Pittsburgh Regional Health Initiative Advancing Quality via Evolving Strategies: *We Follow Where Data Lead*

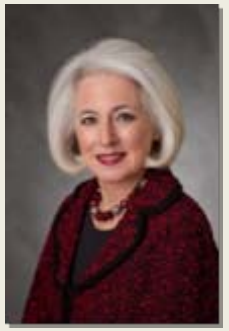
Karen Wolk Feinstein, PhD

President and Chief Executive Officer
Pittsburgh Regional Health Initiative

The Ninth National Pay for Performance Summit

March 24, 2014

What and Why: Pittsburgh Regional Health Initiative



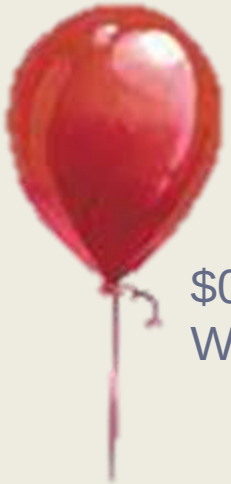
- Pittsburgh Regional Health Initiative (PRHI)
  - A not-for-profit, regional, multi-stakeholder collaborative formed in 1997 by Karen Feinstein and Paul O'Neill
  - An initiative of a business group, the Allegheny Conference on Community Development

PRHI'S MESSAGE

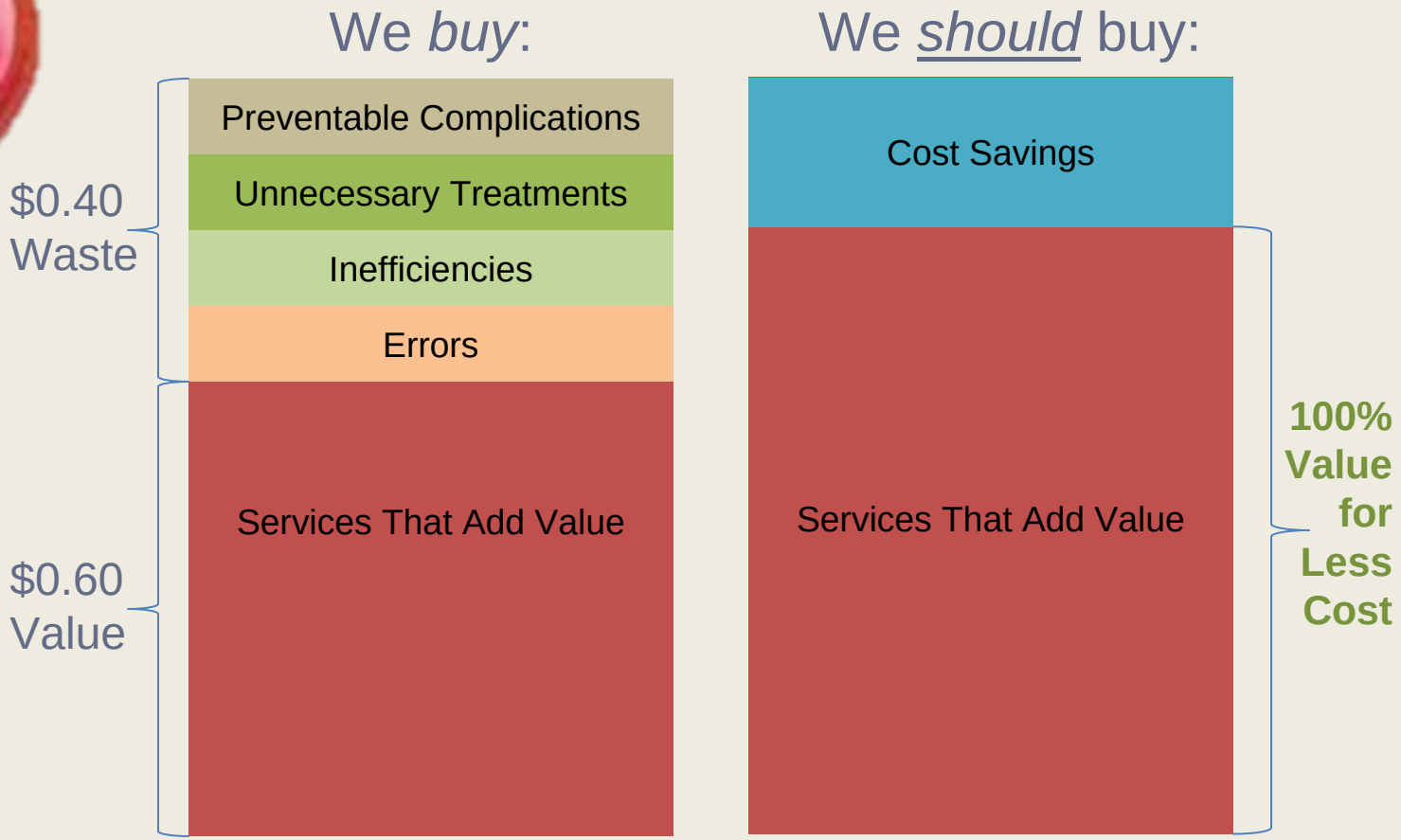
Dramatic quality improvement (approaching zero deficiencies) is the best cost-containment strategy for health care

Popping the Red Balloon

Value Reform From Now to Future



For every $1:



42 Staff, Includes Significant Clinical Depth

- MDs
- Nursing (RNs, MSNs, FNP-BCs)
- Social Work (MSWs, LSWs)
- Occupational Therapy (MOTs, OTR/LS)
- Pathology (SCT (ASCP))

Plus Staff Expertise in Additional Areas of Health Care, Project Management, and Administration

- Research and Epidemiology (PhDs)
- Health Policy, Public Health, Economics (MPHs, MPMs, PhDs)
- Health Information Technology
- Quality Improvement
- Administration (MBAs, JDs, CPAs, MSs)
- Finance, including Fiscal Agency
- Project Management
- Communications and Event Planning
- Grantmaking, Grant Seeking, Grants Management

In the Beginning (circa 1997): Evocative Data Drive the Initial Journey

- *Lucian Leape's "Error in Medicine"*
  - Avoidable in-hospital deaths equivalent to three jumbo jet crashes every two days
  - 180,000 in-hospital deaths partly as a result of iatrogenic injury

We Went Sleuthing:
Health Care is Not Wired for High Value

W. Edwards Deming, PhD: *"Where Art Thou?"*

- *Chaos*
- *Uncertainty*
- *Random Behaviors*
- *Work-Arounds*
- *Confusion*
- *Disorder*
- *Errors*
- *High Turnover*
- *Secrecy*

High-Value Organizations Adopt Toyota/Lean Production Thinking

- Problems identified and solved immediately
- Rapid root cause analysis
- Organized work areas
- Concise communication
- Active involvement of managers
  - "Go and see"
  - On the floor
- Intense respect for the employee
  - Every employee has what they need, when they need it, to succeed
  - Career development
- Team problem solving to meet customer need

We brought Lean QI to Health Care

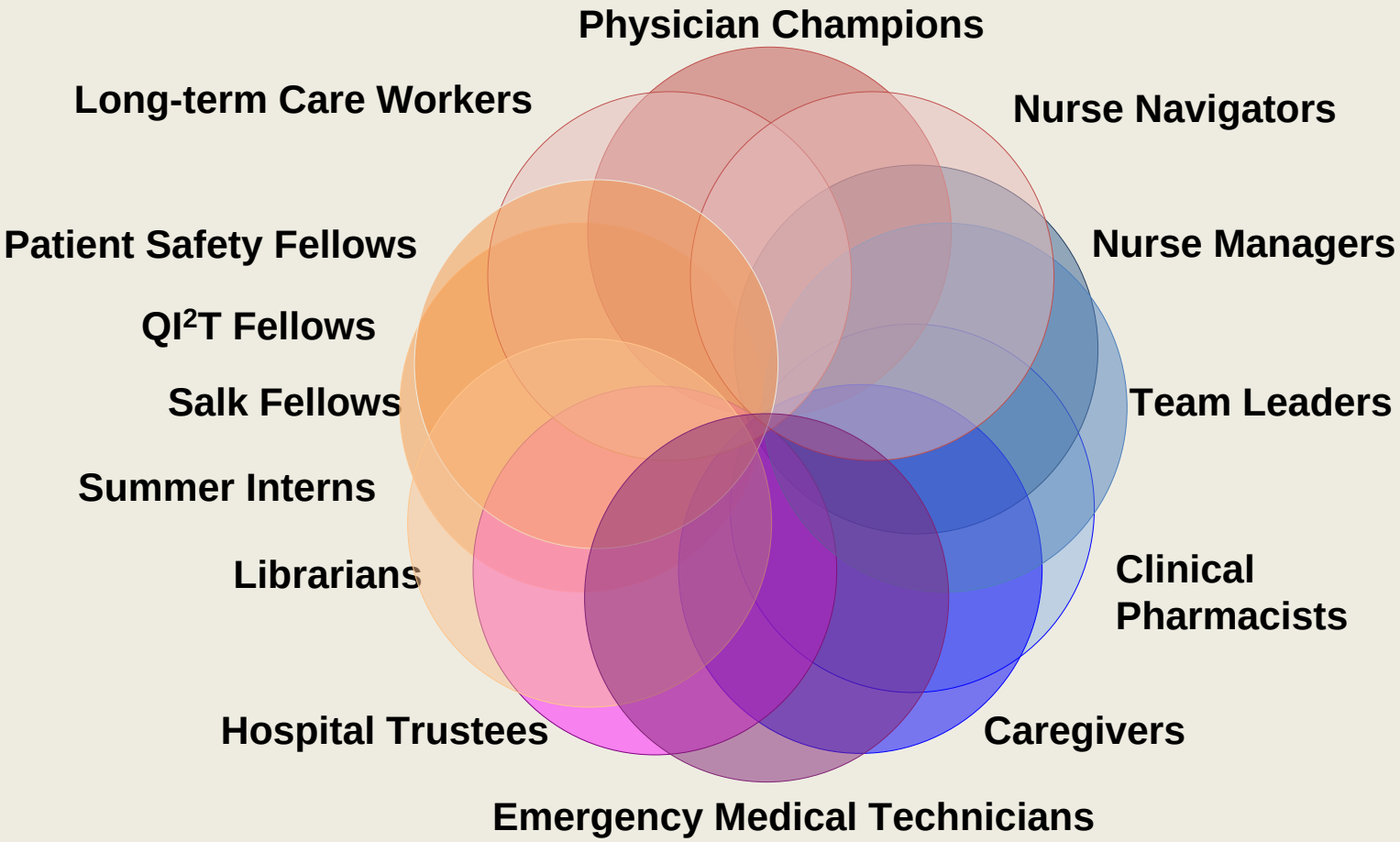
1. JHF, PRHI and HCF are in the Training and Education Business

- Salk and Patient Safety Fellowships
- Perfecting Patient Care℠ Universities (open and project-specific)
- Champions Programs
- *Closure* sessions
- Board and Committee meetings
- REACH extension services
- HIV/AIDS Quality Improvement
- Grant Related: AHRQ/PIC; CMMI (1) and (2) and SNMHI
- Tomorrow's HealthCare™
- Motivational Interviewing
- I-Wise
- Caregiver Training
- Summer Interns
- QI²T Health Innovators Fellowships

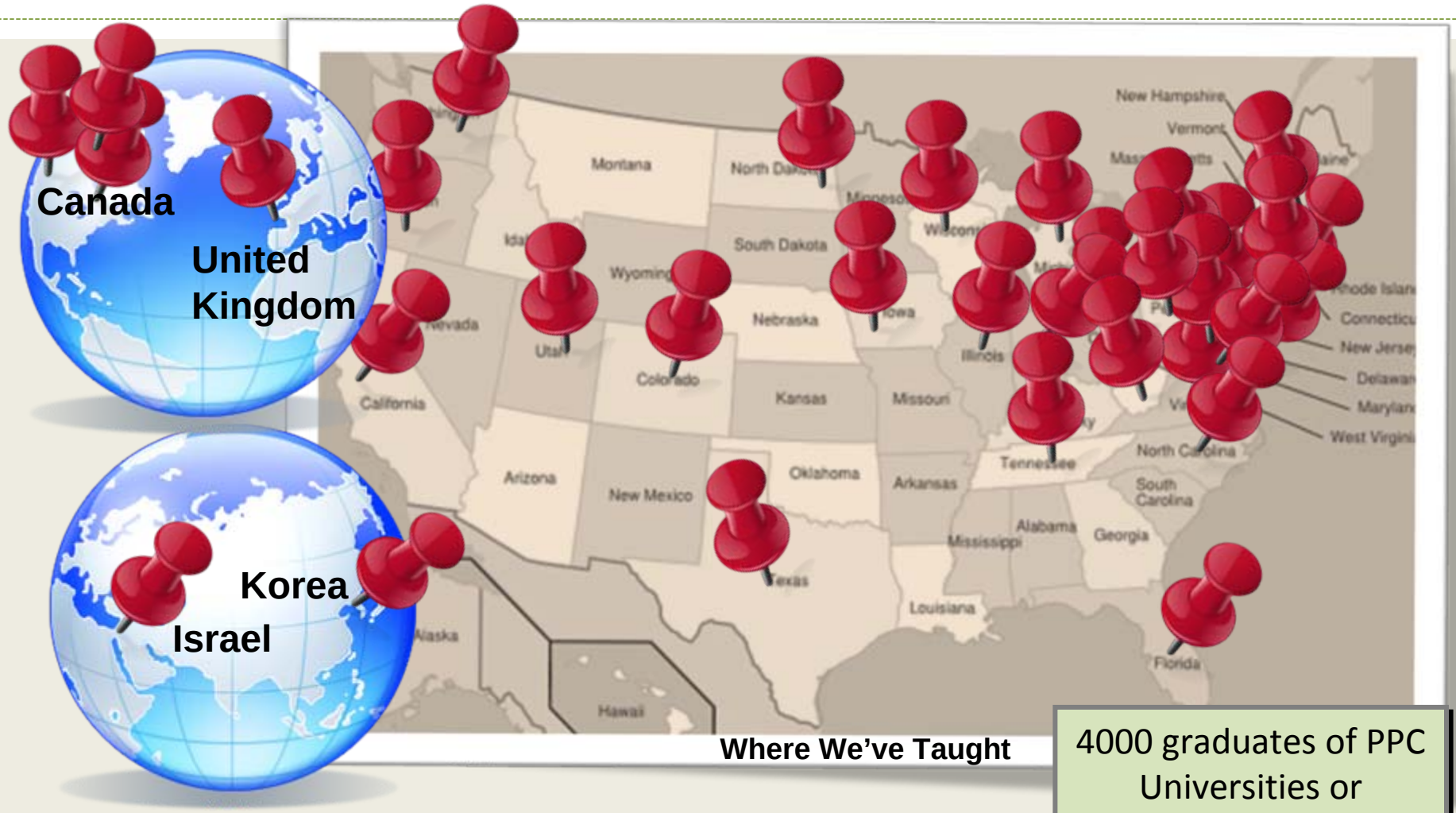
2.

We Created Change Agents

Lean empowers frontline staff…and more



PRHI's Footprint



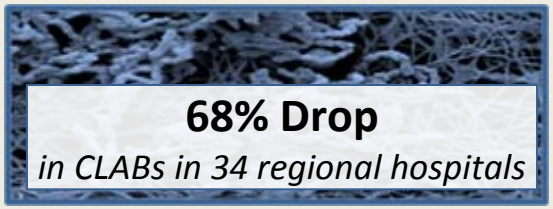
4000 graduates of PPC Universities or customized programs.

3.

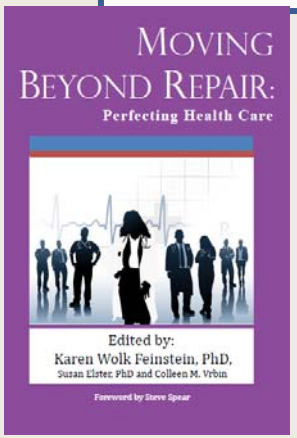
Early PRHI Successes Demonstrated the Value of Lean

86% Reduction
in medication errors

35 to Zero!
defective charts



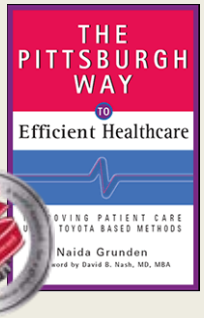
68% Drop
in CLABs in 34 regional hospitals



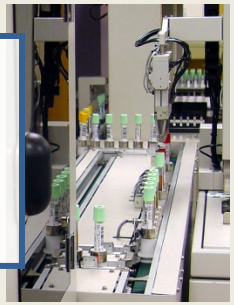
50% Reduction
in pap smear sampling defects

50% Fewer Readmissions
w/ COPD focus

17% Drop
in pediatric clinic wait times



Efficiency Increased 100%
in pathology lab



180 to Zero!
Lost patient hours per month due to ambulance diversions

100% Reduction
in nurse turnover

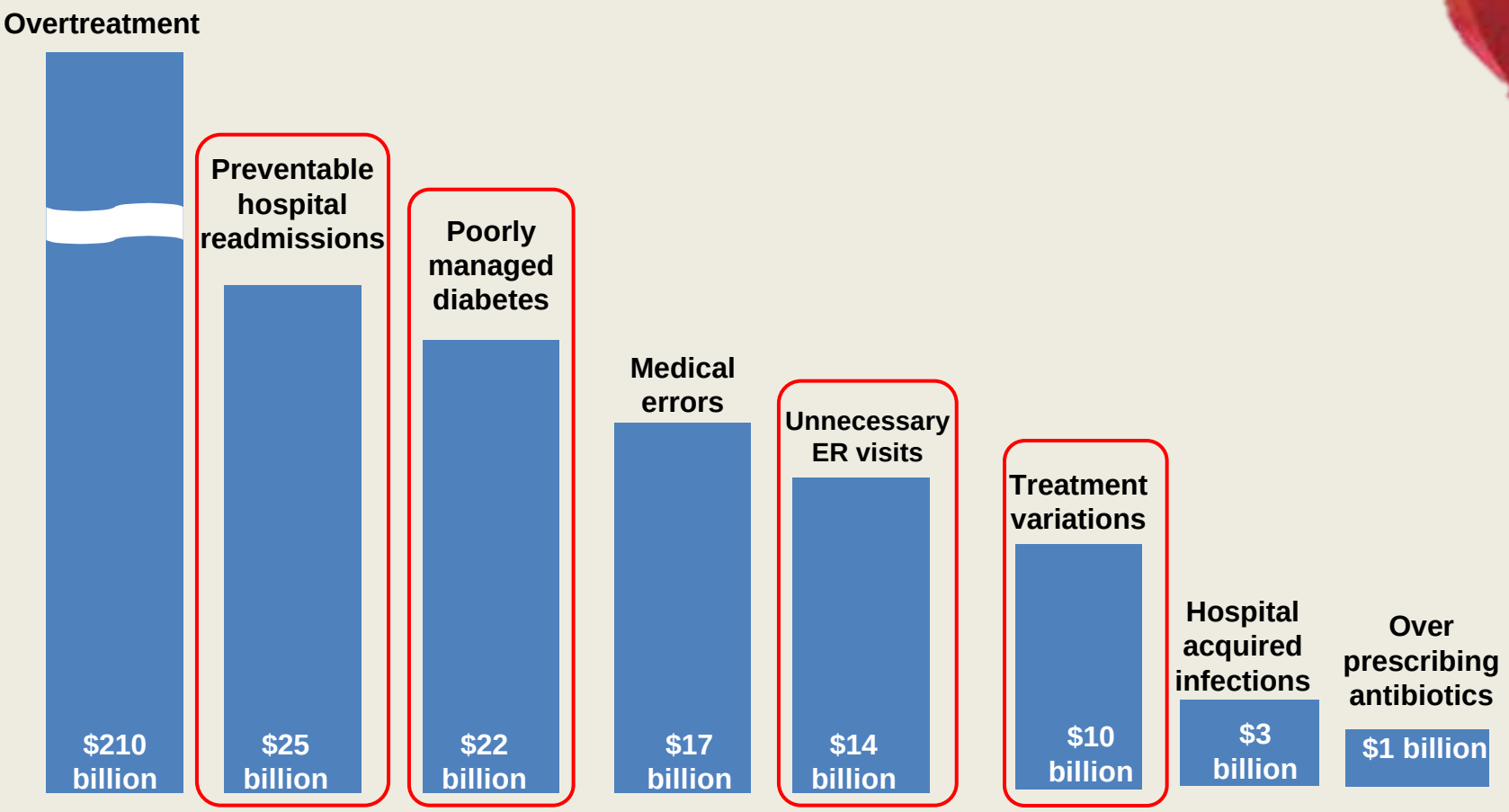
>20% Decline
Nosocomial
C. difficile
infections

100% Compliance
w/guidelines & aspirin use in a diabetes clinic

4. We Attempted Transforming Healthcare Organizations: *Hit all the notes on the xylophone or no music*

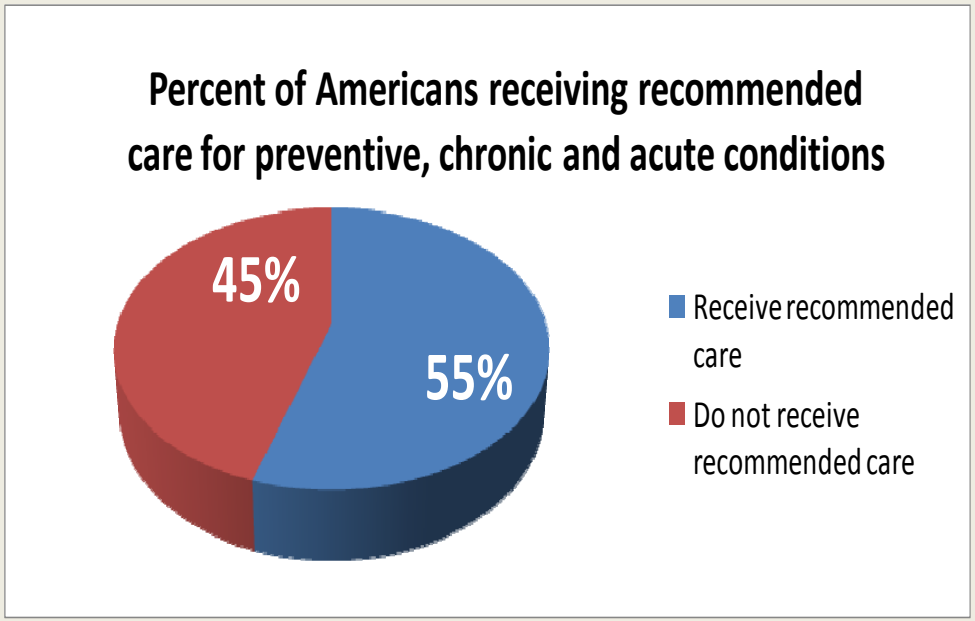
5.

We Focused on Where the Costs of Waste Lie



Source: Institute of Medicine (1999), "The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCoopers (2006), Medpac (2007), American Association of Endocrinologists (2006), Center for Disease Control and Prevention (2005), Solucient (2007), U.S. Outcomes Research Group of Pfizer Inc (2005), National Committee for Quality Assurance (2005), Analysis by PricewaterhouseCoopers' Health Research Institute. 2010

Grim Statistics



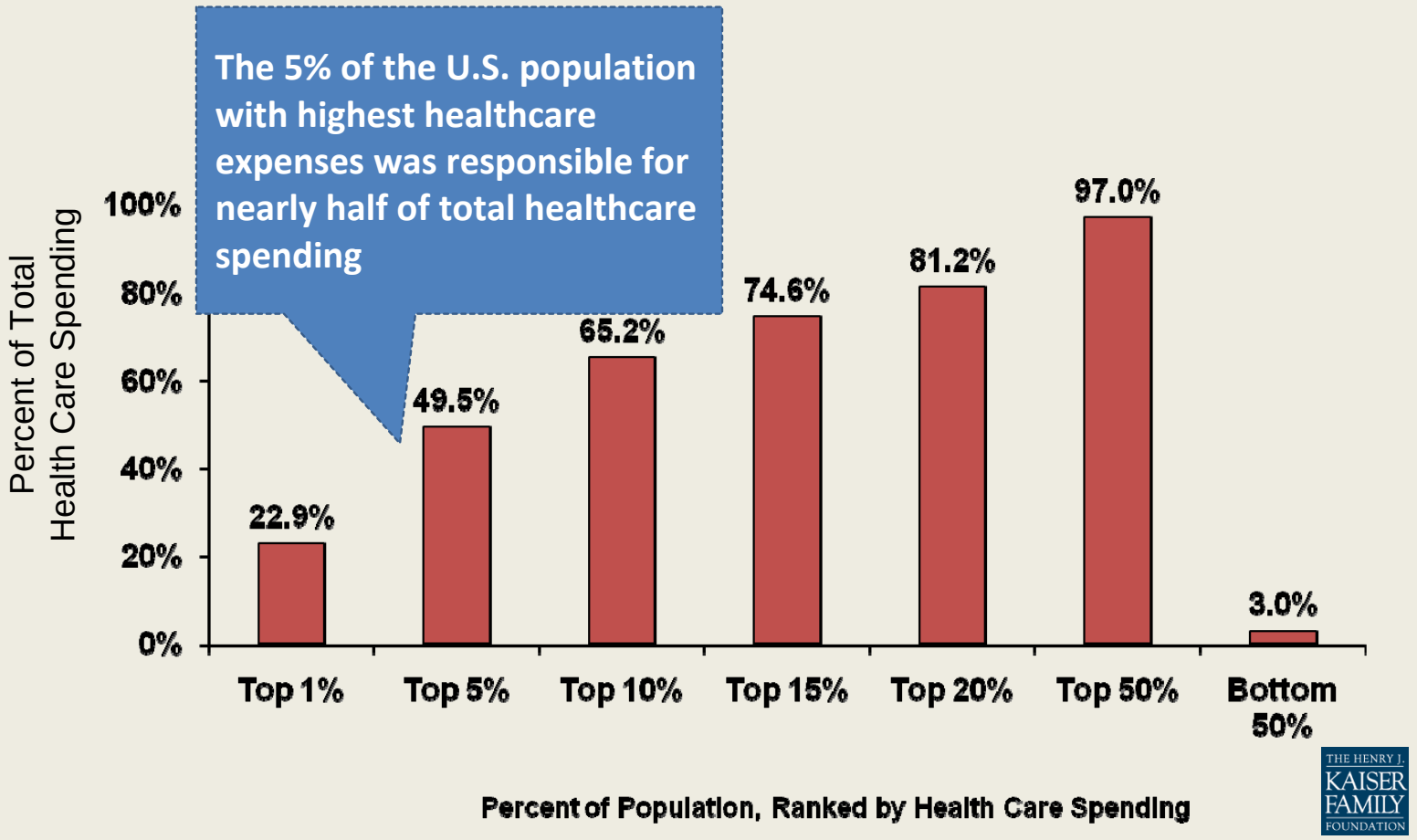
Just over 50% of Americans receive recommended care. Why?

What gets in the way of recommended care being provided 100% of the time?

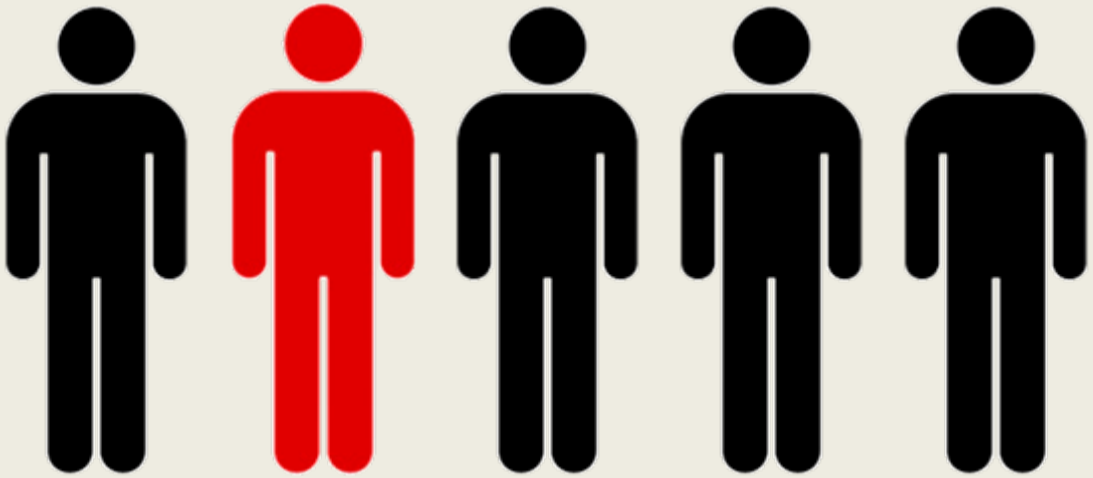
Source: Elizabeth A. McGlynn and Robert H. Brook, Rand, June 2003

Focus on Spending Leads to Complex Patients

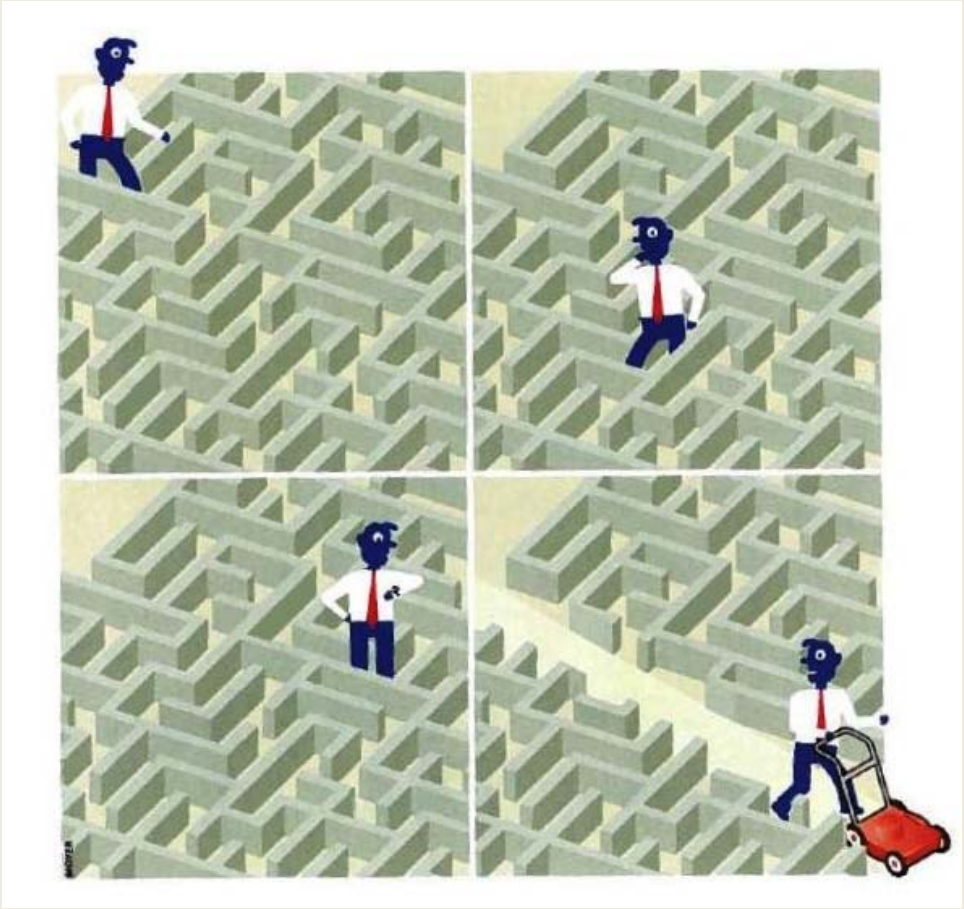
Concentration of Healthcare Spending in the U.S. Population, 2007



PRHI found that approximately **1 in 5** patients discharged from the hospital ***return*** within 30 days



Reboot.
Many problems resist until we reframe them.

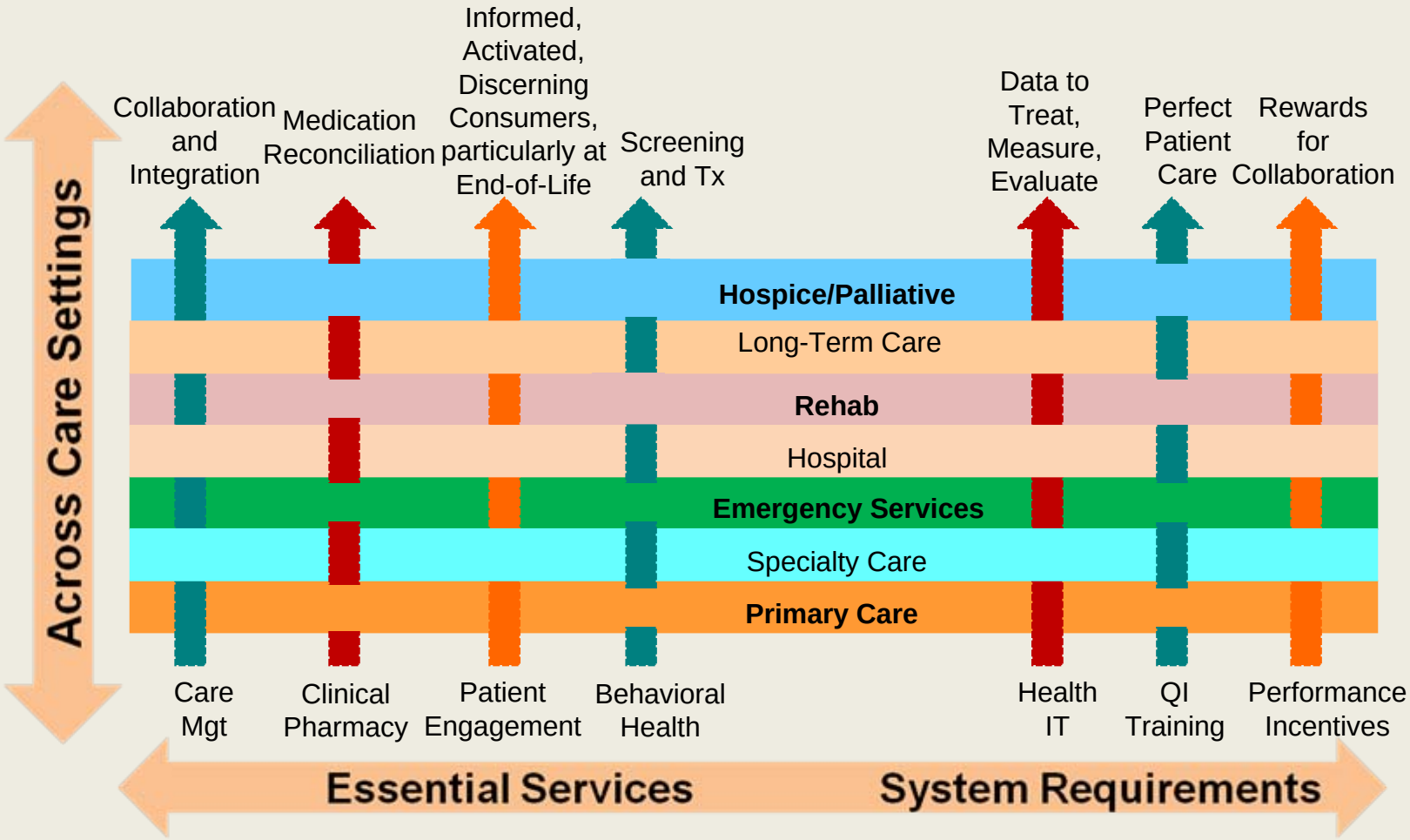


Source: HBR – Don Moyer

From Data to Demonstrations:

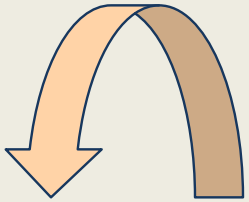
Turning our community into a lab for testing new models of care for keeping people out of hospitals

6. We Adopted The Systems Vision: Transforming the Care of Complex Patients

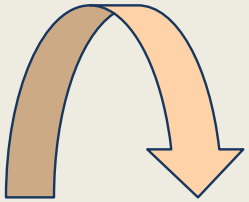


Why So Many Readmissions?

What is essential to our vision for reducing admissions?



***Isn't* reimbursed**



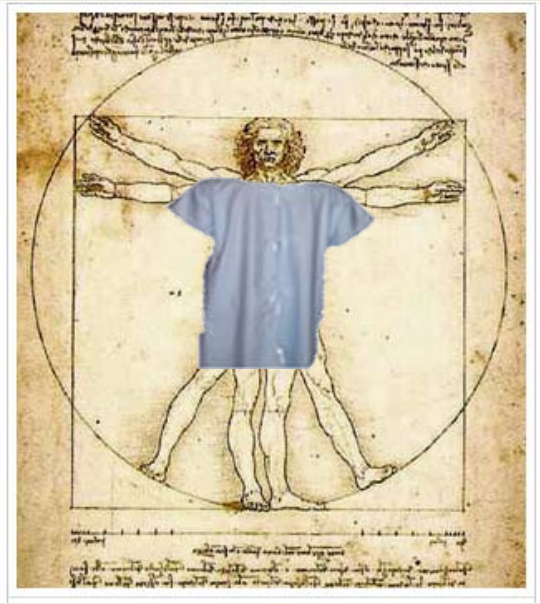
Care Management • **Clinical Pharmacy** • **Patient Engagement** • **Behavioral Health** • **HIT** • **QI Training**

No Money — No Service

7. 2014 Programs: We Keep People Out of Hospitals

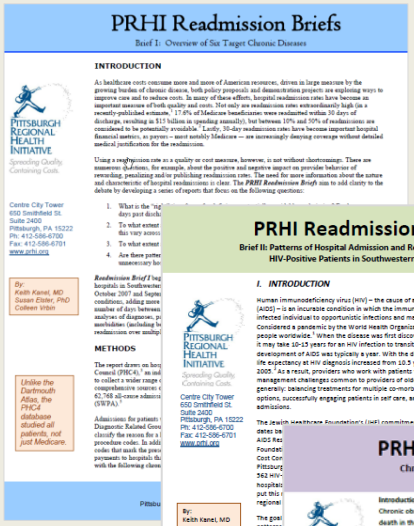
The Complex Patient

Who is frequently hospitalized?

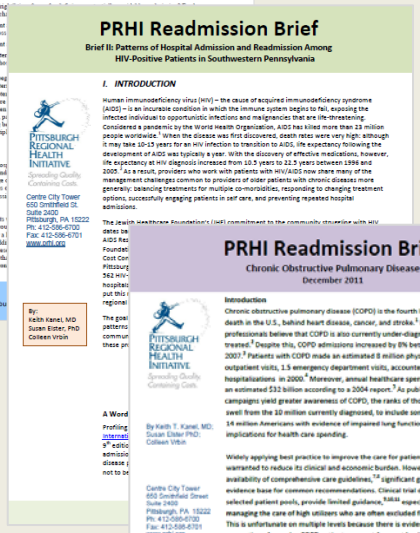


Do you know your customer?

We Did Our Own Sleuthing with PHC4 Data



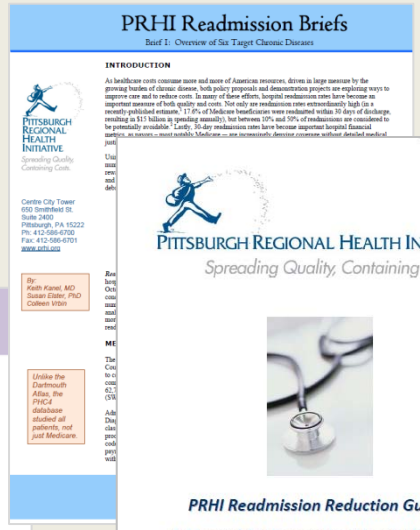
Behavioral Health and Substance Abuse



HIV/AIDS

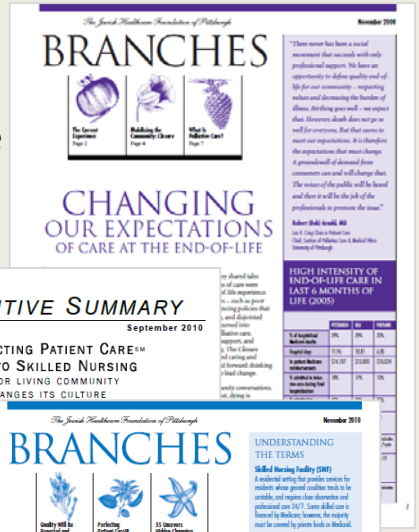
COPD

The Complex Patient



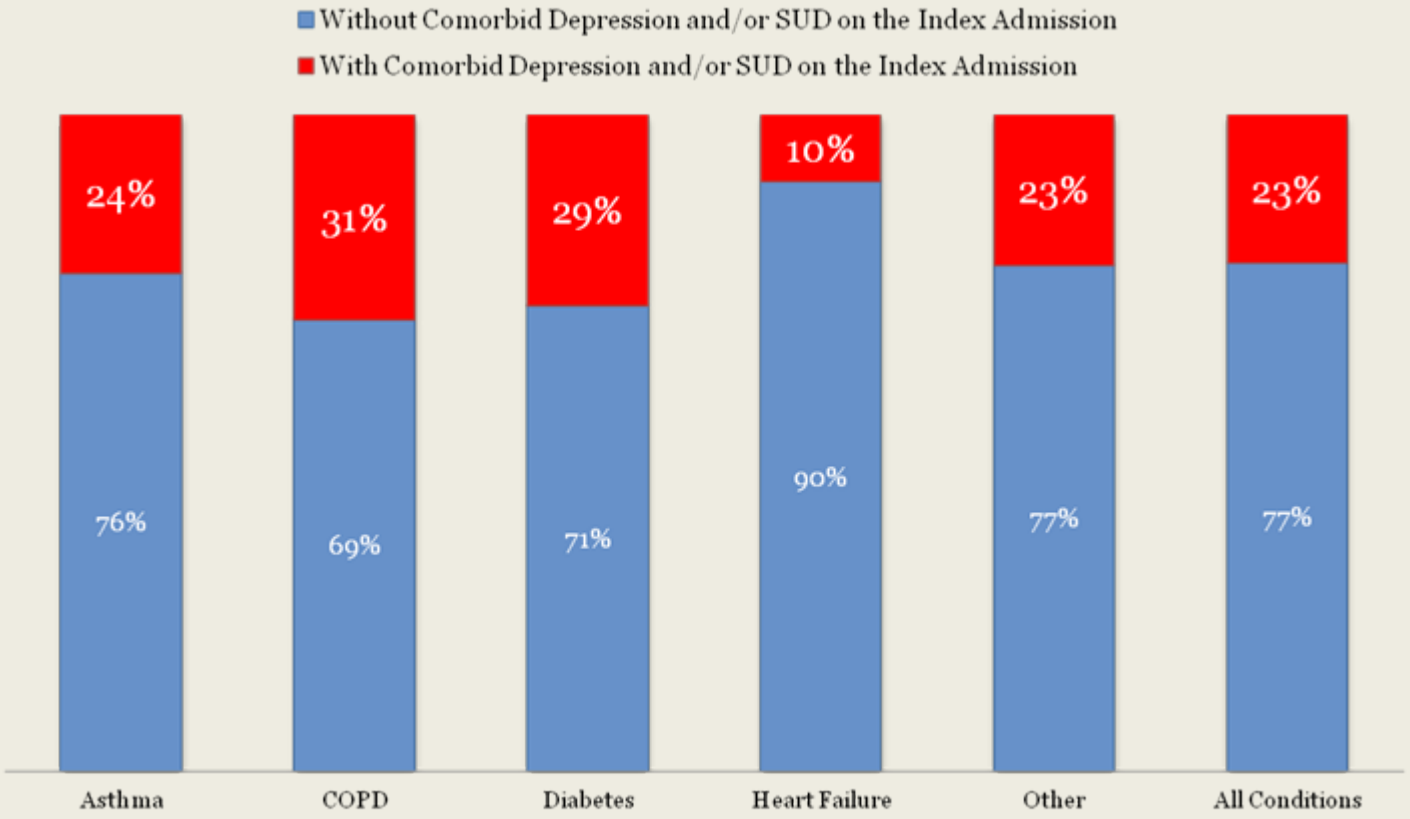
Chronic Disease

End of Life



Skilled Nursing

High Rates of Comorbid Depression and Substance Use Disorders Among 30-Day Readmissions



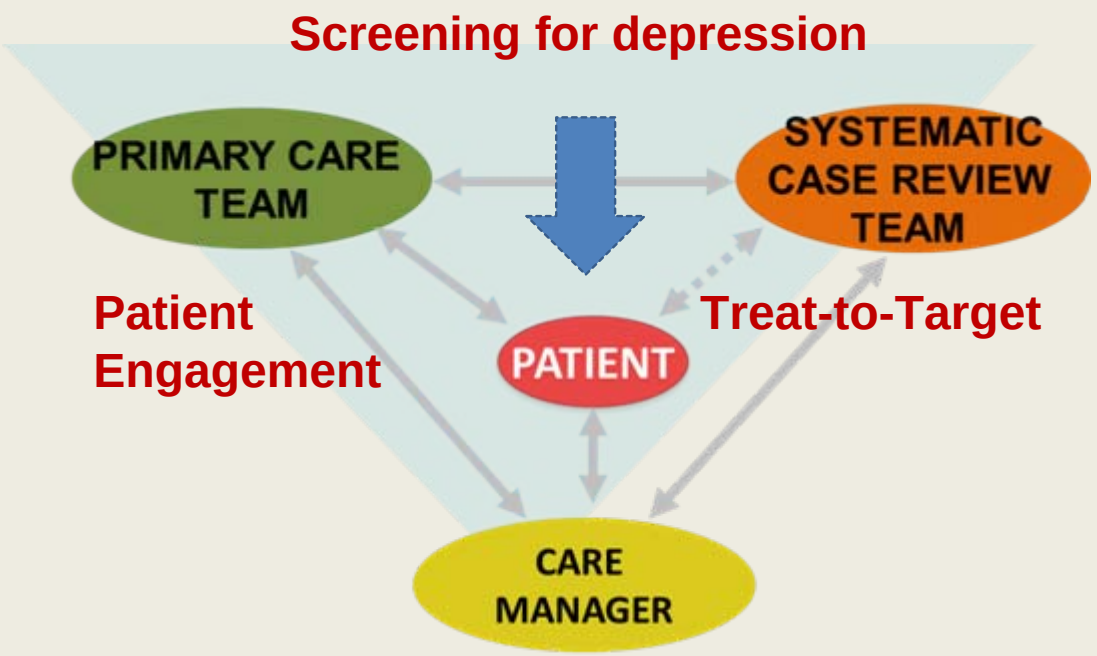
Partners in Integrated Care

- $3.5 million AHRQ grant to integrate depression and unhealthy substance use screening into primary care
  - **4** regional health improvement collaboratives

  - **50** primary care sites; **11** in western PA

COMPASS (Care of Mental, Physical and Substance Use Syndromes)

- $18 million CMMI cooperative agreement led by ICSI



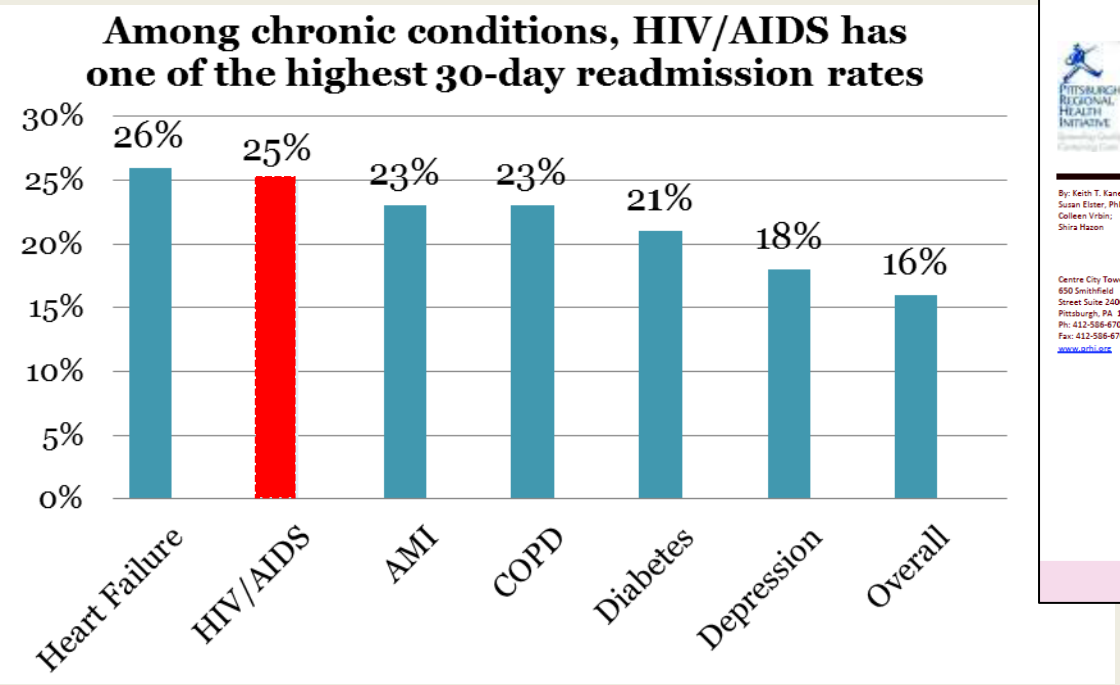
Consortium:

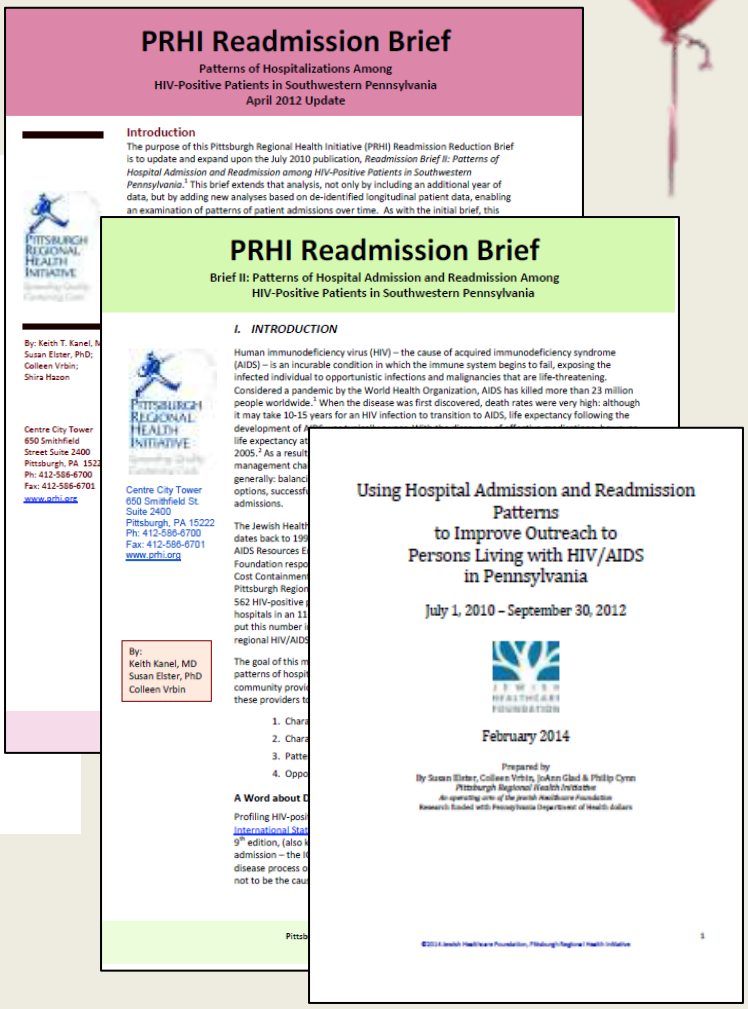
- Community Health Plan of Washington
- Kaiser Permanente Colorado
- Kaiser Permanente Southern California
- Mayo Clinic Health System
- Michigan Center for Clinical Systems Improvement

Mount Auburn Cambridge Independent Practice Association

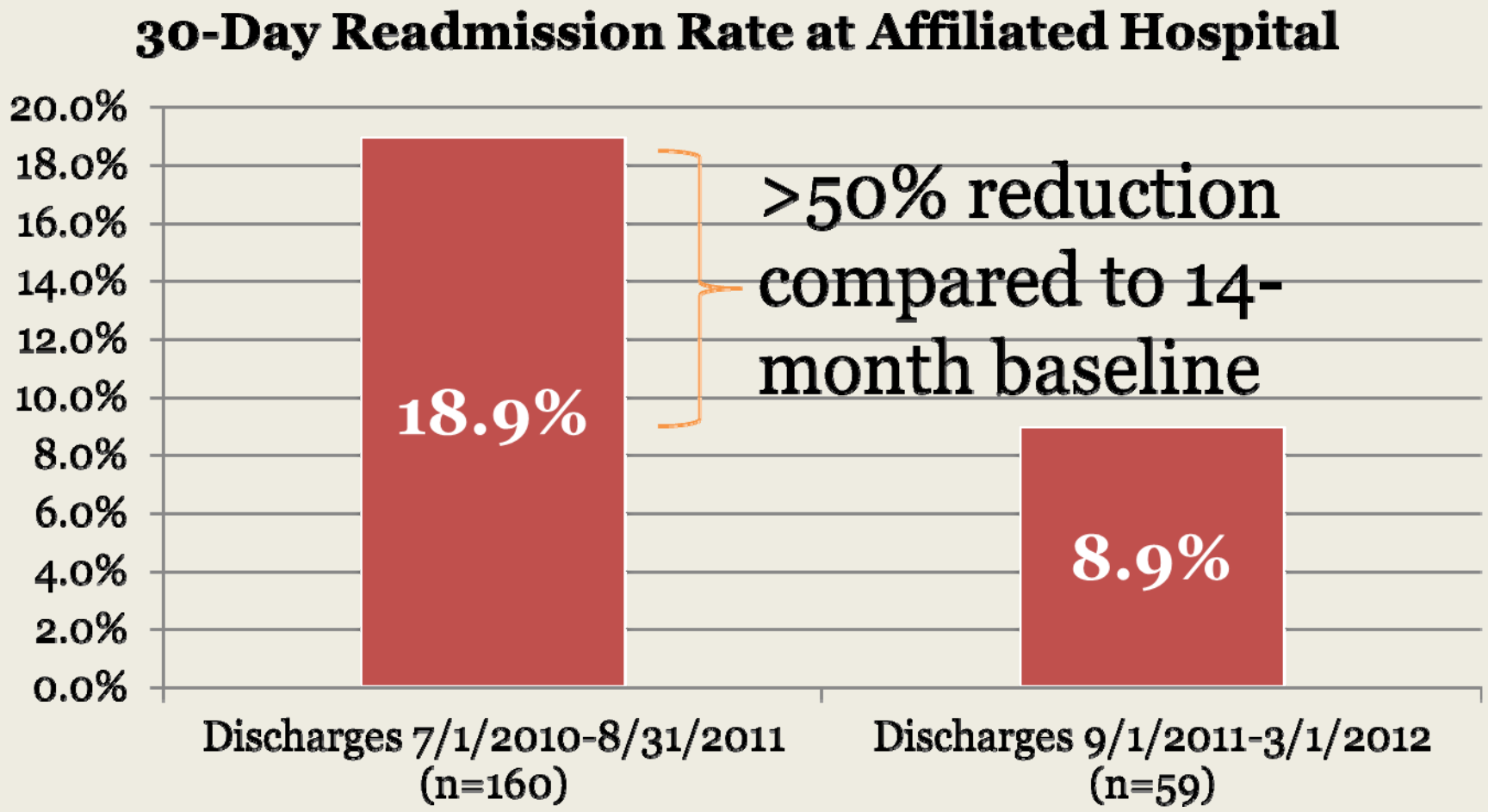
- **Pittsburgh Regional Health Initiative**
- AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington
- HealthPartners Institute for Education and Research

PRHI Data: High Hospital Readmissions Rates Among HIV-Positive Population





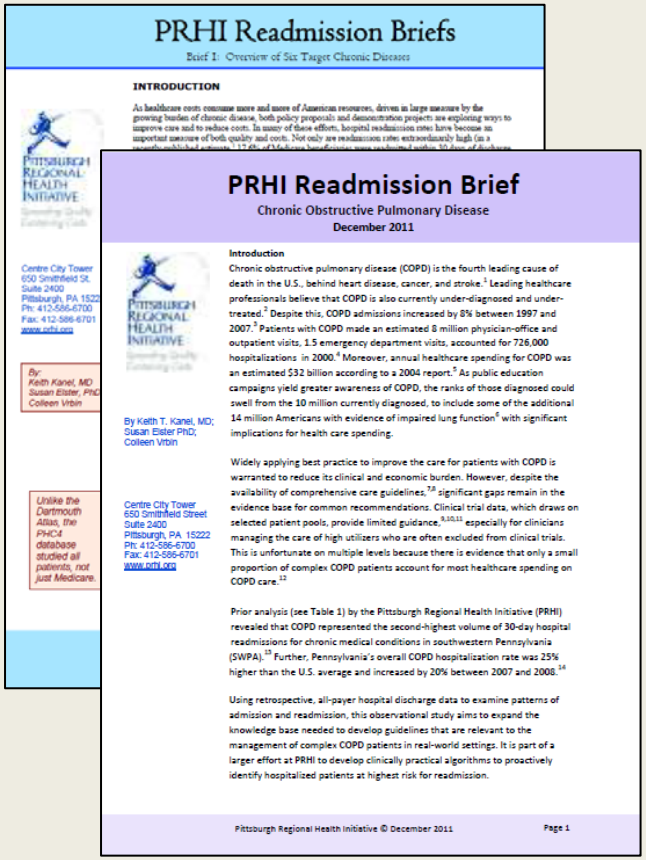
Readmission Reduction Project



Minority AIDS Initiative

- $1.4+ million, two-year grant from the Special Pharmaceutical Benefits Program (SPBP) and Pennsylvania Department of Health
- Effort to locate and re-engage in treatment HIV-positive patients lost to care
- 20 AIDS Service Organizations (ASOs) across Pennsylvania

Complex Patients: Overlap Between High Volume Chronic Diseases



PRHI Readmission Briefs

Brief 1: Overview of Six Target Chronic Diseases

INTRODUCTION

As healthcare costs consume more and more of American resources, driven in large measure by the growing burden of chronic disease, both policy proposals and demonstration projects are exploring ways to improve care and to reduce costs. In many of these efforts, hospital readmission rates have become an important measure of both quality and costs. Not only are readmission rates extraordinarily high (in a

PRHI Readmission Brief

Chronic Obstructive Pulmonary Disease

December 2011

Introduction

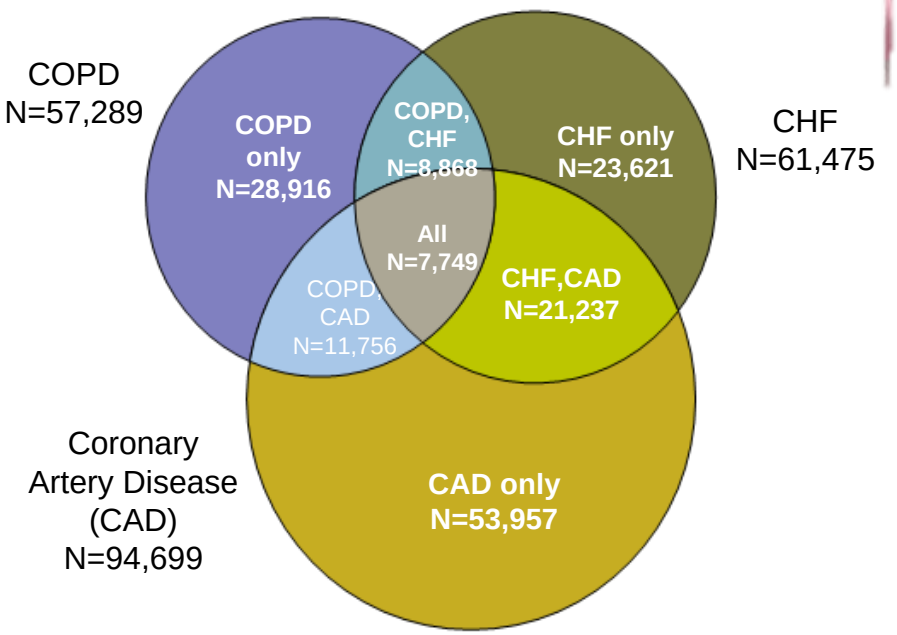
Chronic obstructive pulmonary disease (COPD) is the fourth leading cause of death in the U.S., behind heart disease, cancer, and stroke.[1] Leading healthcare professionals believe that COPD is also currently under-diagnosed and under-treated.[2] Despite this, COPD admissions increased by 8% between 1997 and 2007.[3] Patients with COPD made an estimated 8 million physician-office and outpatient visits, 1.5 emergency department visits, accounted for 726,000 hospitalizations in 2000.[4] Moreover, annual healthcare spending for COPD was an estimated $32 billion according to a 2004 report.[5] As public education campaigns yield greater awareness of COPD, the ranks of those diagnosed could swell from the 10 million currently diagnosed, to include some of the additional 14 million Americans with evidence of impaired lung function[6] with significant implications for health care spending.

Widely applying best practice to improve the care for patients with COPD is warranted to reduce its clinical and economic burden. However, despite the availability of comprehensive care guidelines,[7,8] significant gaps remain in the evidence base for common recommendations. Clinical trial data, which draws on selected patient pools, provide limited guidance,[9,10,11] especially for clinicians managing the care of high utilizers who are often excluded from clinical trials. This is unfortunate on multiple levels because there is evidence that only a small proportion of complex COPD patients account for most healthcare spending on COPD care.[12]

Prior analysis (see Table 1) by the Pittsburgh Regional Health Initiative (PRHI) revealed that COPD represented the second-highest volume of 30-day hospital readmissions for chronic medical conditions in southwestern Pennsylvania (SWPA).[13] Further, Pennsylvania's overall COPD hospitalization rate was 25% higher than the U.S. average and increased by 20% between 2007 and 2008.[14]

Using retrospective, all-payer hospital discharge data to examine patterns of admission and readmission, this observational study aims to expand the knowledge base needed to develop guidelines that are relevant to the management of complex COPD patients in real-world settings. It is part of a larger effort at PRHI to develop clinically practical algorithms to proactively identify hospitalized patients at highest risk for readmission.

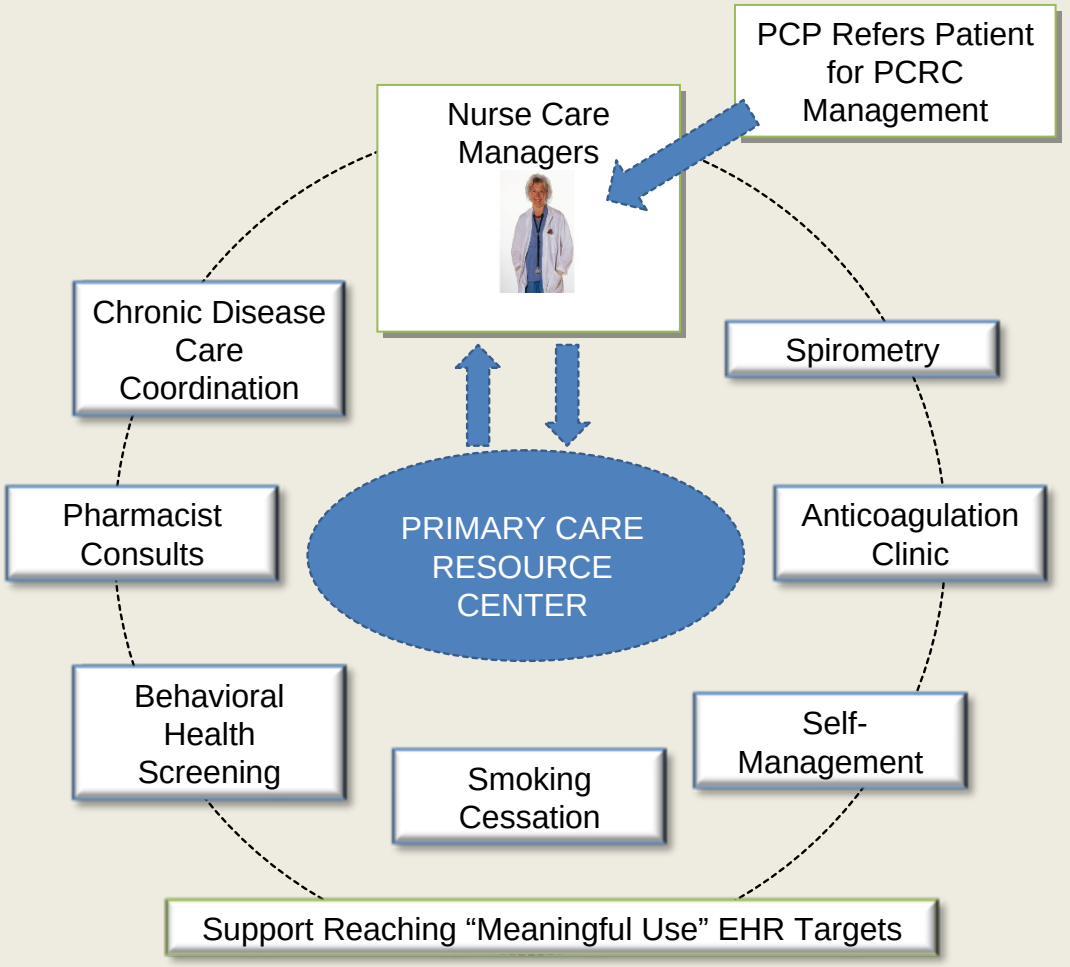
Pittsburgh Regional Health Initiative © December 2011 Page 1



- **50% of COPD** discharges have co-morbid CHF and/or CAD.
- **62% of CHF** discharges have co-morbid COPD and/or CAD.
- **43% of CAD** discharges have co-morbid CHF and/or COPD.

8. We Created New Models of Care:
Hospital-based Primary Care Resource Center

- Supports team-based care coordination of chronic medical conditions
- Provides added-value primary care support services beyond the means of small practices
- Can utilize excess hospital space



Primary Care Resource Centers

- Focus on care coordination and ancillary services for three target chronic diseases to reduce avoidable readmissions

- $10.4 million CMMI grant
- Seven regional hospitals

Revolving Door in Long-Term Care

- One in four Medicare patients is readmitted to the hospital from a skilled nursing facility within 30 days
- 45% of hospitalizations among Medicare and Medicaid enrollees receiving care at either Medicare skilled nursing facilities or Medicare nursing facilities are avoidable

Long-Term Care

- RAVEN
  - Four-year, $19 million grant from the CMMI to reduce hospitalizations among **19** nursing facility residents in western Pennsylvania
  - JHF lead education provider
- Long-Term Care Champions
  - Focus on readmission reduction
  - Working with **5** independent skilled nursing

Responding to the new world:

VBP, data liberation & IT solutions

9. We Developed an E-Learning Knowledge Network

Tomorrow's HealthCare™

- Online knowledge and e-learning network
- C-Suite Dashboard – track real-time progress toward quality targets
- Share quality improvement initiatives
- Track institutional learning, staff member by staff member

Regional Extension Center (REC)

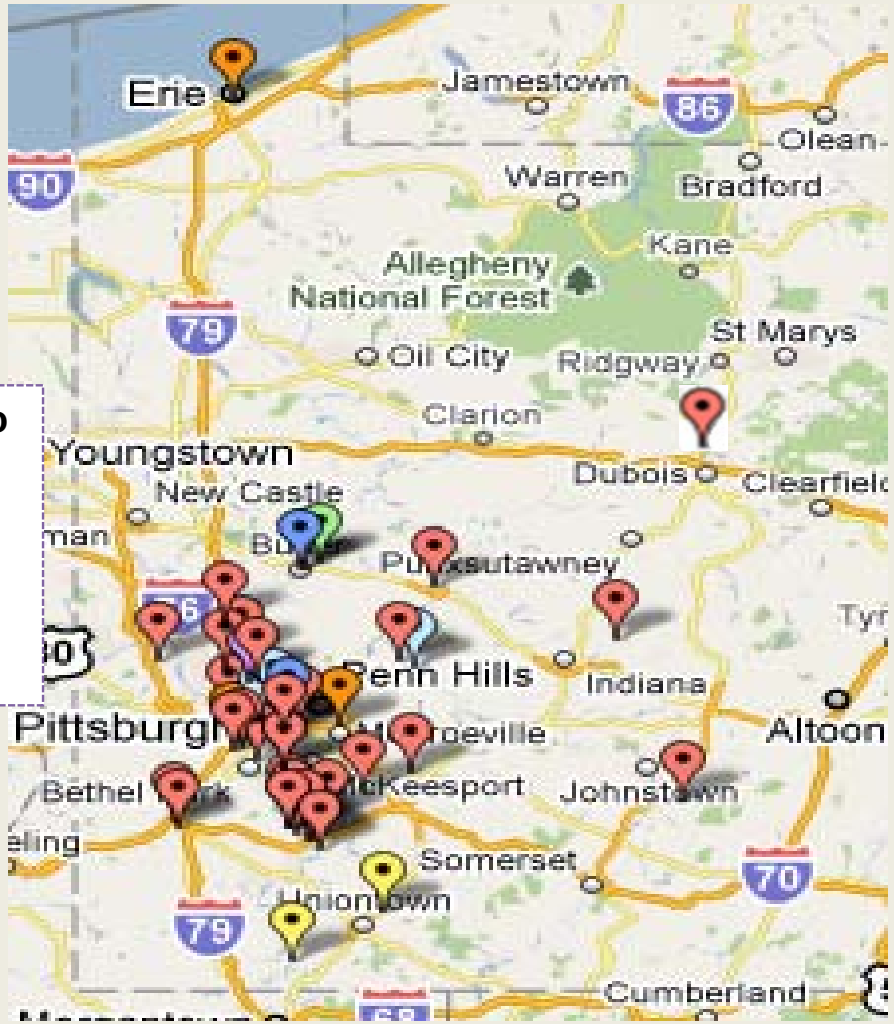
Pennsylvania REACH West Regional Extension & Assistance Center for HIT

Assist primary care providers to install and meaningfully use Electronic Health Records:

865 PCPs in 305 sites

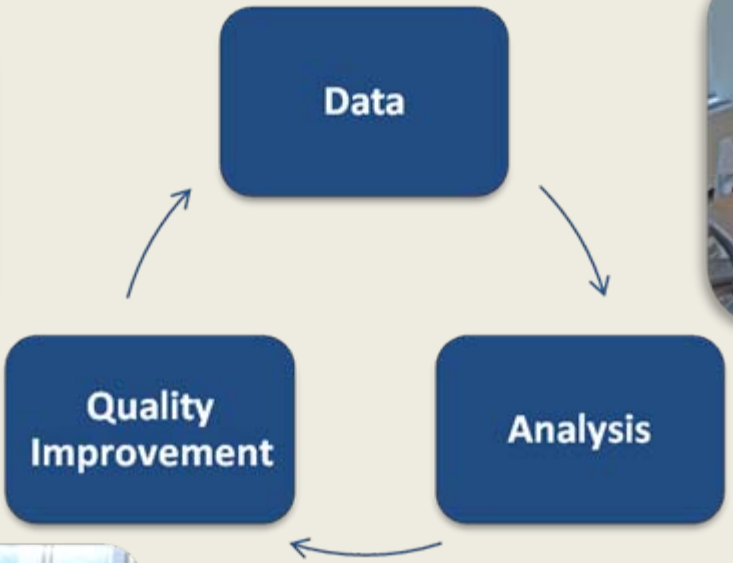
97% now using EHRs

85% at Meaningful Use



10. We Envisioned The Future: Where **Q**uality **I**mprovement Meets **I**nformation **T**echnology (QI²T)

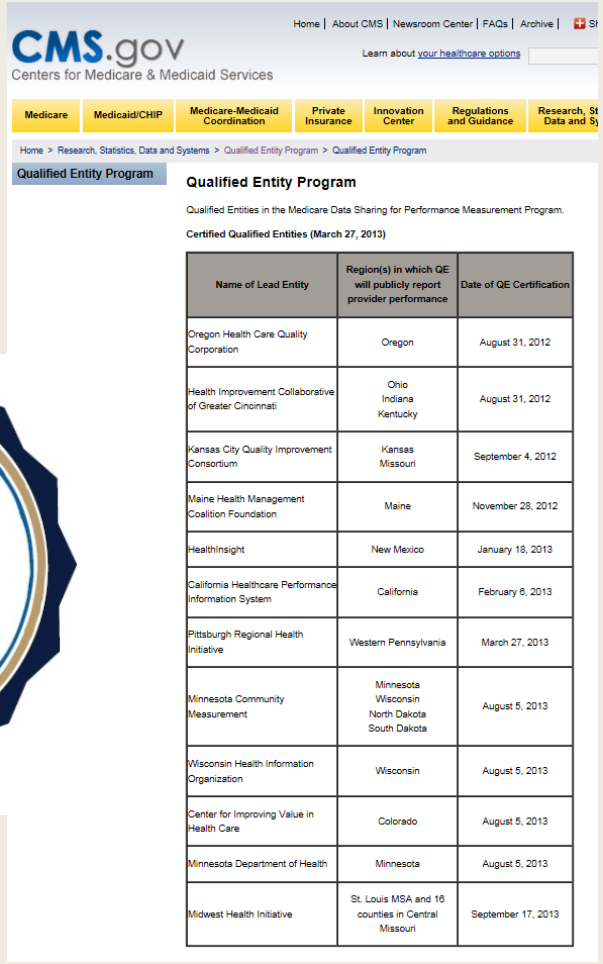
- State-of-the art center will train workers and patients to use health data to drive quality improvement



WHERE QUALITY IMPROVEMENT MEETS INFORMATION TECHNOLOGY

CMS Qualified Entity

- PRHI named one of twelve Qualified Entities (QE) for Medicare claims data



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Home > Research, Statistics, Data and Systems > Qualified Entity Program > Qualified Entity Program

Qualified Entity Program

Qualified Entity Program

Qualified Entities in the Medicare Data Sharing for Performance Measurement Program.

Certified Qualified Entities (March 27, 2013)

Name of Lead Entity	Region(s) in which QE will publicly report provider performance	Date of QE Certification
Oregon Health Care Quality Corporation	Oregon	August 31, 2012
Health Improvement Collaborative of Greater Cincinnati	Ohio Indiana Kentucky	August 31, 2012
Kansas City Quality Improvement Consortium	Kansas Missouri	September 4, 2012
Maine Health Management Coalition Foundation	Maine	November 28, 2012
HealthInsight	New Mexico	January 18, 2013
California Healthcare Performance Information System	California	February 6, 2013
Pittsburgh Regional Health Initiative	Western Pennsylvania	March 27, 2013
Minnesota Community Measurement	Minnesota Wisconsin North Dakota South Dakota	August 5, 2013
Wisconsin Health Information Organization	Wisconsin	August 5, 2013
Center for Improving Value in Health Care	Colorado	August 5, 2013
Minnesota Department of Health	Minnesota	August 5, 2013
Midwest Health Initiative	St. Louis MSA and 16 counties in Central Missouri	September 17, 2013

Pennsylvania Center for Health Information Activation

- Useful, credible information to consumers that is understandable and actionable.
- Changing the asymmetry of information and sharing power.

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