Person-Centered Care COPD Summary of Presentation March 27, 2019

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Pulmonary/Critical Care & Sleep Center

EISENHOWER HEALTH

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A not-for-profit hospital based in Rancho Mirage, California serving the Coachella Valley region of Southeastern California.

A general acute care hospital with 463 beds.

A Magnet Status Hospital

An accredited teaching hospital with a **School of Graduate Medical Education** training of new physicians in family medicine and internal medicine.

MISSION STATEMENT:
Eisenhower Health exists to service the changing healthcare needs of our region by providing excellence in patient care with supportive education and research.

Initial Aim Statement and How It Changed

- What was the focus and why
  - Enhancing the Quality of Life of COPD Severe and Very Severe Groups
    - Intervening provided control of the respiratory disease process
    - Collaborative initiative of provider groups: Acute Care Providers, Post-Acute Care Providers and Community-based Partners
      - Work together to address the person/family goals & their social determinants of health
      - Work together to provide access to healthcare & community support of the person's chronic disease management

About Our Team Members and Structure

- Which team members in our organization were key to this work
  - Shahriyar Tavakoli, MD, FCCP – Medical Director Pulmonary/Critical Care & Sleep Medicine
  - Amil Perumbeti, MD - Pulmonary Section Chief (Physician Champion)
  - Mohammed Al Janabi, MD – Pulmonology Specialist
  - Mohammad Mojarad, MD, FACP, FCCP
  - Rigoberto Lopez, MBA, RN - Chief Administrative Officer Ambulatory Services
  - Christine Johnstone, MHA, MSN, RN, PHN – VP of Quality & Process Improvement (Chairperson)
  - Janet Mirabella, *MS, BSN, RN, CPHQ*, – Director, Quality Improvement & Patient Safety Officer
  - Sedrick Bedolla, MBA, RRT, RCP – Director of Respiratory/Pulmonology Care/Neurology
  - Sue Frederick B.A., RCP, RRT – Respiratory Case Manager
  - Sandra Magana BS, RCP, RRT, ACCS – Respiratory Case Manager
  - Debra Fuller RN – Coordinator, EH Pulmonary Rehabilitation
  - Donna MacKenzie RN – EPIC Systems Analyst (Outpatient)
  - Megan Moe – EPIC Systems Analyst (Inpatient)
  - Elizabeth Smith RN, MS – Pulmonary Clinic Nurse Navigator

About Our Team Members and Structure
(cont'd)

- Which existing hospital committees helped design and direct our efforts
  - Utilization Management Team
  - Pulmonary Section Team
  - Person-Centered Care Team
  - Person-Centered Strategic Planning Team
  - COPD Task Team
  - Business Plan ROI Team
  - MACRA/MIPS Team

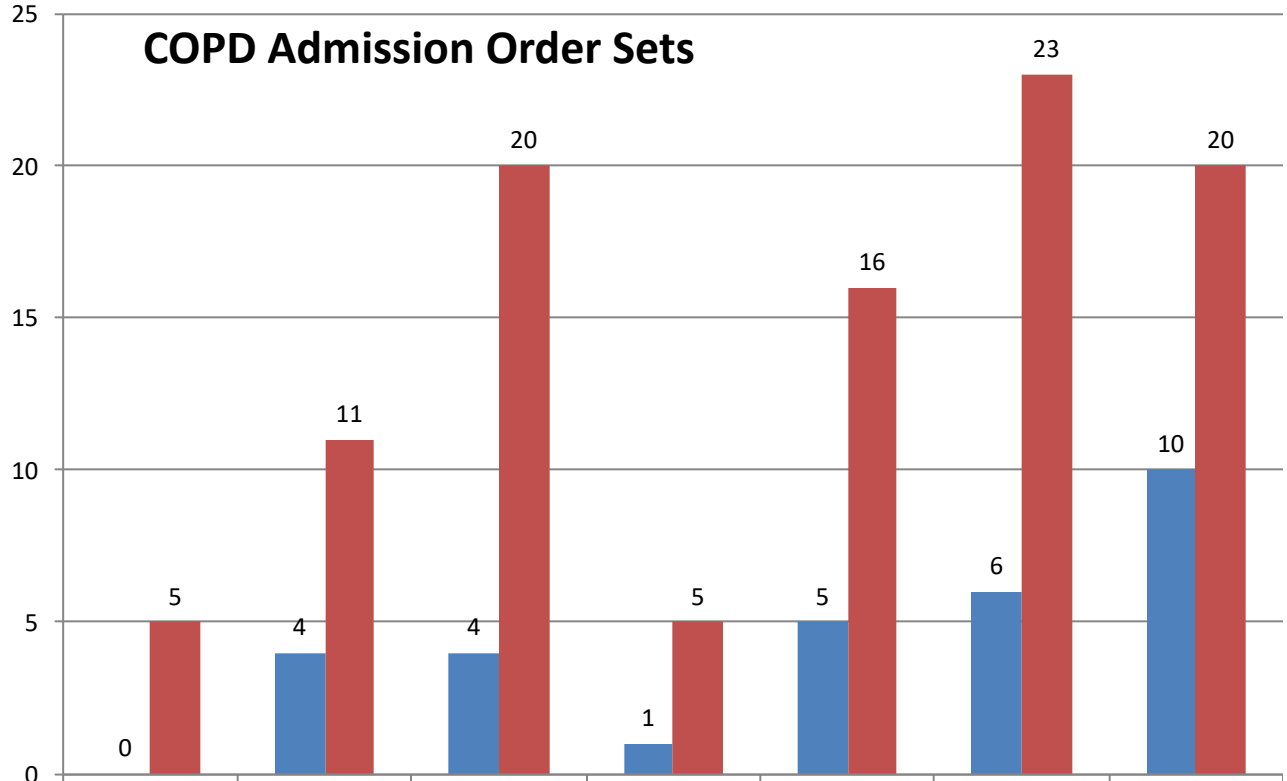
About Our Post-Acute and Community Partners

- How we developed a shared strategy with the hospital inpatient staff, post-acute pulmonary clinic staff, pulmonary rehabilitation staff & community-based organizations
  - Committee Teamwork
  - Education programs
  - Community Outreach Programs
  - Attending various hospital/clinic department meetings
  - Physician Involvement
  - Administrative involvement

What Process Changes We Implemented

- Processes originating at the hospital
  - Respiratory Case Managers call the discharged person with COPD weekly x 4 weeks & as needed
  - EPIC documentation template was created for bedside education & follow up calls
  - Respiratory Case Managers provide education to community-based organizations
  - Physician COPD Admission & Discharge Order Sets in EPIC
- Processes taken on by our post-acute partners
  - Education of pulmonologists & pulmonary clinical staff
  - Mandatory class: Functional Status Assessments
  - EPIC COPD assessment templates
  - Nurse Navigator manages Group 3 (severe) & 4 (very severe) persons with COPD
  - Pulmonary Rehab has enhanced services

COPD Admission Physician Order Sets



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
#of COPD Admission Order Sets Initiated	0	4	4	1	5	6	10
# of COPD Admissions	5	11	20	5	16	23	20

About the Implementation Experience

- Pleasant surprises or barriers encountered
- Surprises:
  - Overwhelming Physician involvement & support
- Barriers:
  - July 1, 2017 Go-Live date for EPIC
  - Coming out of silos & creating “new” relationships, contacts
  - No Social Worker available
- How barriers were overcome
  - Acceptance that the EPIC transition would take time & we had no control
  - A Social Worker position is still being considered
- Executive support
  - CAO, VP and multiple directors participated in the development of the project
  - Received approval for time out of the office to attend HASC conferences, webinars, etc.

What We Have Accomplished

- Quantitative data about the population served with your new person-centered care process
  - As an Organization, in 2013-2014, our COPD readmission rates averaged 21%. Through early patient identification and education in collaboration with physician, nursing, respiratory therapists, case management partners, we have reduced the rates to 12% and have been as low as 8% during previous quarters (HASC Readmission Data, 2018)

What We Have Accomplished (cont'd)

- Qualitative findings about the Quality of Life and Functional Status discussions of the person with COPD
  - The following are Person-Centered Care-COPD participant testimonials

https://youtu.be/oQDm7Armzqg

How Our Organization Has Benefitted

- Quantitative Data about the time investment of our team members/process and the cost/benefit ratio
  - The chief benefit and ROI is witnessed in patient outcomes and reduced hospitalizations
  - Direct cost savings is demonstrated by reduced complications & overall annual readmission prevention
  - The reduction of COPD re-admissions equated to an average of 4 less patients readmitted in Dec 2018 or $36K-$48K in savings.

- Qualitative assessment about what our team members and our organization gained
  - Insight into what the person with COPD thinks is important and what the person wants to achieve.
  - As an organization, there is a continuum of care & we need to work together in the transitions of care

Overall Lessons Learned

- If you were to advise another organization to embark on an intervention like yours, what advice or lessons learned would you share?
    1. Identify your stakeholders, and partners in the community
    2. Administrative support was very valuable
    3. It's tough to start a project at the same time you are transitioning to a new system-wide computer program (EPIC).

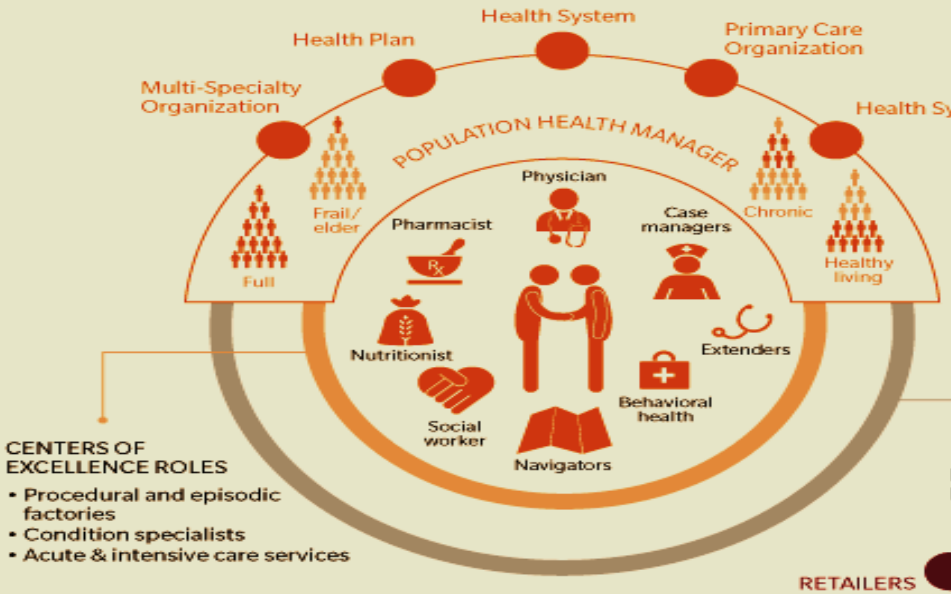
Going forward…..

– We have developed a model of care that can be applied to any population, i.e., CHF, Stroke, etc.

Person-Centered Care – COPD Team

Person-Centered Care Model

Patient-centered, whole person care:
Population health manager with multidisciplinary, cross-collaborative care teams and networks



CENTERS OF EXCELLENCE ROLES
- Procedural and episodic factories
- Condition specialists
- Acute & intensive care services

HEALTHCARE IT & TECH ENABLEMENT

CONSUMER HEALTH WELLNESS SERVICES
- Social media/e-health
- Remote monitoring
- Transparency tools

PHARMA/ MEDICAL DEVICES
- Advanced diagnostics
- Patient support
- Patient access programs

RETAILERS
- Fitness/lifestyle companies
- Retail & grocery
- Retail pharmacies
- Convenience clinics/urgent care

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