about their condition
• Patients need more reassurance during and after episodes of care
• Patients need access to advice between visits

Annals of Emergency Medicine

Deliver

Address whole person needs, over time and across settings
Improve standard transitional care for all

*Identify and address post-hospital needs; link, don’t refer*

Risk Score v. Risk Screen

Readmission Risk **Score:**
- “Does this patient have a high readmission risk score?”
- If so, we do something different for them....

Readmission Risk **Screen:**
- “Does this patient have needs that could lead to a readmission?
- If we find a risk (or need), we address that risk (need)
Readmission Risk Screening Tools

9th "P" = poverty
10th "P" = patient preference

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

Proposed New Standards for Transitional Care

- **Identify** all patients at high-risk of readmission
- **Assess** clinical, behavioral and social needs
- **Communicate** with patients simply and effectively
- **Link** patients to follow-up and post-hospital services
- **Provide real-time** information to receiving providers
- **Ensure timely** post-discharge contact

AND

- **Have a process**
- **Track, trend and review** readmissions
- **Continuously improve** the process to meet needs

ASPIRE Tool 8: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html
Emerging Practice: ED Care Alerts

High-value, need-to-know information about a patient to support better decision-making at the point of care

- Instantly accessible in the ED
- Brief
- Guidance from a clinician who knows the patient
- Convey baseline
- Identify clinician, care team with contact info
- Intended to inform the decision to admit


Example ED Care Alert

“Mr. F is a gentleman who commonly dials 911 on weekends and holidays, noting shortness of breath. He does have COPD and his baseline, everyday physical exam is notable for wheezes and rhonchi. His CXR will show a LLL ‘infiltrate’ that has been stable for 15 years. Please call his PCP, Dr. C, on her cell phone (#) if you are contemplating invasive testing or admission. Please note patient can be (and often is) seen daily in her office, which is located in his apartment building. Please note he has low literacy skills and will not be able to comprehend written discharge or medication instructions.”

Courtesy Dr Patricia Czapp, Anne Arundel Medical Center
ED Care Alerts: “Reach In – Transition Out”

In practice: High-risk Care Team Alerts (Rejections from ED)

“Our patients look bad on their best day”

A highly successful high risk, high cost care management demonstration program leveraged the emergency department as an important opportunity to avoid an admission or re-admission. When a high risk patient registered in the ED, a notification was sent to the care management team. The expectation was that the team would collaborate with the emergency department staff to identify whether a discharge, rather than (re)admission, was a safe and appropriate option.

In reflecting on their success, factors that program and the care managers and primary care physicians’ longitudinal knowledge of their patients was critical to providing context to admission decisions, stating “our patients look bad on their best day,” reflecting the importance of knowing a patient’s “baselines” in order to accurately determine whether an acute change in clinical status has occurred. In addition, the fact that a high cost complex patient had a “learn” willing to provide timely and close follow up allowed care to be delivered in the home or other lower cost settings.

Collaborate across settings

Not just a handoff; a purposeful collaboration with shared aim
Warm Handoffs with “Circle Back” Call

Circle Back Questions (“Sender” calls “receiver” <1 day of transition):

✓ Did the patient arrive safely?
✓ Did you find the information complete?
✓ Were the medication orders correct?
✓ Does the patient’s presentation reflect the information you received?
✓ Is patient and/or family satisfied with the transition?
✓ Have we provided you everything you need to provide excellent care to the patient?

Key Lessons:

• Transitions are a process (forms are useful, but need intent)
• Best done iteratively with communication

Source: Emily Skinner, Carolinas Healthcare System

Circle Back: “Ideas that Work”
Implementation Example

“6 simple questions are making a difference in the Richmond community”

https://www.youtube.com/watch?v=SG28aJhs63s

“Anytime I discover an issue, I always follow up. When I started making the calls, I found issues 26% of the time; last month I only had issues 8% of the time”

- Hospital RN
Collaborate with “Receivers”: Beyond PAC

- SNF
- Visiting Nurse Agencies
- Patient Centered Medical Homes
- Adult Day Care Centers
- Behavioral Health Centers
- Medicaid Managed Care Plans
- Health Homes
- Group Homes
- Housing Authority
- Transportation Providers
- County Health Departments
- Food Assistance
- Legal Advocacy Assistance
- Peer Support

“You don’t understand, there are just no resources in the community”
“We would be thrilled if someone from the hospital called us”

In Practice: New Partnership with Behavioral Health Center

A hospital had established a vibrant cross-continuum community coalition. The coalition was comprised primarily of post-acute and aging services providers. Together over the years, the coalition had developed a shared understanding of the opportunity to reduce readmissions, reviewed readmission data together, reviewed readmissions to identify root causes, and developed better processes for handing off patients from the hospital to post-acute providers.

After several successful years and in response to new market incentives, the hospital expanded its focus from Medicare readmissions to all-payer readmissions. In the course of reviewing the composition of the cross-continuum team, the hospital recognized there were no behavioral health providers. The natural first choice was the large community behavioral health center.

The collaboration started with a meeting between the director of programs of behavioral health center and the director of case management at the hospital. They arranged to begin monthly collaborative team meetings with the behavioral health center contact, ED case management, the behavioral health crisis team, and inpatient psychiatry service to reduce inappropriate ED utilization and readmissions by:

• Gaining a better understanding of the behavioral health center’s services;
• Establishing a key contact in each organization to facilitate collaboration;
• Sharing data by using the state health information exchange to notify both the center and ED/hospital providers when a behavioral health center patient enters the ED;
• Training in motivational interviewing for hospital staff who care for patients with behavioral health diagnoses;
• Making health center enrollment packets available at the hospital; and
• Creating individual care plans for high-utilizers.

Cross Continuum Coordination – Getting Started

- Hold regularly scheduled monthly meetings
- Start with a “coalition of the willing” – doesn’t need to be perfect
- Invite new partners/ agencies as you learn about them
- Allow 3-4 months for the group to gel
- Start with common agenda items:
  - Readmission data
  - Readmitted patient stories
  - Handoff communication
  - What can we do together to achieve our aims for our shared patients?

ASPIRE Tool 12: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

Lessons from Cross-Continuum Collaboration

- **Takes time** to develop a collaborative rapport
- No substitute for verbal communication and **problem solving**
- **Establish a point person** to be the “back door” facilitator
- **Active** co-management and care management gets results
Execute

*We can’t get results unless we actually serve the patient*

Engagement → Implementation → Outcomes

- Focus on engagement to drive outcomes
- We can’t get outcomes we seek unless we are meeting patient needs
- Low levels of “engagement” signals a need to change our approach
- Breakthroughs: be personable, low-barrier, be helpful, navigate, link
- Effective engagement is a marker for good outcomes; it is a virtuous cycle
“Whole-Person” Adaptations to Care Management

- Navigating
- Hand-holding
- Arranging for....
- Providing with....
- Harm reduction
- Meet “where they are”
- Patient priorities first
- Relationship-based
- Motivational interviewing

Whole-Person Approach

Successful teams state:

- “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”
- “Our navigators are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills”
- “We do whatever it takes”
Summary

• Use a **data-informed approach** to designing efforts
• Design efforts targeted at **root causes** of readmissions
• Prioritize effective **engagement**
• **Address** whole-person needs
• **Actively collaborate**: this is a team sport
• **Deliver** interventions: change what we do until we are effective

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**Thank you for your commitment to improving care**

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