

# Teachable Moments – Reducing 30-Day COPD Readmissions

## Pay for Performance Summit

Karen Wolk Feinstein, PhD  
President and Chief Executive Officer  
Jewish Healthcare Foundation and  
Pittsburgh Regional Health Initiative

San Francisco, California  
March 10, 2010



# Agenda

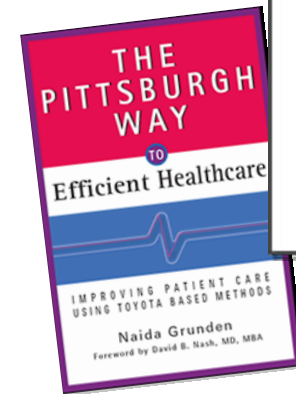
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- ▶ The Pittsburgh Regional Health Initiative
- ▶ Reducing COPD readmissions
- ▶ From reducing readmissions to building population health

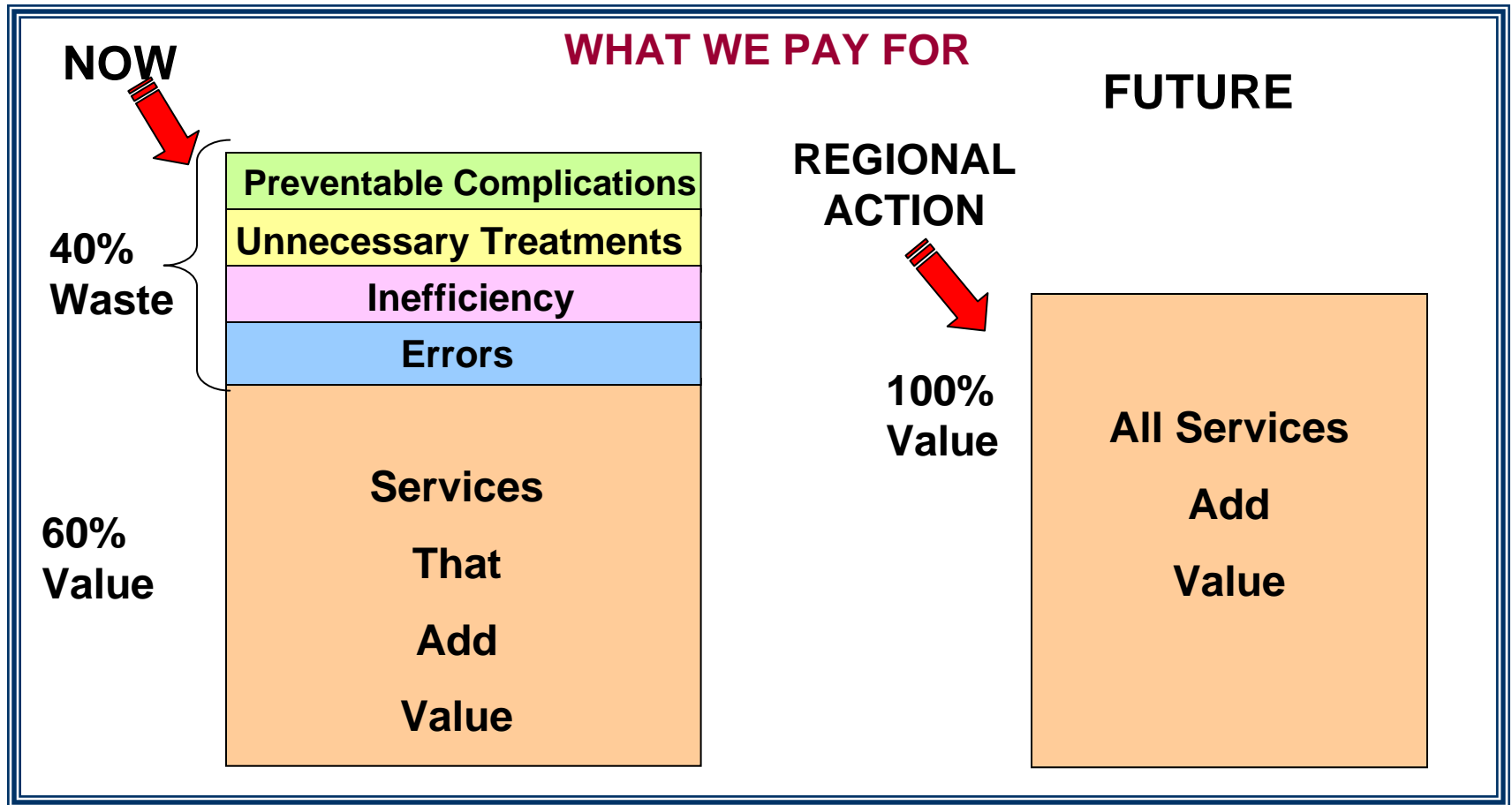
# Pittsburgh Regional Health Initiative

## *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***

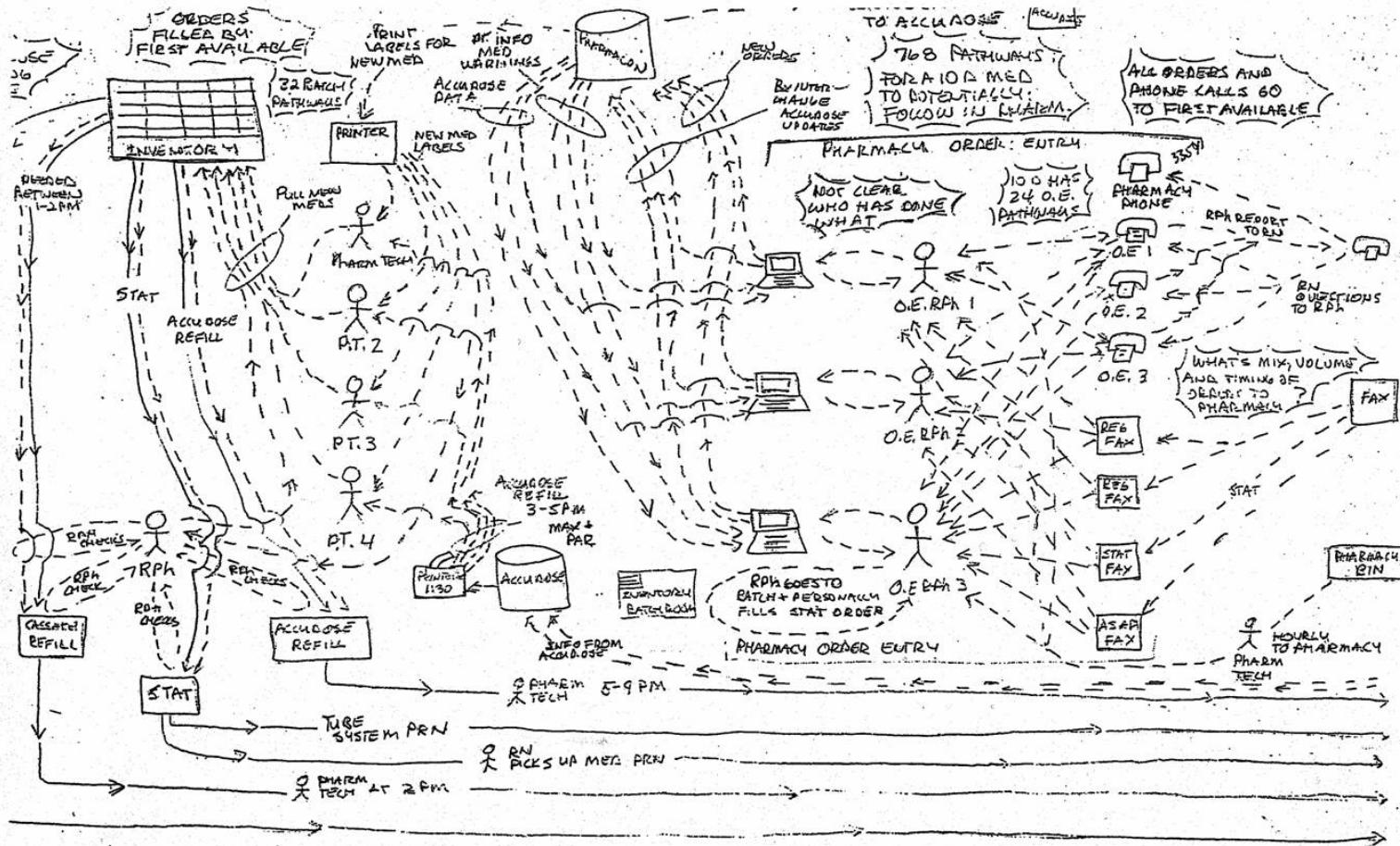


# Pittsburgh's Prescription for Healthcare Reform



A federally designated Community Leader

# The Healthcare Status Quo: waste and chaos



# What Comprises 100% Value?

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## Five core principles for perfecting care

1. Care systems organized to meet patient need, safely, efficiently and completely
2. Ambitious targets for eliminating error, waste and obstacles to the best care
3. Teamwork for 100% compliance with proven clinical and safety practices
4. 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

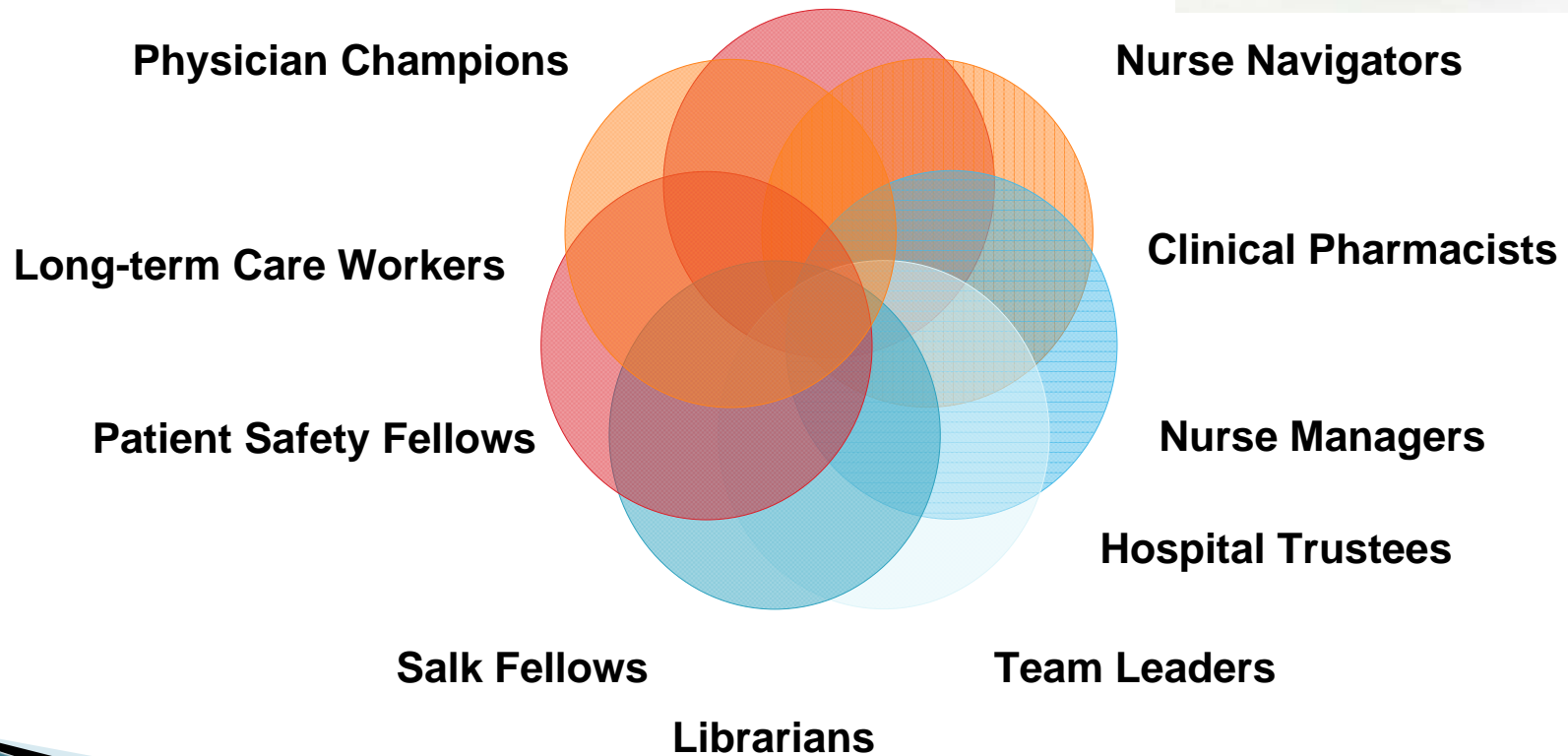
- ▶ Adapted from Lean
- ▶ Patient-focused systems redesign
- ▶ Can be applied in the course of everyday work
- ▶ The ultimate goal is perfection



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



## PPC METHODS





# PPC as a Common Platform

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- ▶ 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 problem-solving at all levels of the organization
- ▶ It keeps everyone focused on the goal: **ZERO**

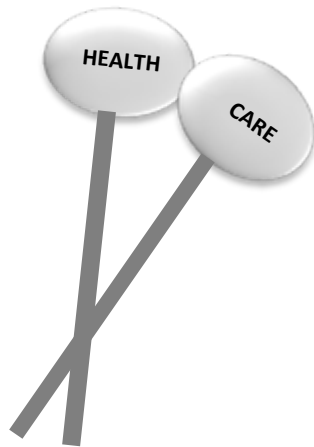
# Our Vision of the Ideal

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

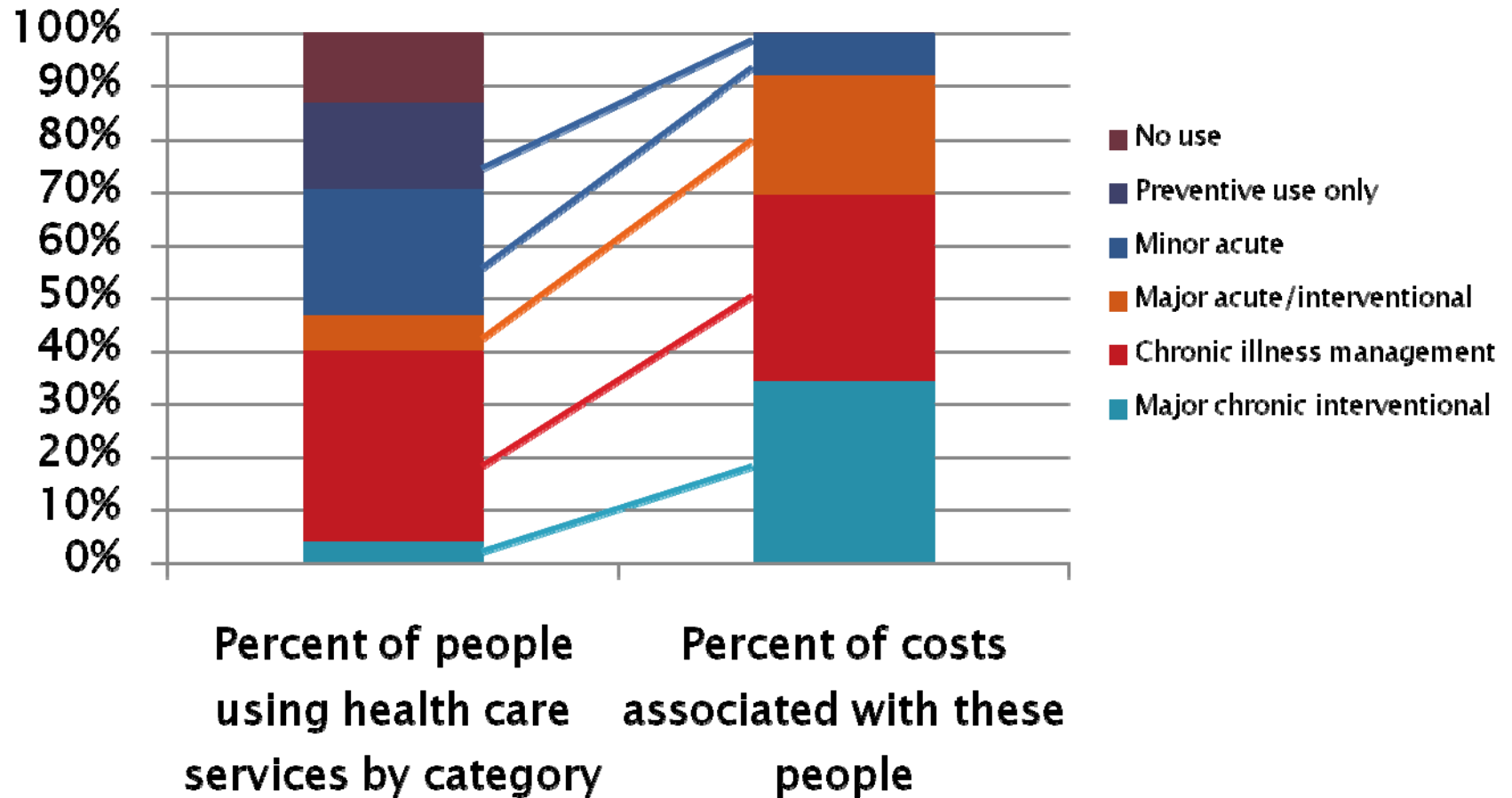
**Perfect = Safe • Efficient • Proven Best Practices**

# Xylophone for **VALUE**



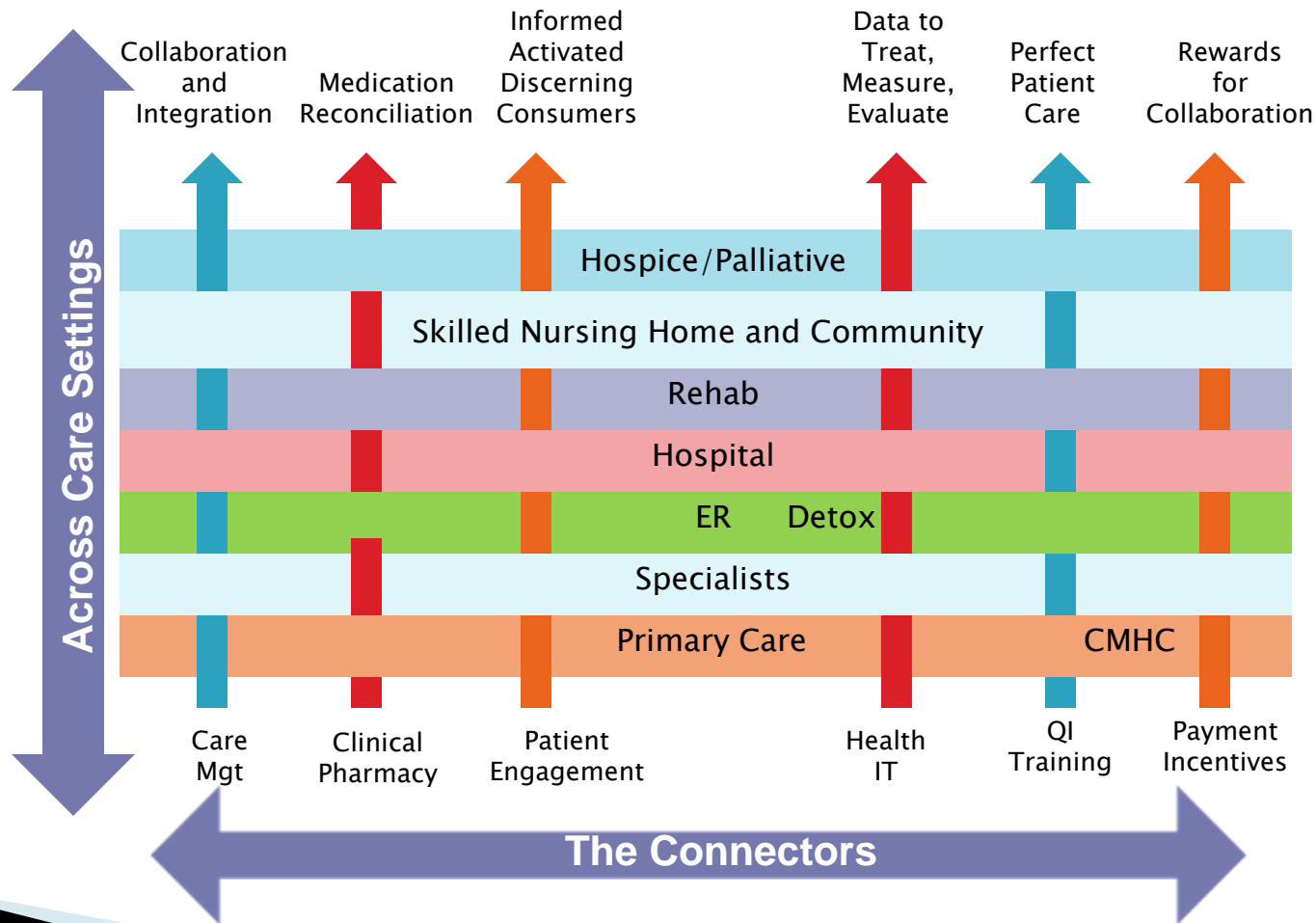
or we don't make music

# Proportion of Health Care Costs and Use in 2003



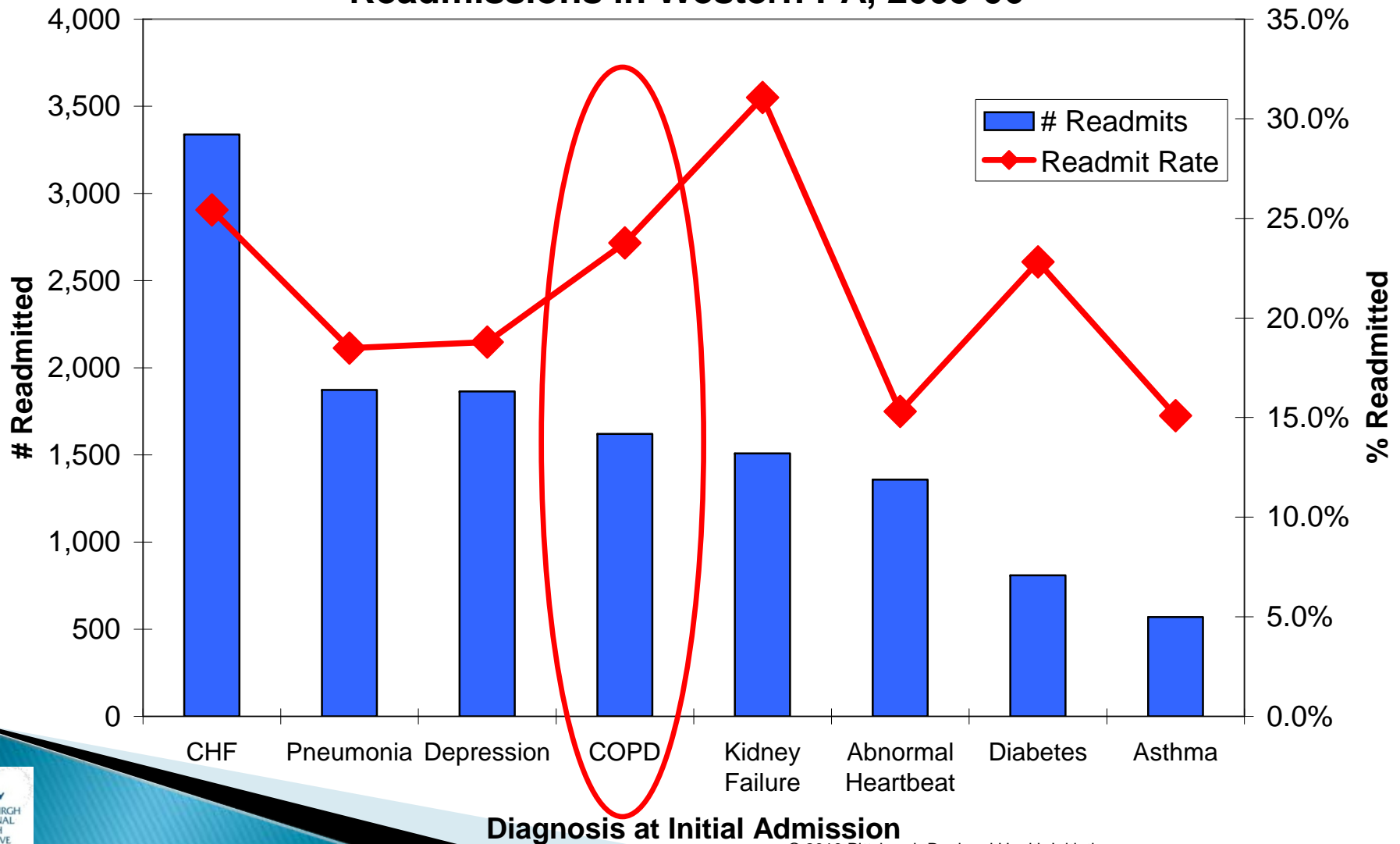
Source: Luft, Harold. *Total Cure*. Cambridge, 2008: Harvard University Press. pg. 66

# Integrated Accountable Patient-centric Care



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

## Readmissions in Western PA, 2005-06

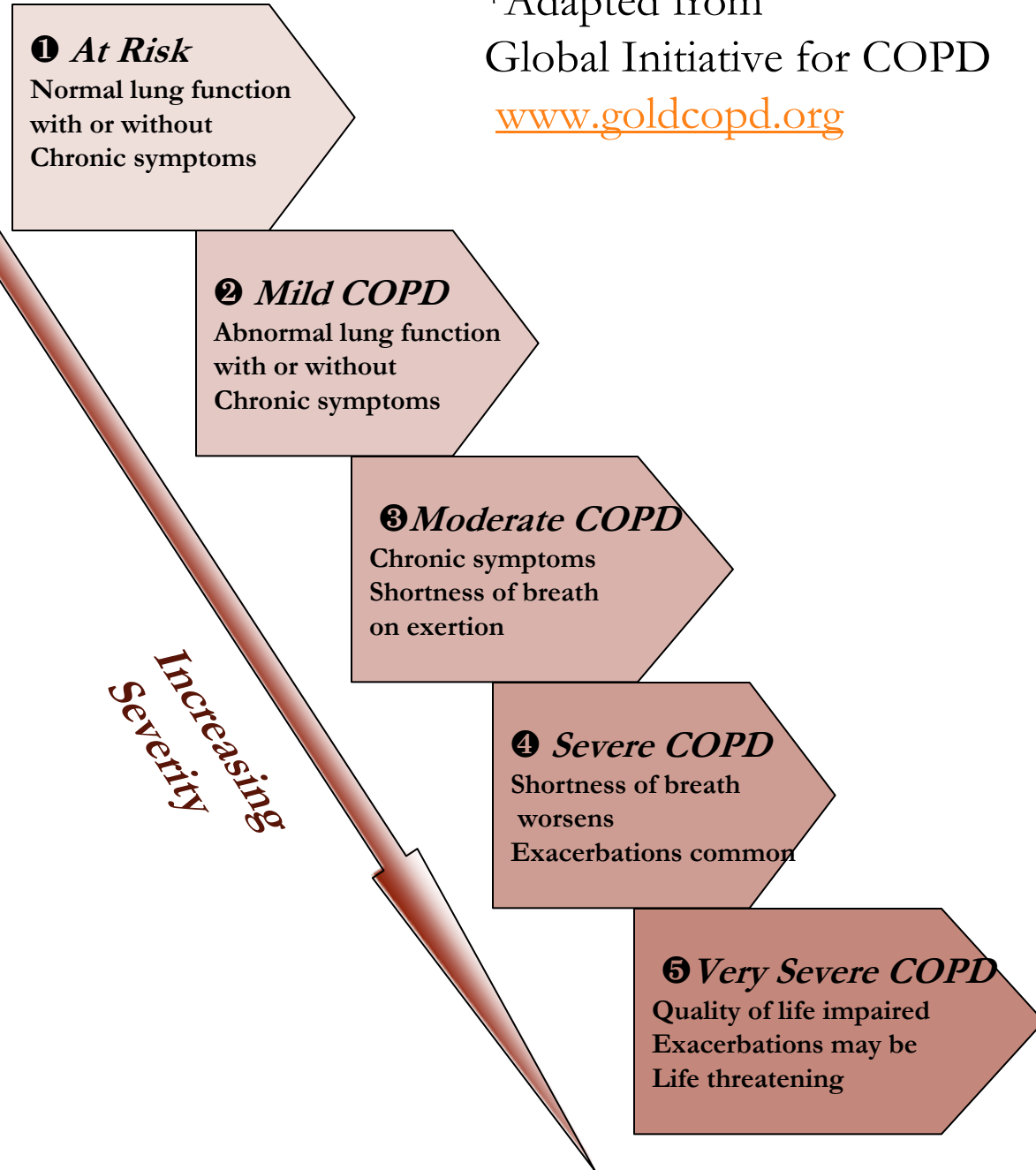


\*Adapted from  
Global Initiative for COPD  
[www.goldcopd.org](http://www.goldcopd.org)

# Clinical Practice Guidelines Exist:

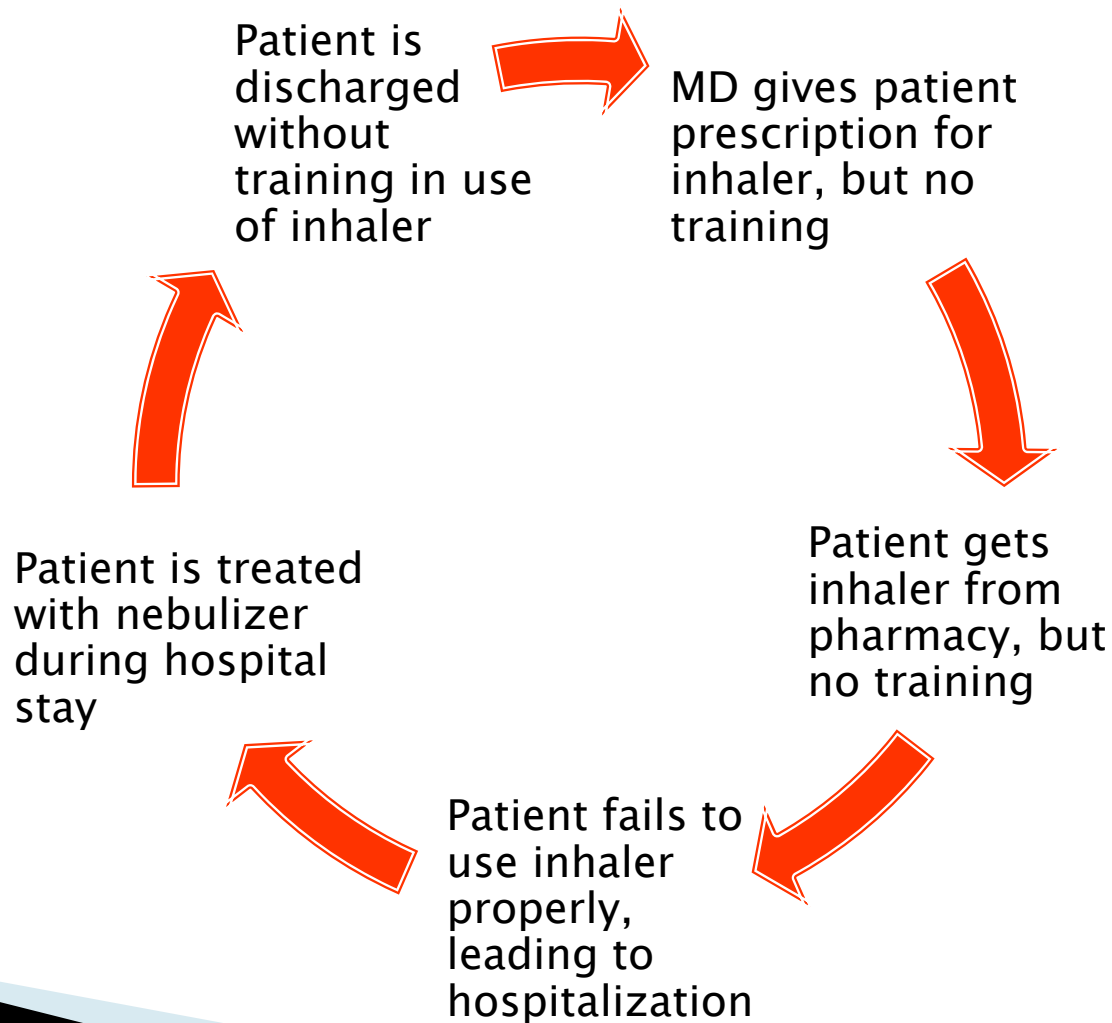
## \*Long-Term Treatment for Stable COPD

- ① 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*
- ⑤ Add long-term oxygen;  
consider surgical referral



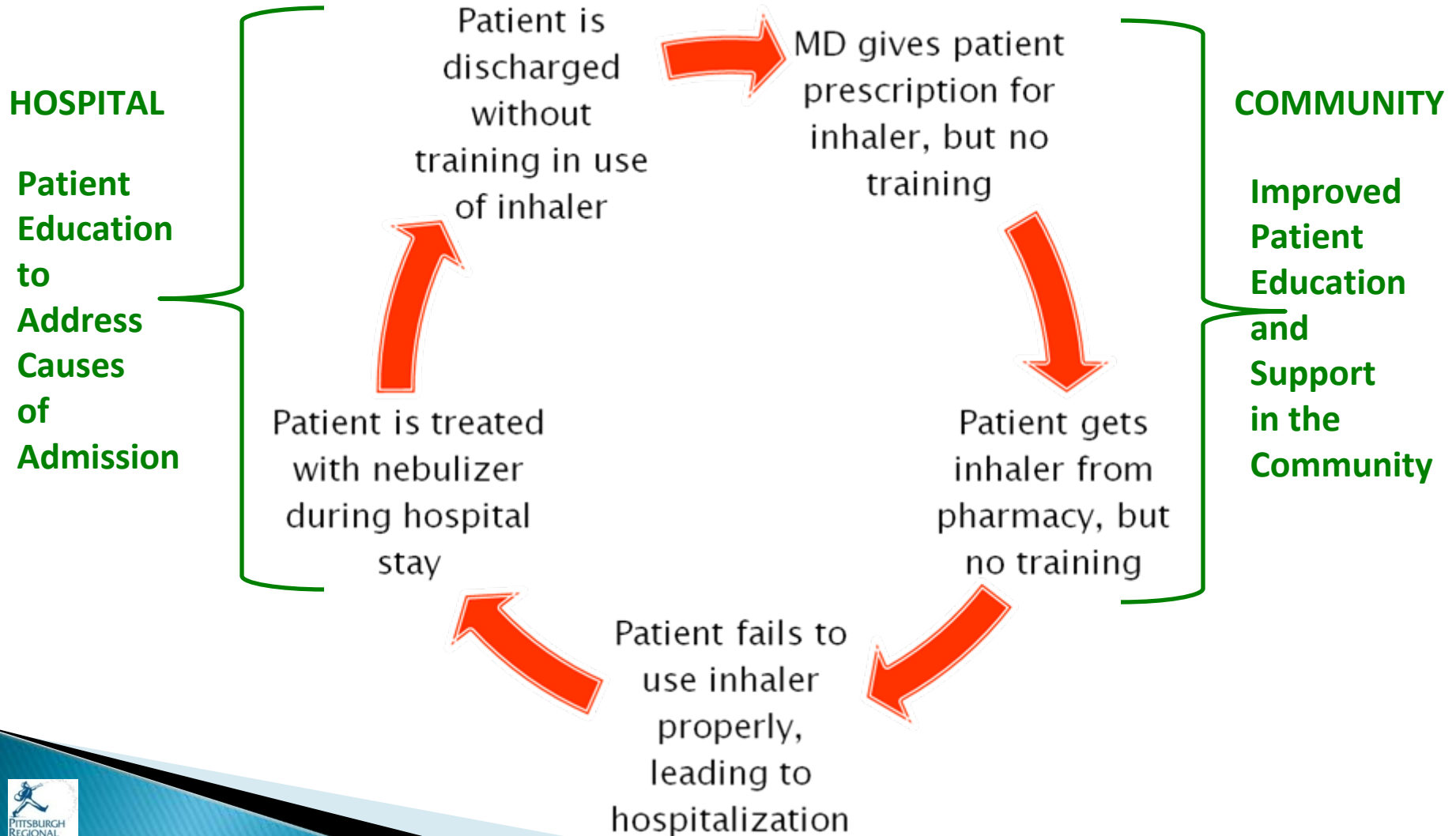
# The Vicious Cycle of Chronic Disease Readmissions (COPD)

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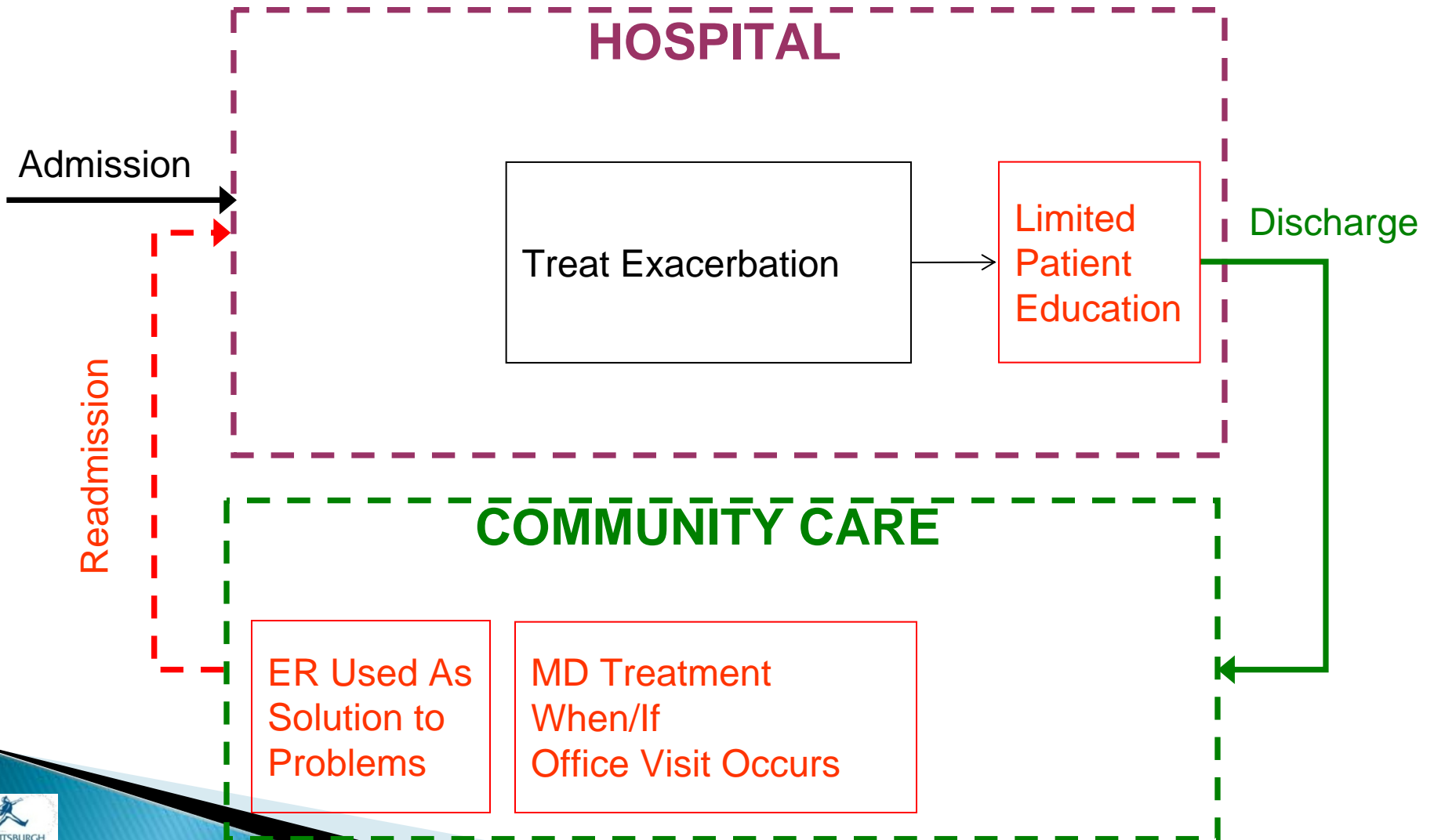




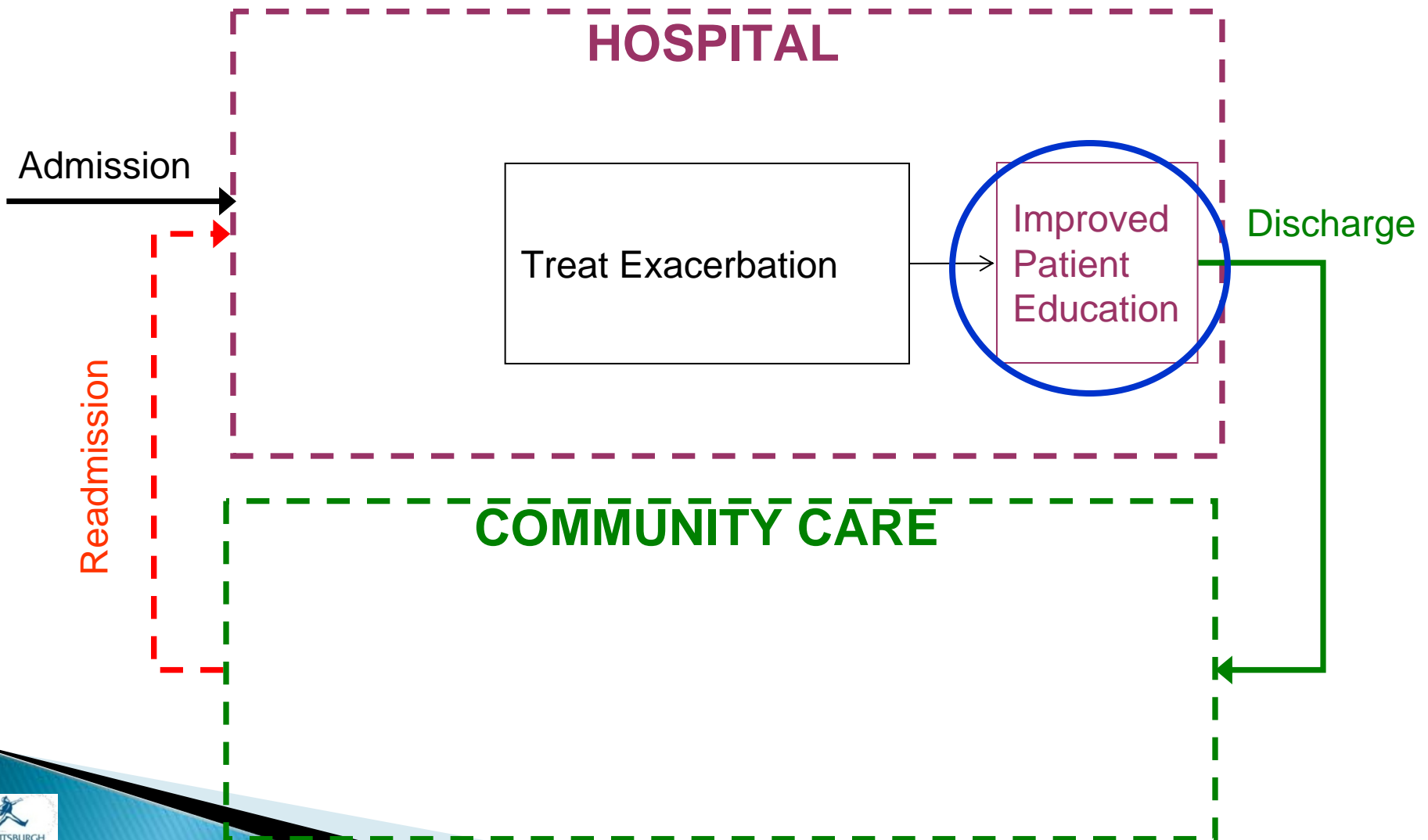
# Solution Requires Change Both In Hospital and Community (COPD)



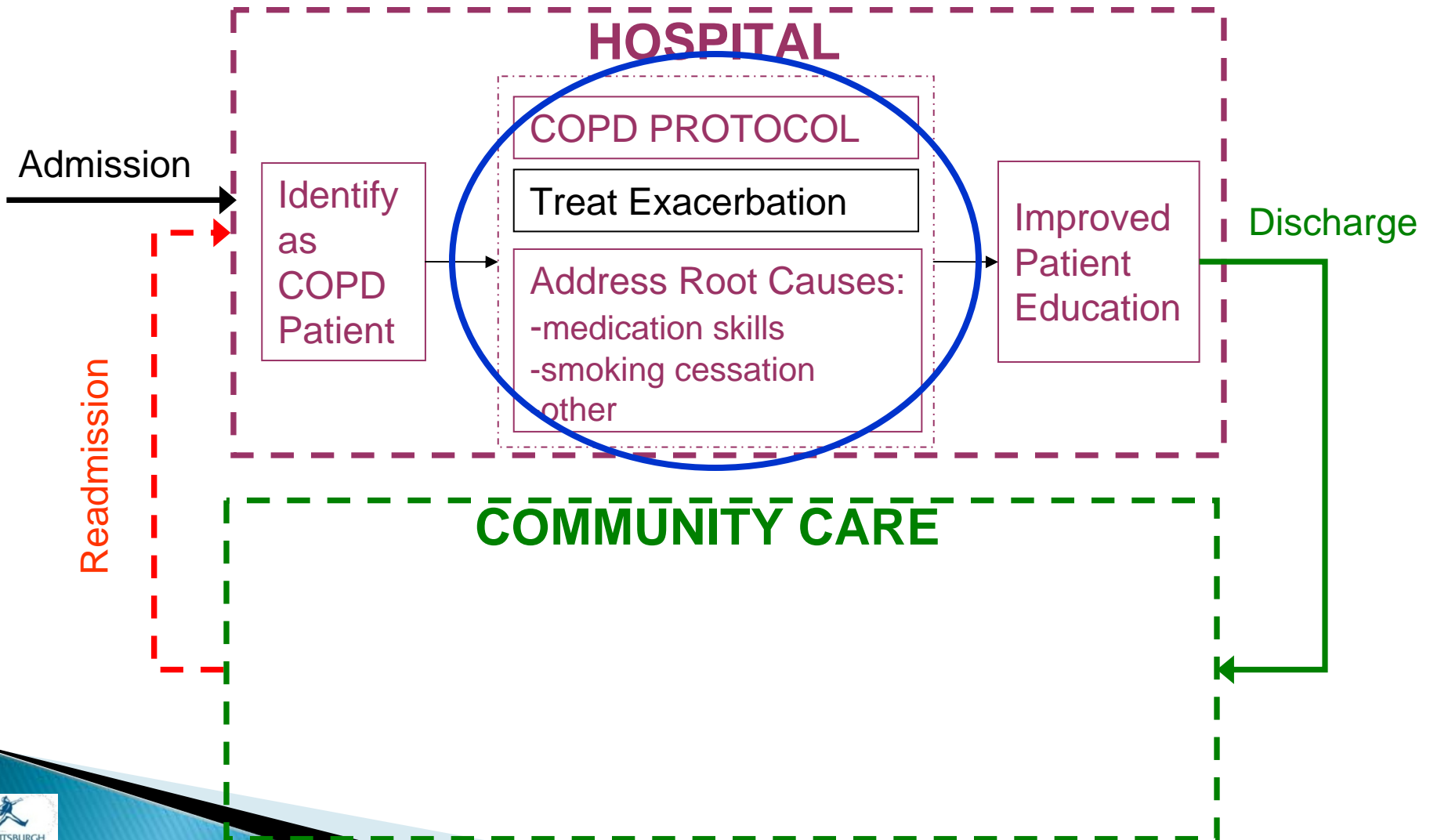
# The Process Today



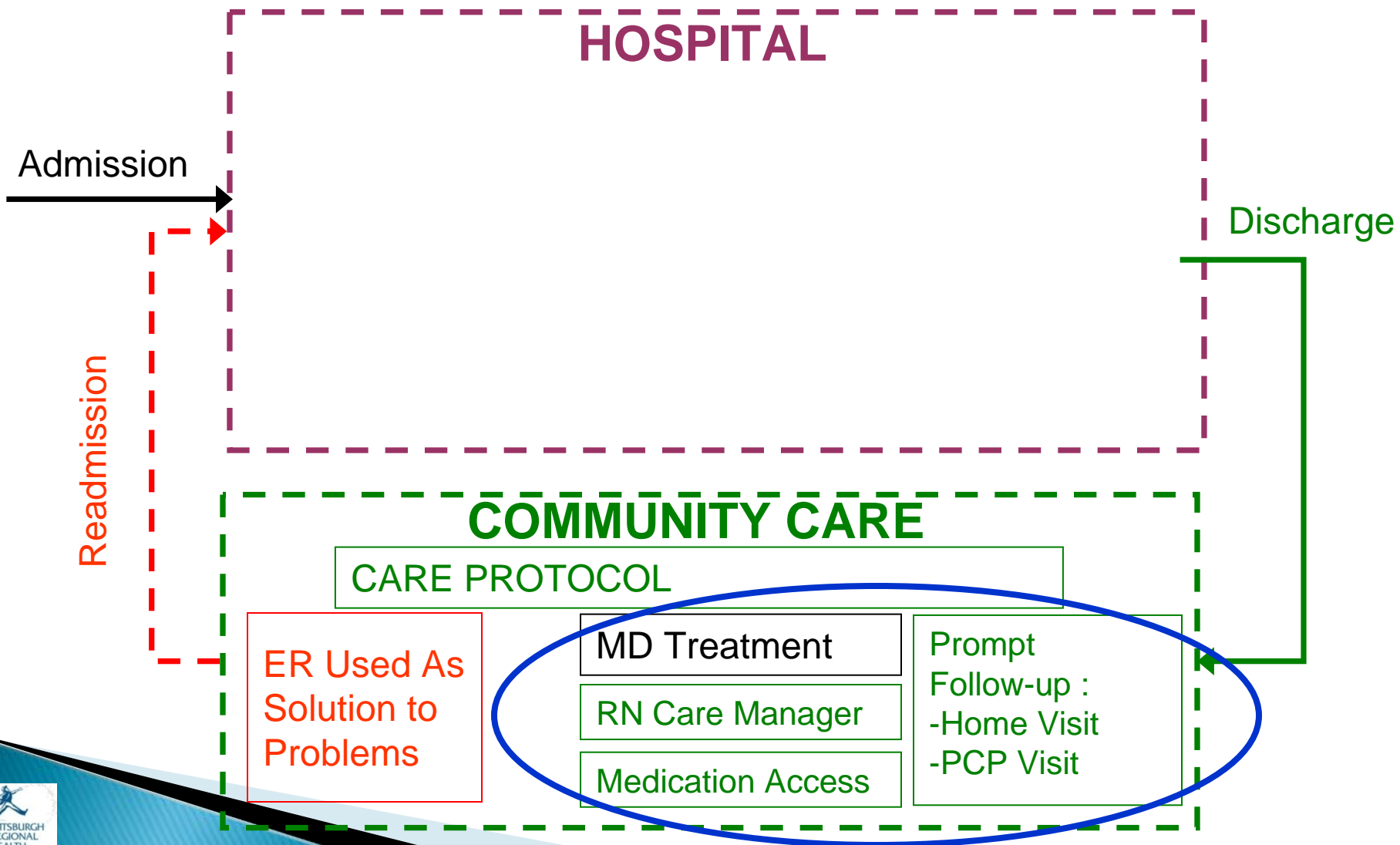
# What We've Tried to Fix: Better Discharge Planning and...



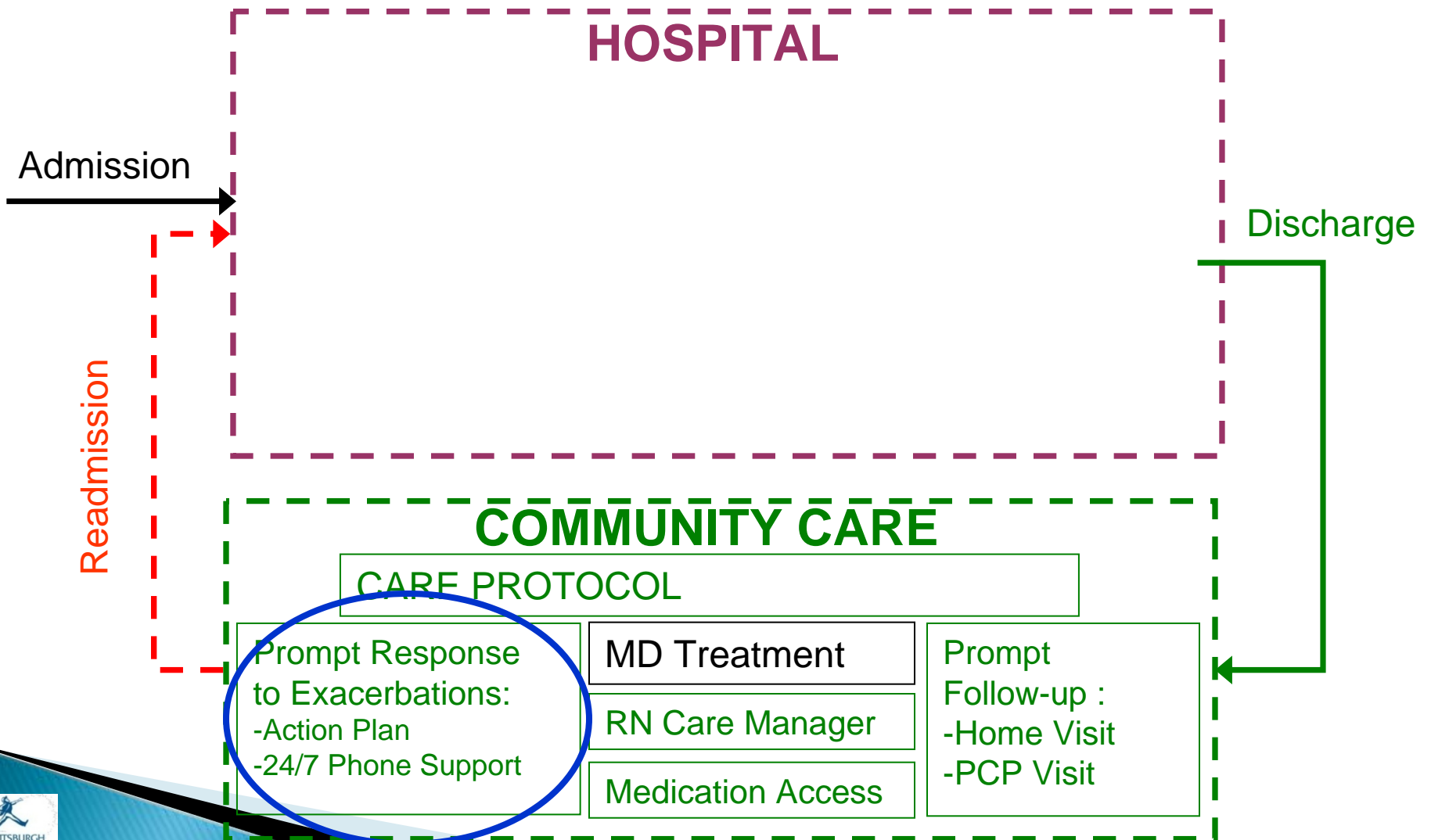
# What We've Tried to Fix: ...Better Care in Hospital...



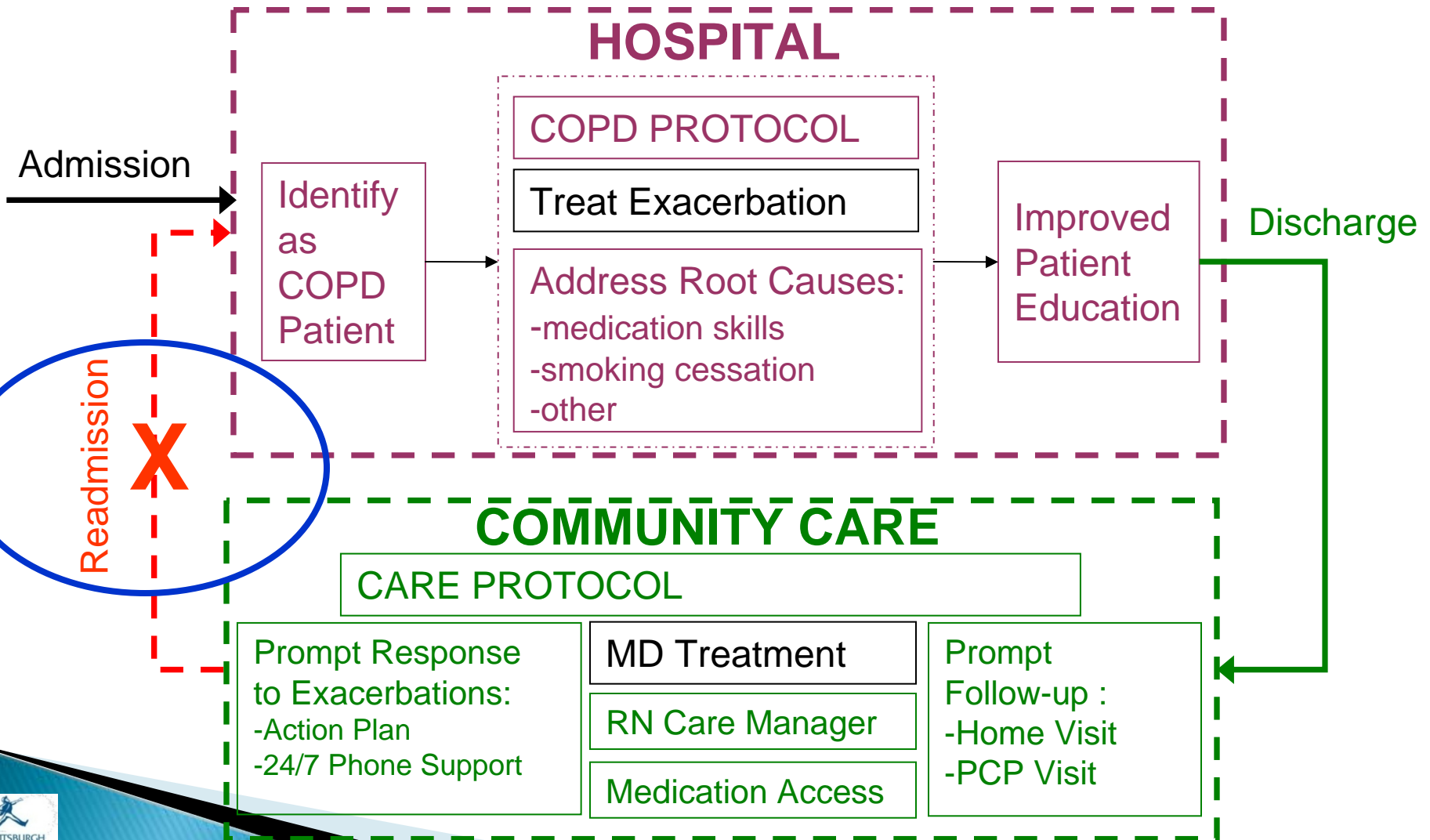
# What We've Tried to Fix: ...Prompt PCP/Care Mgr Support..



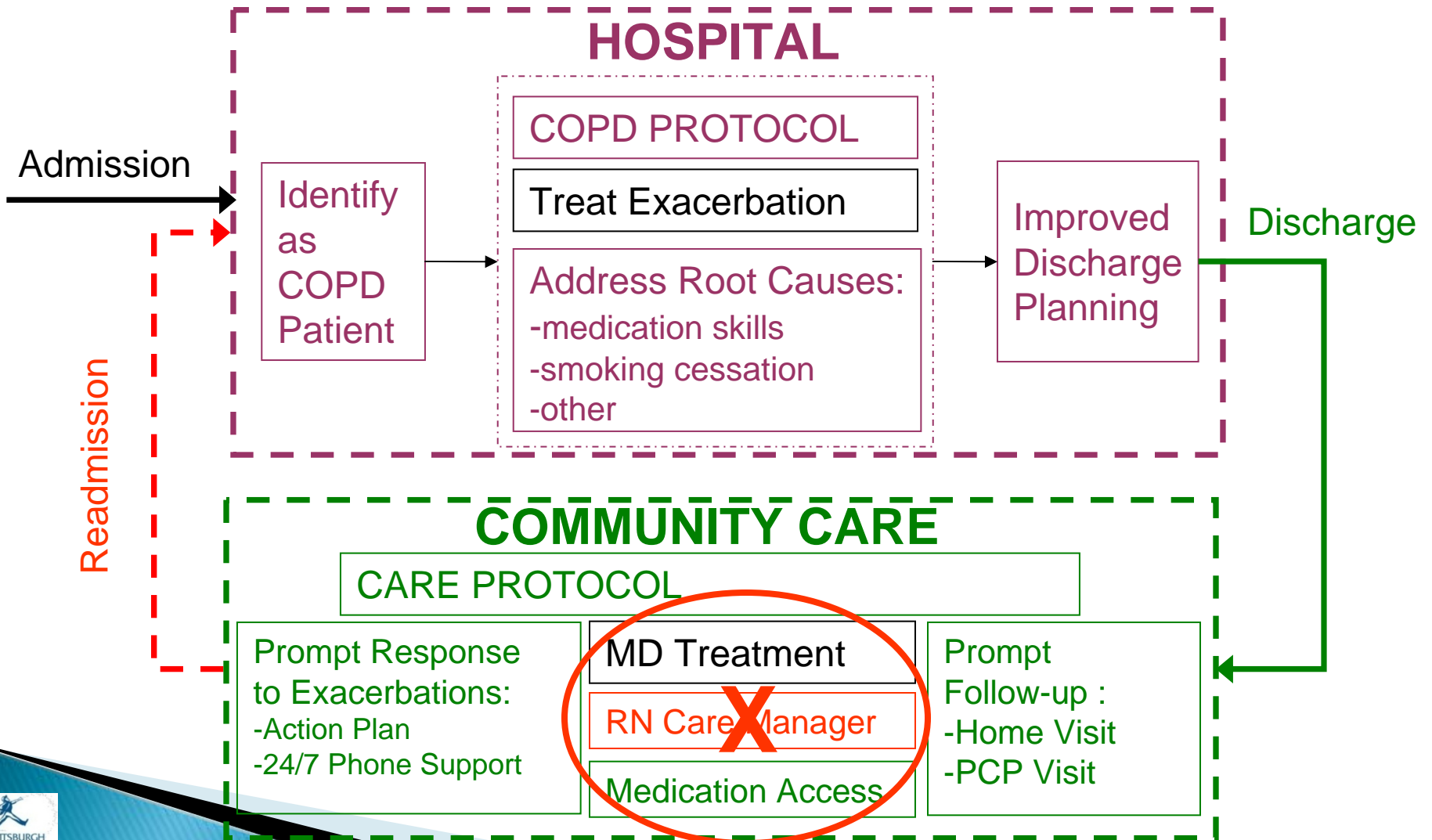
# What We've Tried to Fix: Non-Hospital Solution to Problems



# ...To Prevent Readmissions



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



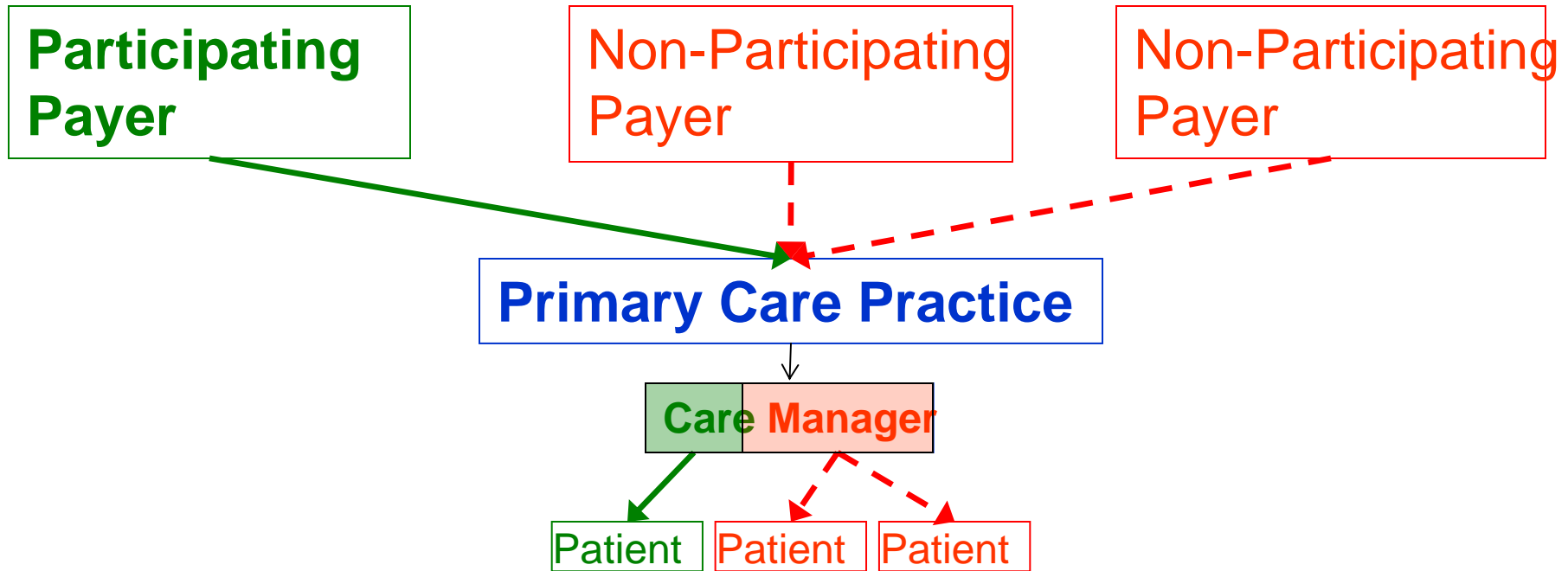


# Challenge 2: Getting Payers to Pay PCPs for Care Management

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- ▶ 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*

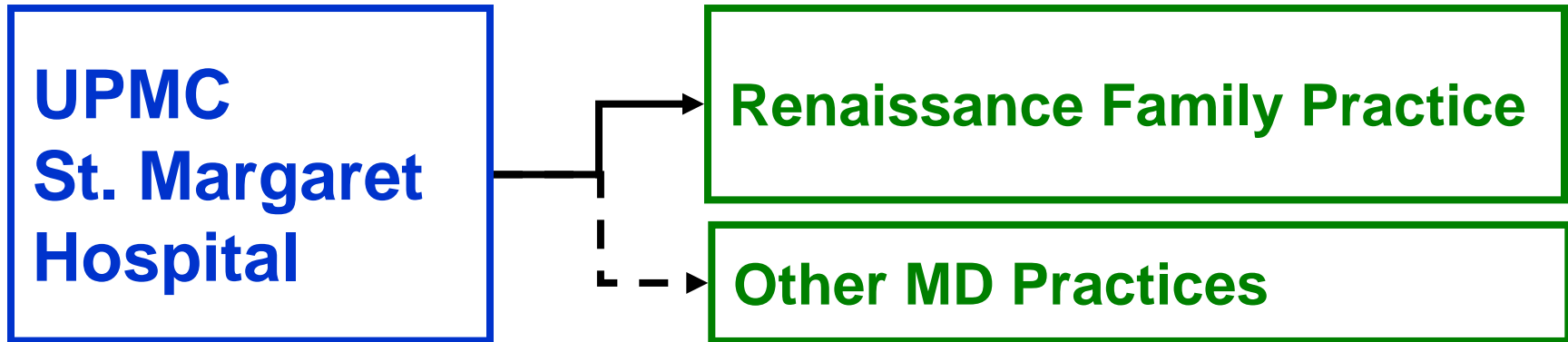
# Challenge 3: Gaining Support from a Critical Mass of Payers



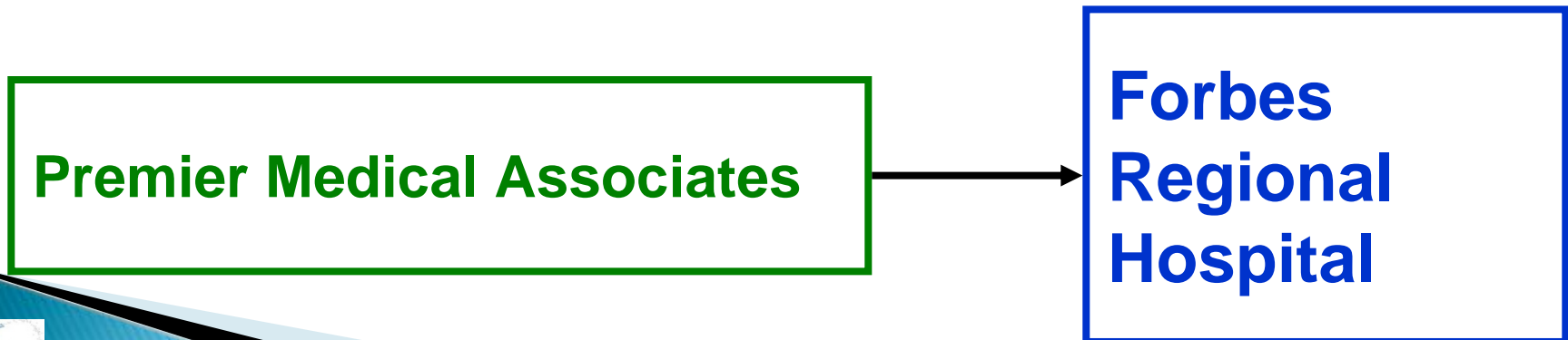
***PCP is only compensated for changed practices for the subset of patients covered by participating payers***

# Two Demonstration Sites

## DEMONSTRATION SITE 1



## DEMONSTRATION SITE 2



# Significant Savings Exceeds Cost of Care Management

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## CURRENT

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# Admissions/Year:	500
% Readmitted: (<30 Days)	<b>25%</b>
\$/Admission (Medicare/No Complic.):	\$5,400
Cost of Readmissions:	<b>\$675,000</b>

# Savings Potential Exceeds Cost of Care Management

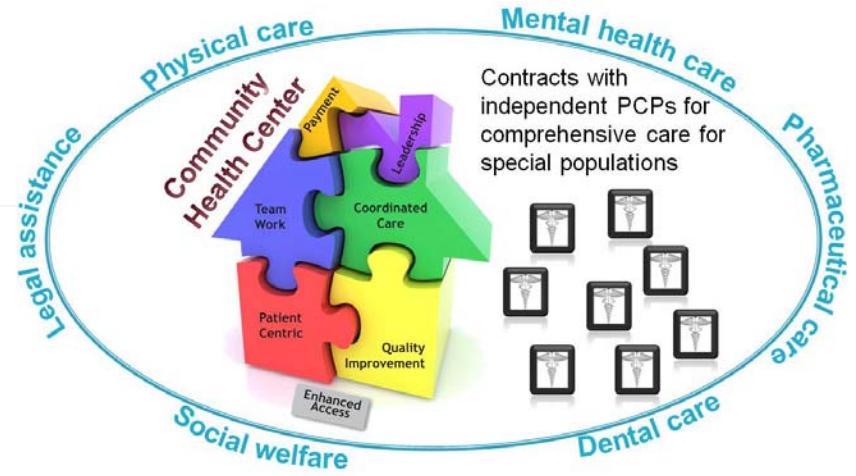
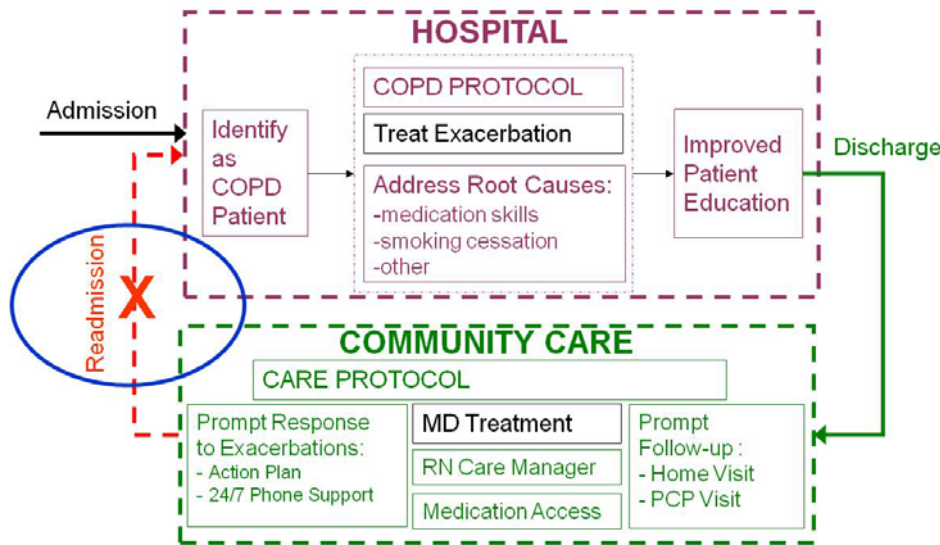
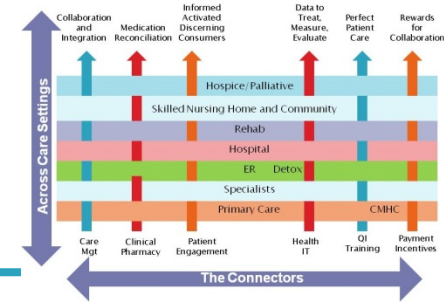
	<b>CURRENT</b>	<b>40% REDUCTION</b>
# Admissions/Year:	500	500
% Readmitted: (<30 Days)	<b>25%</b>	<b>15%</b>
\$/Admission (Medicare/No Complic.):	\$5,400	\$5,400
Cost of Readmissions:	<b>\$675,000</b>	<b>\$405,000</b>
<b>Savings:</b>		<b>\$270,000</b>

# Teachable Moment

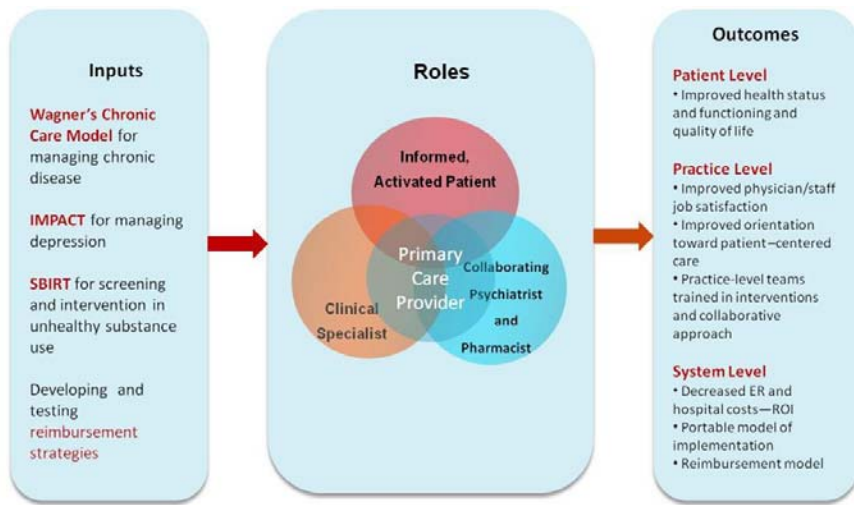
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## Reducing 30-Day COPD Readmissions Video

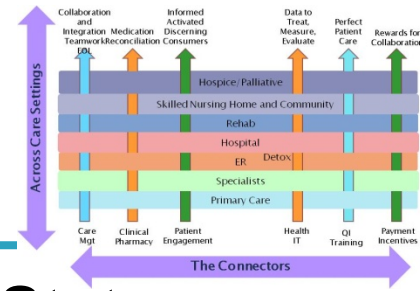
# But can we build something better?



## Integrating Treatment in Primary Care



# Community Care - Paying Providers to Improve Performance

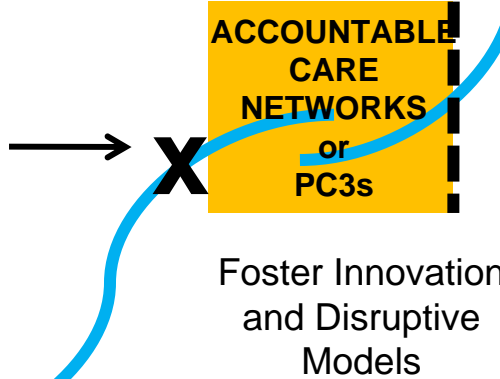


## Now

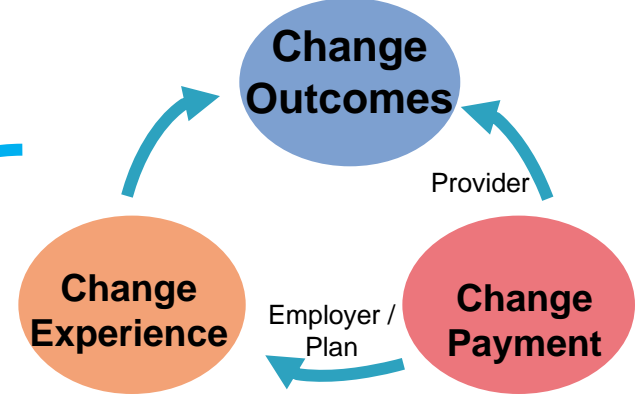
Providers are not aligned for comprehensive care

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

## Transitions



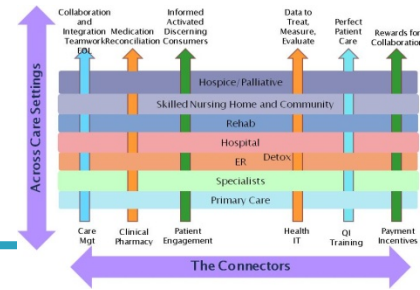
## Future State



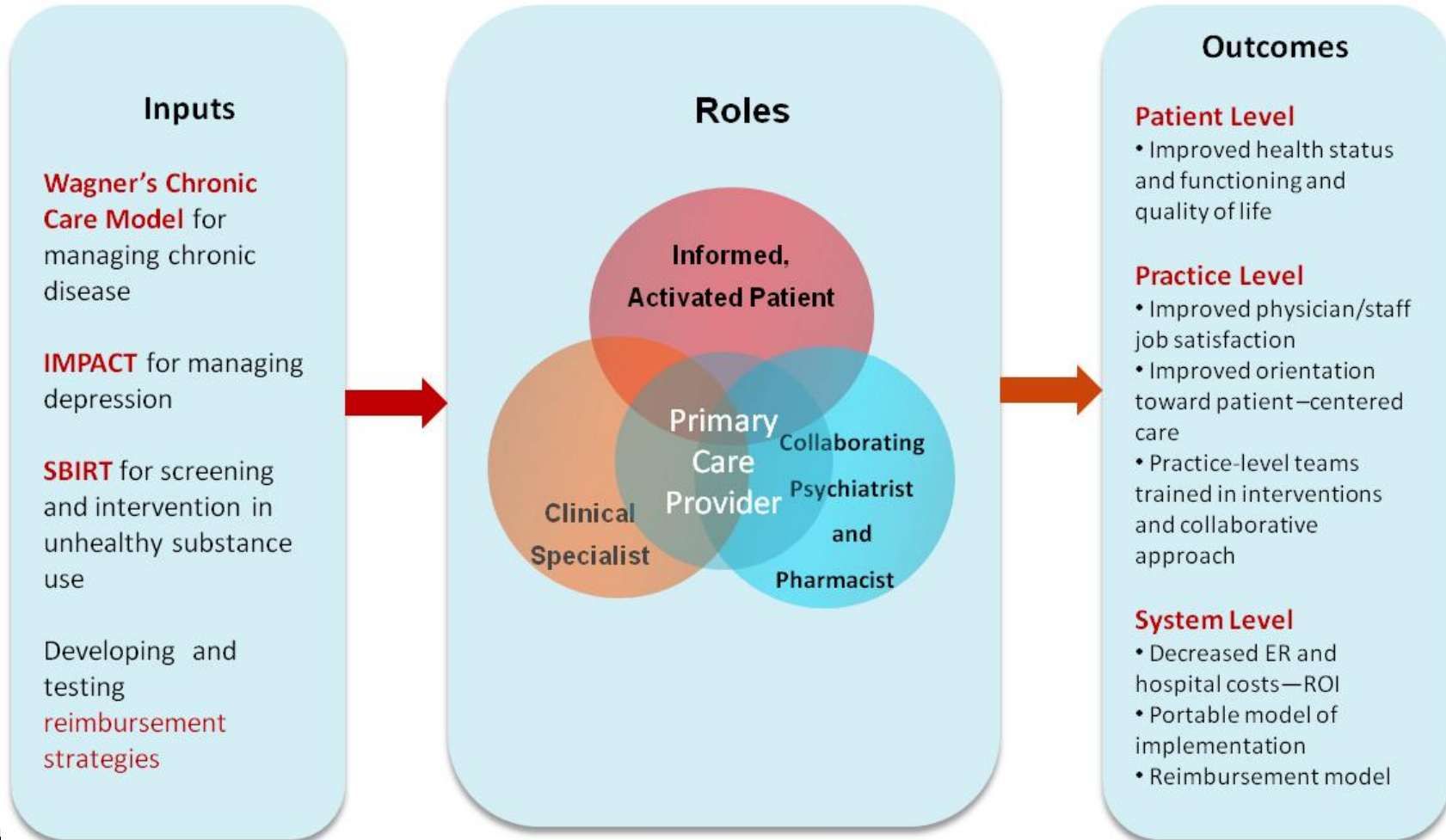
**Future Healthcare Delivery And Payment Systems (Outcomes-Based)**



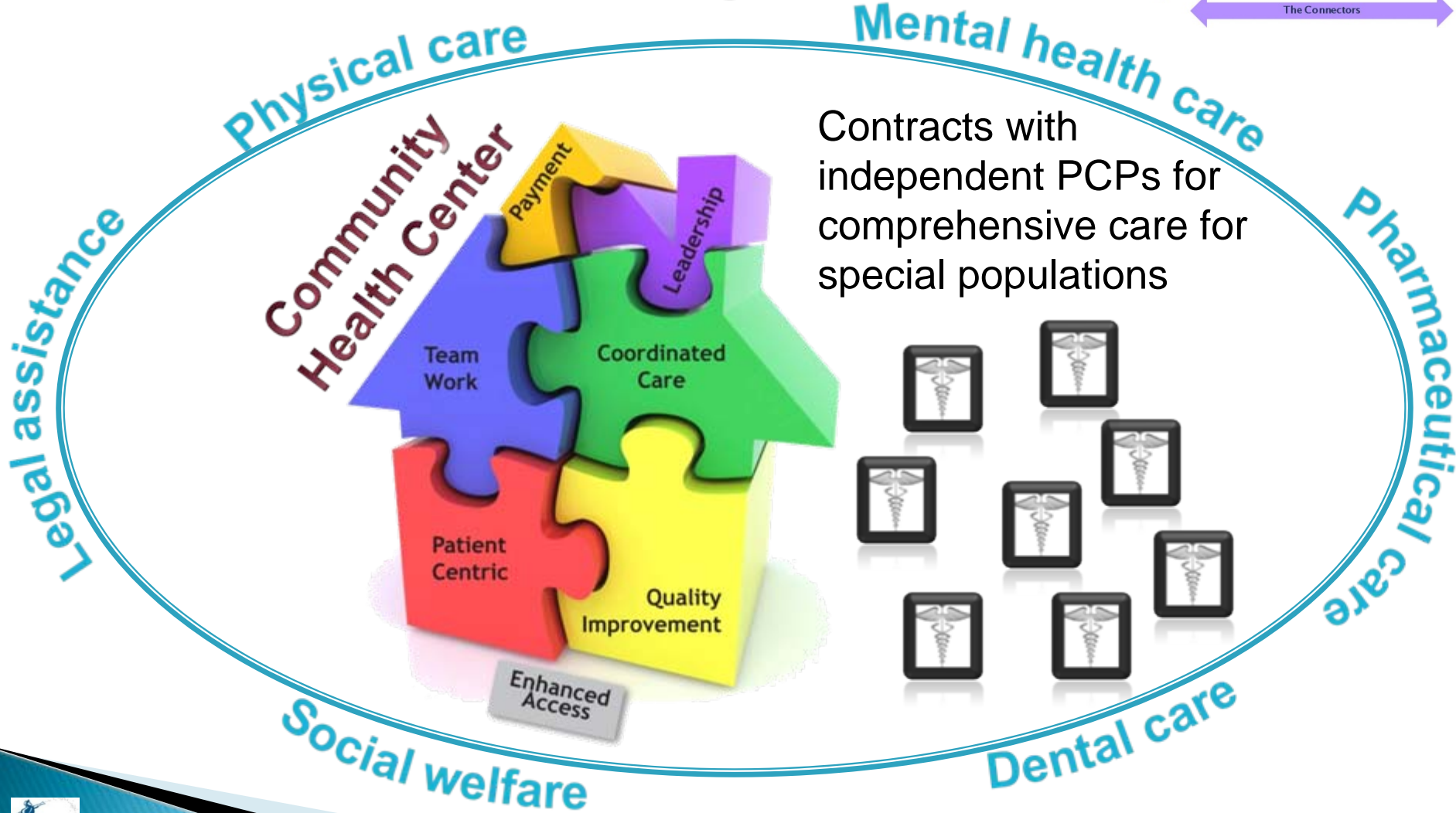
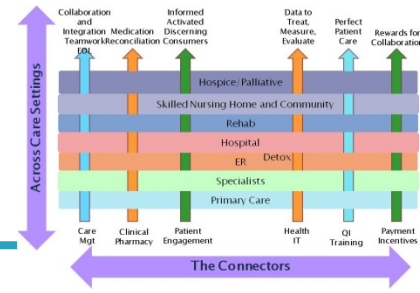
# Community Care - Integrating Treatment in Primary Care



## Integrating Treatment in Primary Care



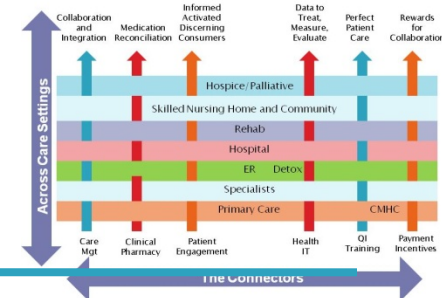
# Community care - Safety Net Medical Home as Integrator



Contracts with independent PCPs for comprehensive care for special populations



# Introducing the PC3

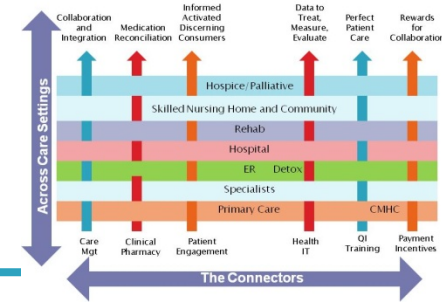


- ▶ **Primary Care Comprehensive Support Center**
  - Combines elements of the Medical Home, Integrating Treatment in Primary Care, Readmission Reduction
  - Builds on the social service models of immigration Settlement Houses in the 19<sup>th</sup> century
  - An entry point for the community into a range of both medical and nonmedical services
- ▶ Without this type of support, some populations will struggle to be “healthy”



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

# 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
  - Clinical Rx
  - Patient Education
  - Home Visits
  - Quality Improvement
  - Consultations
- ▶ Share savings
- ▶ Integrate primary care in sub-areas
- ▶ Make incentive payments for improved population health