# Teachable Moments – Reducing 30-Day COPD Readmissions

Pay for Performance Summit

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### Agenda

- The Pittsburgh Regional Health Initiative
- Reducing COPD readmissions
- From reducing readmissions to building population health



### Pittsburgh Regional Health Initiative

### Spreading Quality, Containing Costs

- Not-for-profit, regional consortium
- Promotes patient safety & quality care
- Developed the quality improvement method Perfecting Patient Care<sup>SM</sup> based on Lean



### PRHI Cornerstones:

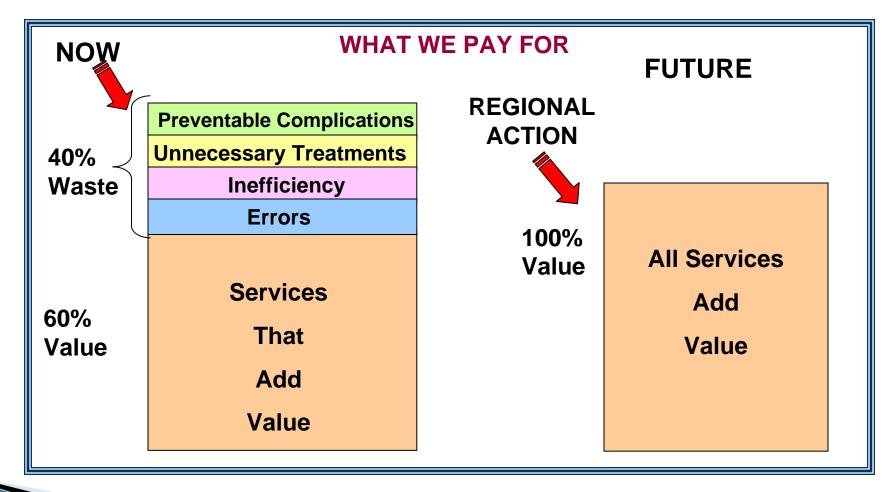
- Dramatic quality improvement is the best cost-containment strategy for health care
- All efforts must be organized around patient- need
- Improvements are made by those at the point of care

### Our Goal:

The delivery of the right care that is safe & efficient every time

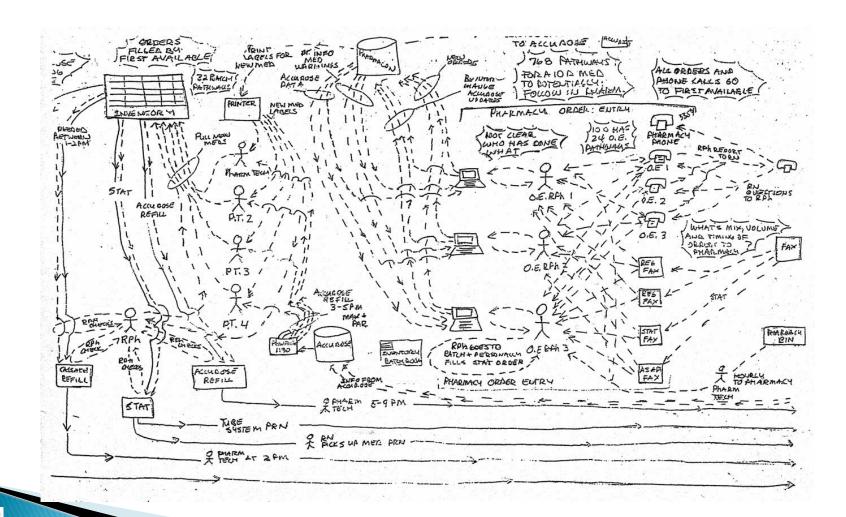


## Pittsburgh's Prescription for Healthcare Reform





## The Healthcare Status Quo: waste and chaos





### What Comprises 100% Value?

### Five core principles for perfecting care

- Care systems organized to meet patient need, safely, efficiently and completely
- Ambitious targets for eliminating error, waste and obstacles to the best care
- Teamwork for 100% compliance with proven clinical and safety practices
- Work redesign experiments for rapid problem solving during daily work
- 5. Leadership support for continuous improvement



# Perfecting Patient Care<sup>SM</sup> PRHI's Unique Brand of Quality Improvement

- Adapted from Lean
- Patient-focused systems redesign
- Can be applied in the course of everyday work
- The ultimate goal is perfection

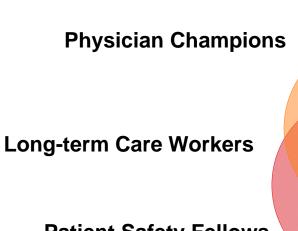




## Whom We Empower: frontline staff...and more



#### **PPC METHODS**





**Clinical Pharmacists** 

**Nurse Managers** 

**Hospital Trustees** 



**Salk Fellows** 

Librarians

**Team Leaders** 



### PPC as a Common Platform

- It's not just a set of tools but a philosophy
- It's easily grasped and used by people on the front line of care
- It instills practical, new thinking about problemsolving at all levels of the organization
- It keeps everyone focused on the goal: ZERO



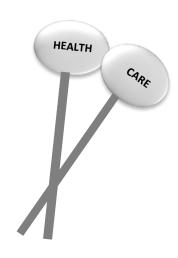
### Our Vision of the Ideal

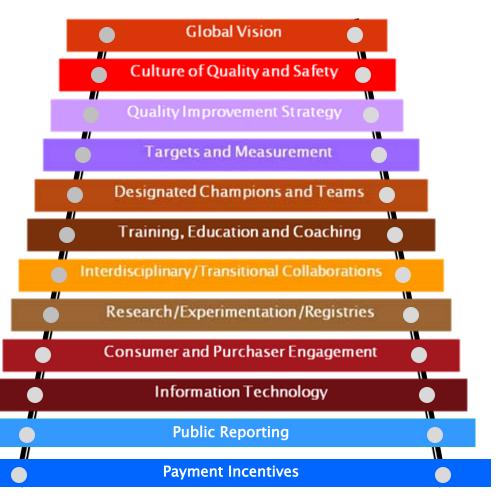
Frontline clinical teams applying daily problem solving methods and work process improvement techniques to deliver perfect care to patient

Perfect = Safe • Efficient • Proven Best Practices



### Xylophone for **VALUE**

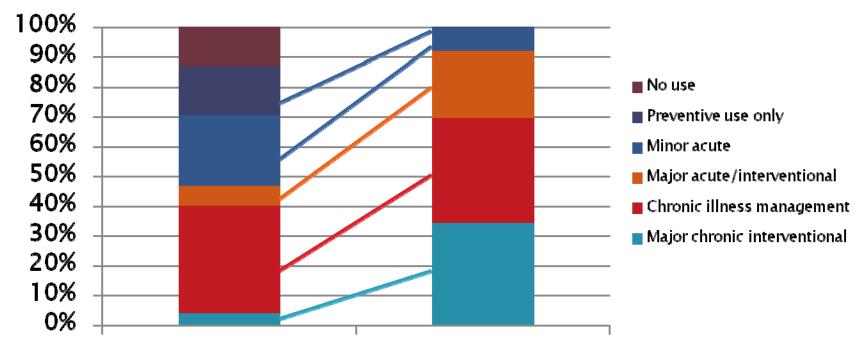








## Proportion of Health Care Costs and Use in 2003



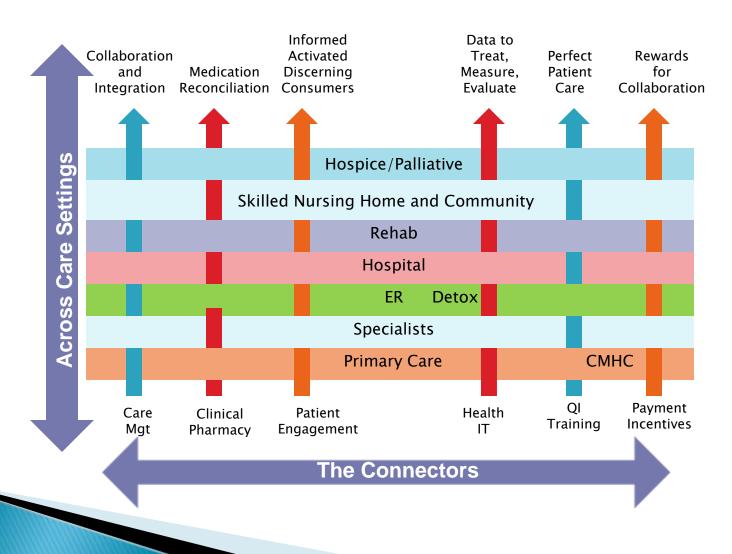
Percent of people using health care services by category

Percent of costs associated with these people



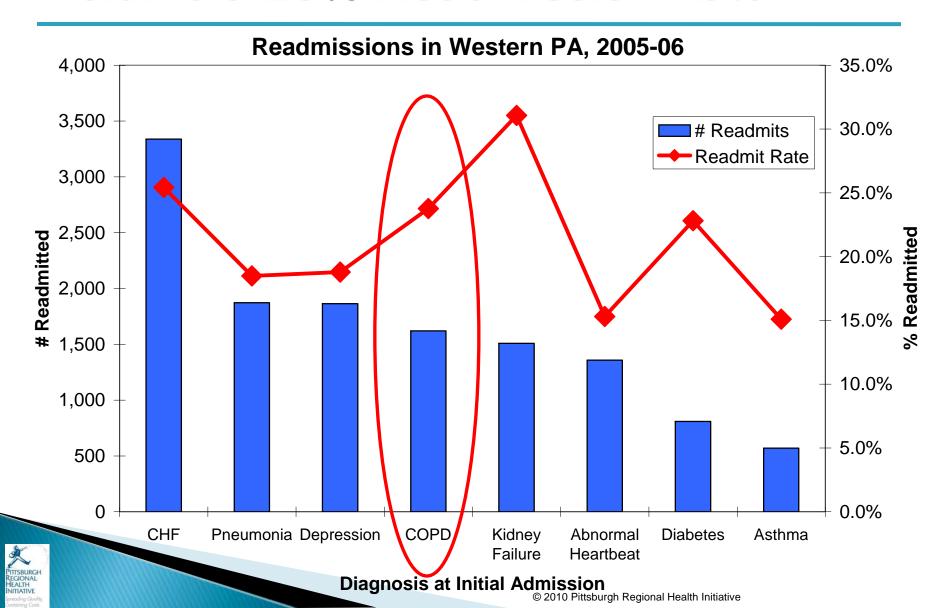
Source: Luft, Harold. *Total Cure*. Cambridge, 2008: Harvard University Press. pg. 66

### Integrated Accountable Patient-centric Care





# Initial Focus: COPD is 4<sup>th</sup> Highest Volume & 25% Readmission Rate



## Clinical Practice Guidelines Exist:

\*Long-Term Treatment for Stable COPD

**O**Avoidance of Risk Factors; Influenza Vaccination

**2** Add Rapid-Acting

Bronchodilator when

indicated

**3** Add Short or Long-acting

Bronchodilators and

Pulmonary Rehabilitation

**4** Add medium to high-dose

inhaled or oral

glucocorticosteroids or

antibiotics when indicated

**6** Add long-term oxygen; consider surgical referral

**0** At Risk

Normal lung function with or without Chronic symptoms

\*Adapted from Global Initiative for COPD www.goldcopd.org

**2** Mild COPD

Abnormal lung function with or without Chronic symptoms

**9**Moderate COPL

Chronic symptoms Shortness of breath on exertion

4 Severe COPD

Shortness of breath worsens

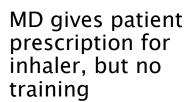
Exacerbations common

6 Very Severe COPD

Quality of life impaired Exacerbations may be Life threatening

### The Vicious Cycle of Chronic Disease Readmissions (COPD)

Patient is discharged without training in use of inhaler







Patient is treated with nebulizer during hospital stay

Patient gets inhaler from pharmacy, but no training



Patient fails to use inhaler properly, leading to hospitalization



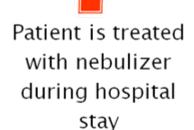
### Solution Requires Change Both In Hospital and Community (COPD)

#### **HOSPITAL**

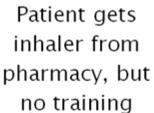
**Patient Education** to **Address** Causes of

**Admission** 

Patient is discharged without training in use of inhaler



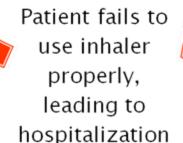
MD gives patient prescription for inhaler, but no training



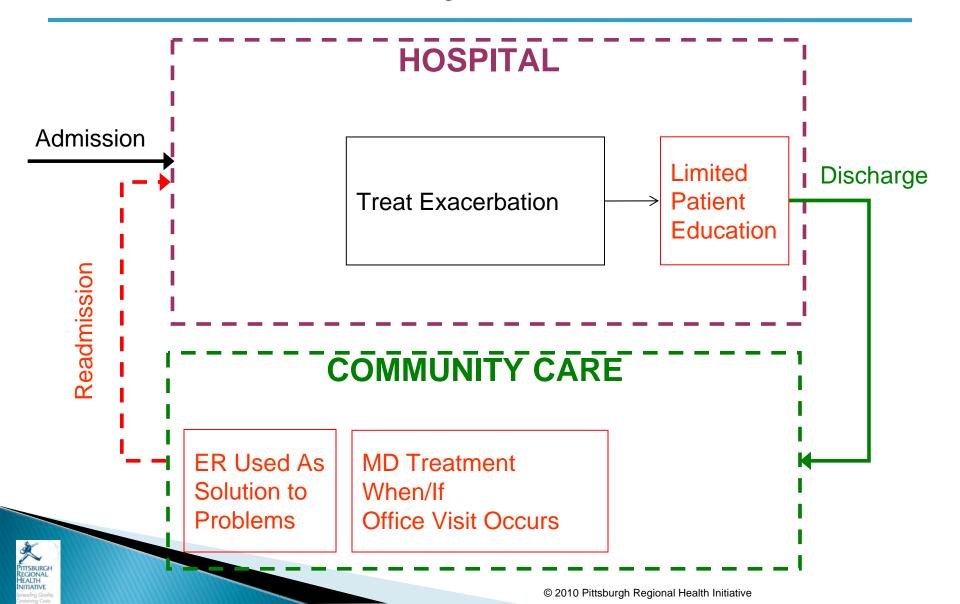
in the

#### **COMMUNITY**

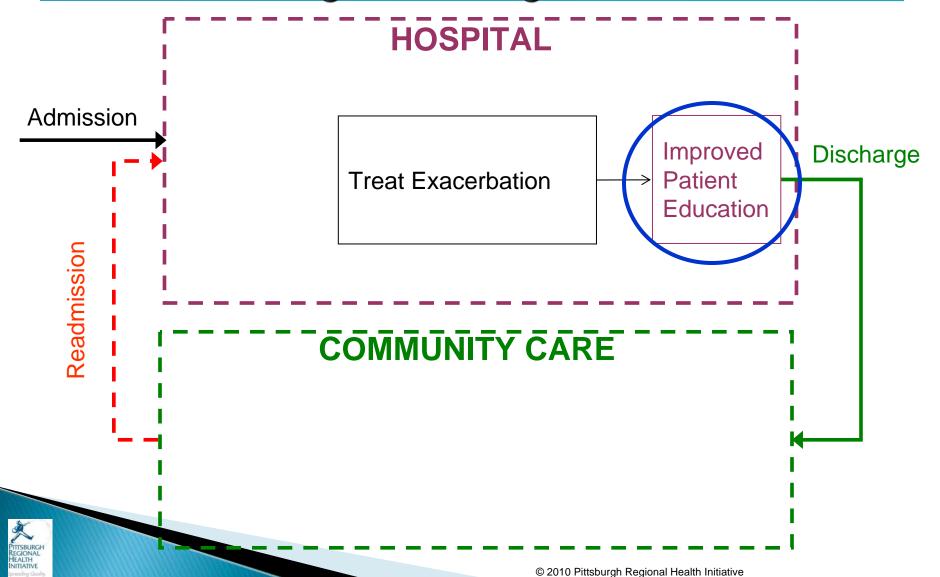
**Improved Patient Education** and **Support** Community



### The Process Today

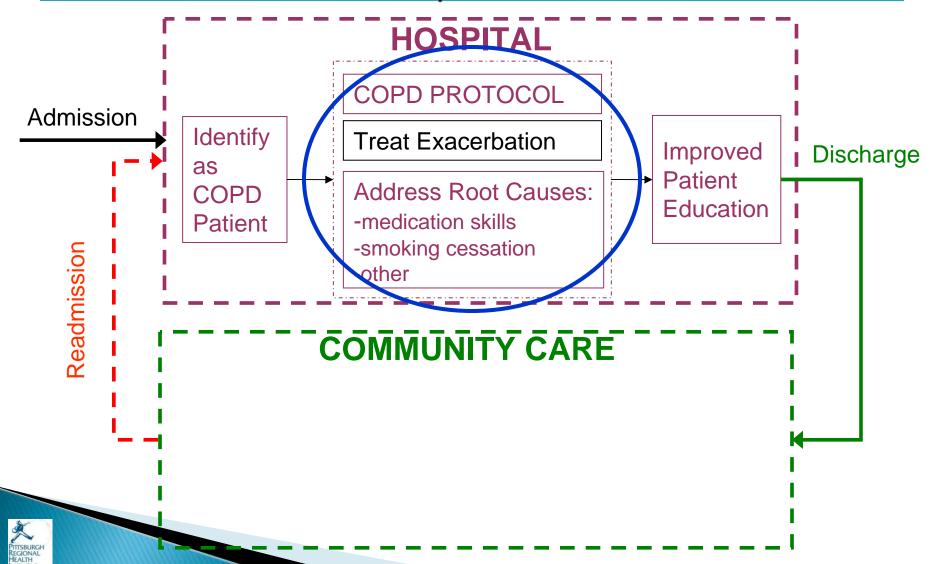


## What We've Tried to Fix: Better Discharge Planning and...

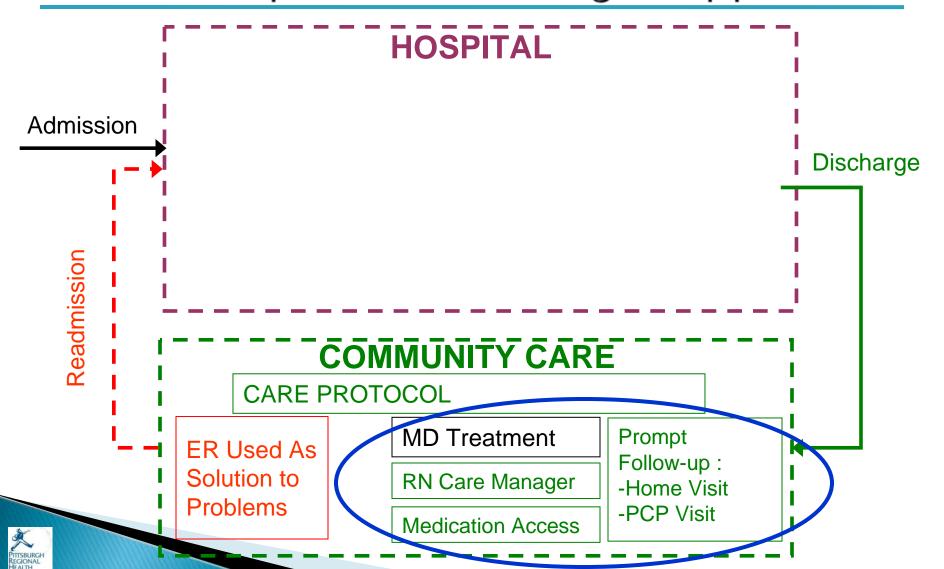


## What We've Tried to Fix:

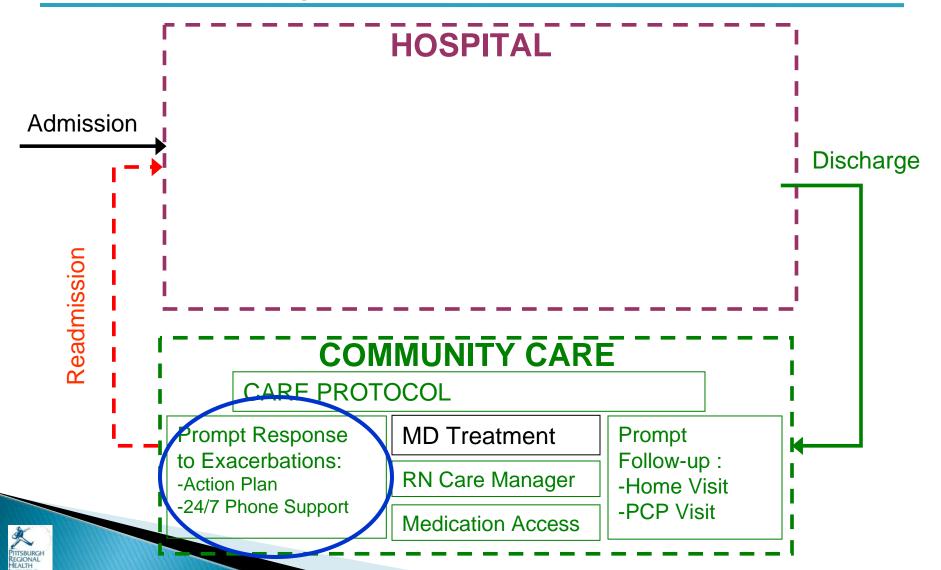
...Better Care in Hospital...



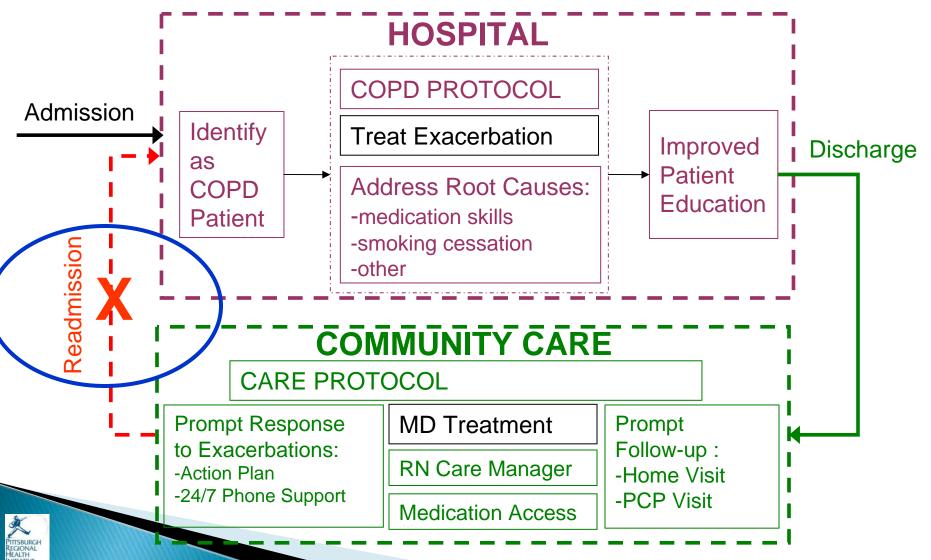
# What We've Tried to Fix: ...Prompt PCP/Care Mgr Support...



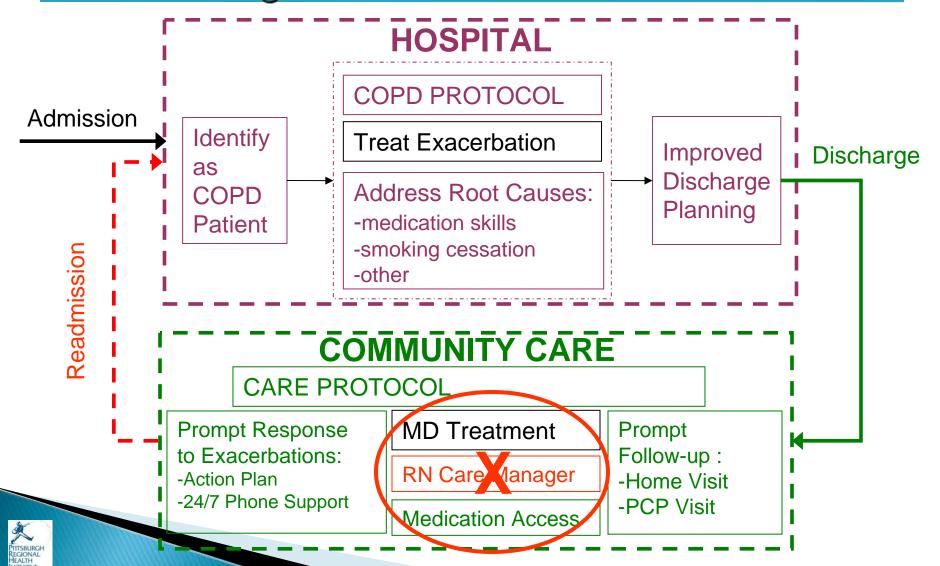
# What We've Tried to Fix: Non-Hospital Solution to Problems



### ...To Prevent Readmissions



### Challenge 1: Payers Don't Reimburse for Care Managers

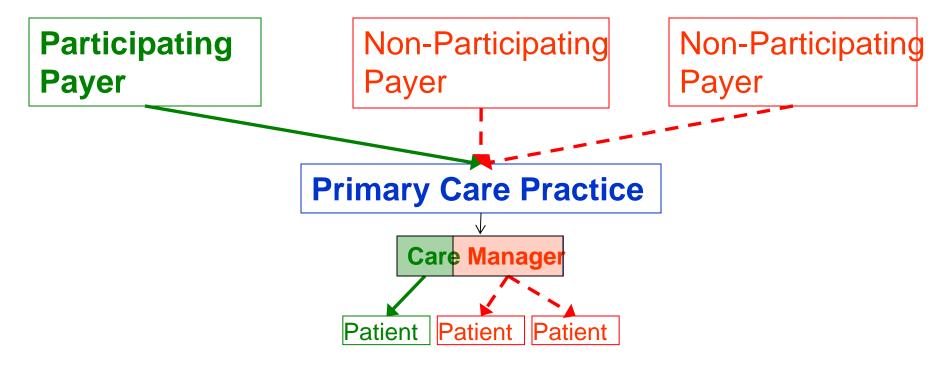


# Challenge 2: Getting Payers to Pay PCPs for Care Management

- Major health plans already employ their own care managers, at considerable expense
  - not integrated with physician practices
  - little or no face-to-face contact w/patients (primary mode of contact is by telephone)
  - paying for care managers in MD practices seems like (and is) duplication
- Different solutions from different health plans means providers can't treat all patients alike
  - e.g., "practice-based care manager" employed by a particular health plan could span multiple small providers, but would only improve care for the patients of that particular health plan



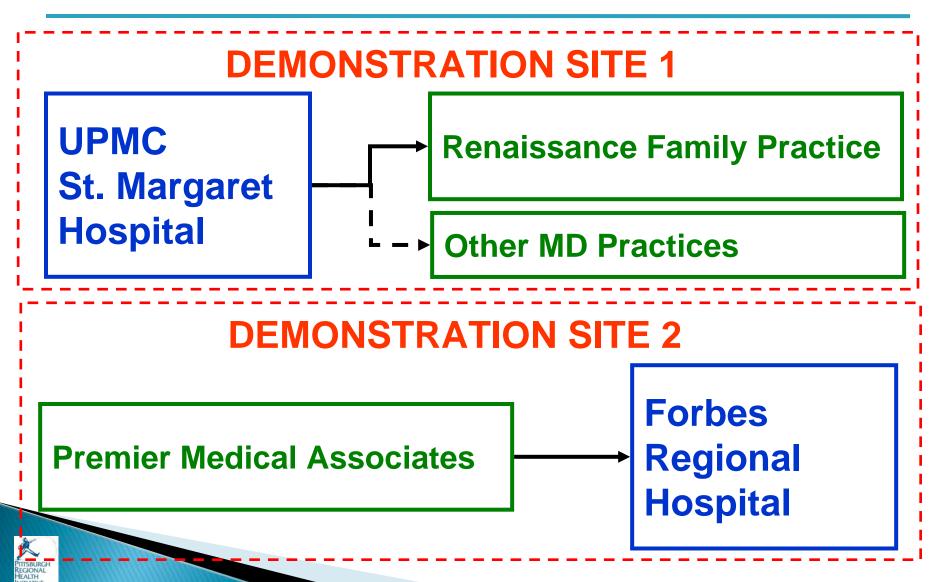
# Challenge 3: Gaining Support from a Critical Mass of Payers



PCP is only compensated for changed practices for the subset of patients covered by participating payers



### Two Demonstration Sites



## Significant Savings Exceeds Cost of Care Management

### **CURRENT**

# Admissions/Year: 500

% Readmitted: 25%

(<30 Days)

\$/Admission \$5,400

(Medicare/No Complic.):

Cost of Readmissions: \$675,000



### Savings Potential Exceeds Cost of Care Management

	CURRENT	40% REDUCTION
# Admissions/Year:	500	500
% Readmitted: (<30 Days)	25%	15%
\$/Admission (Medicare/No Complic.):	\$5,400	\$5,400
Cost of Readmissions:	\$675,000	\$405,000
Savings:		\$270,000

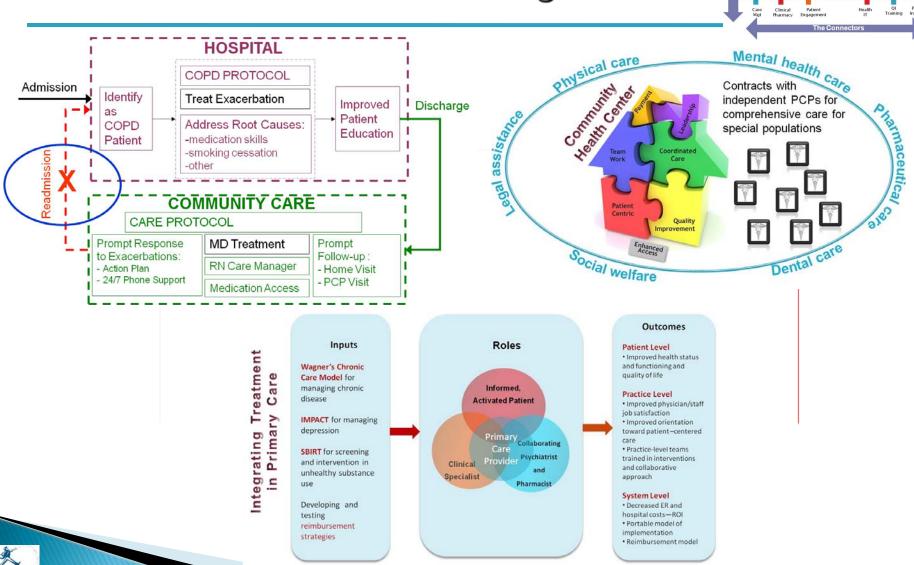


### **Teachable Moment**

# Reducing 30-Day COPD Readmissions Video



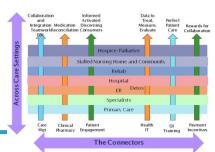
### But can we build something better?



killed Nursing Home and Community

Specialists

### Community Care - Paying Providers to Improve Performance



<u>Now</u>

**Transitions** 

**Future State** 

Change Outcomes

Providers are not aligned for comprehensive care

Payment model is not aligned with new expectations of the care models

ACCOUNTABLE
CARE
NETWORKS
or
PC3s

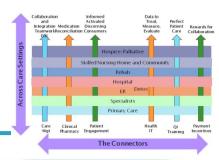
Foster Innovation and Disruptive Models

Change Employer / Plan Change Payment

Future Healthcare
Delivery
And Payment Systems
(Outcomes-Based)



### Community Care - Integrating Treatment in Primary Care



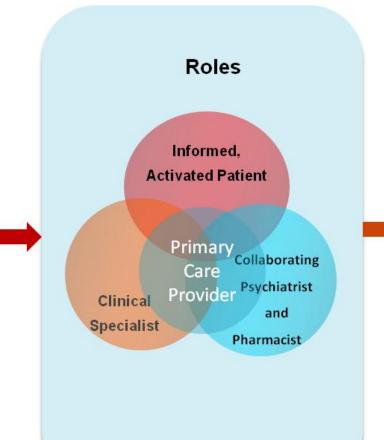
#### Inputs

Wagner's Chronic Care Model for managing chronic disease

**IMPACT** for managing depression

**SBIRT** for screening and intervention in unhealthy substance use

Developing and testing reimbursement strategies



#### **Outcomes**

#### **Patient Level**

 Improved health status and functioning and quality of life

#### Practice Level

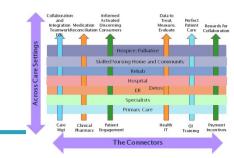
- Improved physician/staff job satisfaction
- Improved orientation toward patient—centered care
- Practice-level teams trained in interventions and collaborative approach

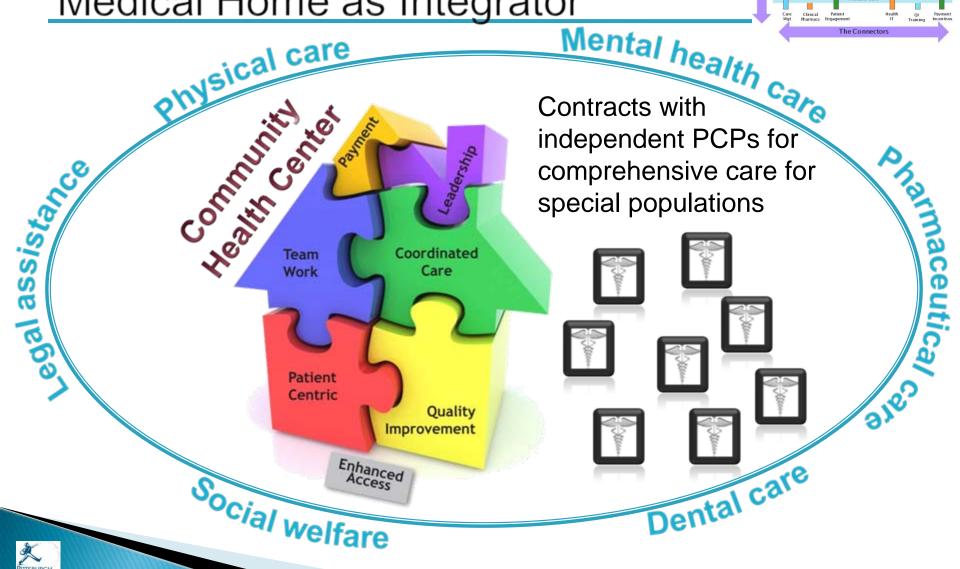
#### System Level

- Decreased ER and hospital costs—ROI
- Portable model of implementation
- · Reimbursement model

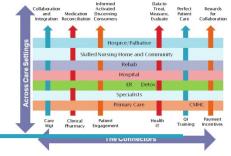


## Community care - Safety Net Medical Home as Integrator





### Introducing the PC3



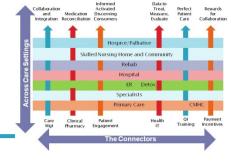
- Primary Care Comprehensive Support Center
  - Combines elements of the Medical Home, Integrating Treatment in Primary Care, Readmission Reduction
  - Builds on the social service models of immigration
     Settlement Houses in the 19<sup>th</sup> century
  - An entry point for the community into a range of both medical and nonmedical services



http://www.squirrelhillhealthcenter.org/entrance.jpg

Without this type of support, some populations will struggle to be "healthy"

## How do we pay for this?



## Pay for Performance

- Pay for the extra services that really improve outcomes (for less money) for the most challenging patients
  - Care Management
- Patient Education
- Clinical Rx
   Home Visits

- Quality Improvement
- Consultations

- Share savings
- Integrate primary care in sub-areas
- Make incentive payments for improved population health

