The ASPIRE Method was developed by Dr. Amy Boutwell who is a nationally recognized leader in the field of reducing readmissions. It was the first equity-focused readmission reduction strategy in the country – specifically designed to adapt readmission reduction strategies developed for Medicare populations to better serve the needs of Medicaid recipients. The ASPIRE Method has supported teams across the country in developing more equitable systems, processes, and practices to reduce disparities in readmission rates through better person-centered care and systems-based transformation.

EVALUATION

Groups to consider when evaluating readmissions

Younger adults
Multi-visit patients (3+ inpatient admits in past 12 months)
- Do not allow colleagues to claim that these patients are "un-impactable". Commit to not using stigmatizing labels such as "frequent flier" or "high utilizer"

Behavior dx
Race/Ethnic groups
Covid
Medicaid adult, non-OB
Medicare <65 years
Sepsis
- Everything is "out of whack" after Sepsis
- Remember: Held home meds, pumped full of fluids and broad-spectrum antibiotics, deconditioning and delirium

Substance Use Disorder patients
Health disparities (food insecurity, housing, transportation issues)

Questions to ask your readmissions evaluation team
What is your readmission reduction goal? Why?
Which patients have you been focusing your readmissions reduction efforts on? Why?
What patients might you not have considered high risk because we weren't looking at them?

ACTION .

Questions to ask the patient who is coming back in to understand why readmissions are happening

- Consider who you could have help ask the patient these questions…ER nurse? Admitting nurse? Aide during a conversation while providing care that day? Quality staff? Care coordinator or social worker? Anyone!! (See script on page 2)
- Use the insights from the short conversation to inform your person-centered transitional plan and individualized guidance
- Use the information to learn about root causes of "why" patients come back in. Use patient stories to generate improvement ideas from your team

How did you feel when you left the hospital and the day after?
What happened on the day you decided to come back in?
At what point did you decide to return?
Who made that decision? (you, home health nurse, family member)
What were you hoping for by coming back to the ER?

Set up ADT Notifications if you don't already have these and need to know when patients are readmitted

Creating linkages where none exist is equity work:
Where are the resources in your community?

- There are some in every community
- Commit to regularly updating your scan of local and virtual resources

"Share the Care" don't just refer
Reach out to collaborate

INTERVIEW SCRIPT EXAMPLES

The (re)Admission Interview

"I see you were recently in the hospital; I hope you're doing ok. I'd like to take 5-10 minutes to learn a bit more about what happened between the day you left the hospital and the point at which you decided you needed to return to the ED." Prompt:

+ ***When***…did they notice something was going on
+ ***How long***…. did this go on?
+ ***What***…. did they do to respond to that recognition?
+ ***Who***…. did they involve for help?
+ ***Why***….did they – or someone else – decide they ought to go to the ED?

Re(admission) interview:

- Intro script (**if readmission**): "Hi I'm Amy from the quality improvement team here at the hospital. We are working to make sure all our patients have the support they need after a hospitalization. I see you were recently hospitalized with us, and it would be really helpful to us if I could ask you a few questions about your experience? It will just take about 5 minutes."
- Let's start at the day you were discharged. How did you feel? How did things go?
- And then? And then?
- At what point did you encounter an issue? What did you do/call/ask for help with that issue?
- At what point did you – or maybe it was someone else – decide you ought to return to the ED?
- "Thank you for sharing, my team will learn from this as we work to deliver great care to all patients."

- If it's an ***admission*** interview, same idea, just start with:
  - "At what point did you start not feeling well?" [bring them to this current phase of the story]
  - "What did you do? Who did you call? Who did you ask for help? How long did this go on?"
  - "At what point did you – or maybe it was someone else – decide you ought to go to the ED?"

- This story tells you so much about the person:
  - Their awareness of changes
  - How long they wait to act on those changes
  - What they do in response to changes
  - Who they reach out and involve
  - What or who prompts them to go to the ED

- Use this information to learn about the root causes of "why" patients really come to the hospital

Patient Case Example:

- 80M, retired farmer, lives alone, family around, declining in abilities to self-manage
  - Recurrent hospitalizations this year for falls, increasing frailty
  - Concern about his ability to care for self at home led to a current nursing home placement
  - He is miserable, this is not his goal and he wants to go home
  - ….and he has now been readmitted even from the nursing home

- Multi-visit patients are a group of patients experiencing inequity in our delivery system
  - They receive "a lot" of care – but it is care that is not contributing to health, wellness, or recovery
  - It is waste, and often it does harm (overtreatment, over-medicalizing, iatrogenic errors)
  - Consider patients with a personal history of multiple visits a group for whom current state is not working

- Person-centered and systems-based view
  - This man wants to live at home
  - Have we done all we can do to enrich his home environment to make it safe?
  - Have we done all we can to create a response system to his day to day needs to bring help to him?
  - Probably not, because the tools we have at our disposal focus on disease, treatment, placement
  - Probably not, because the conversations we have with him often take control out of his hands

- What is his goal? How does he want to achieve that? Who is involved? Who is not yet involved?
  - Put control back in his hands
  - Guide a conversation about how live according to his goals
  - Align goals for independence with mobilizing adequate supports with goal of avoiding ED/hospital use