

# **Community-Wide Congestive Heart Failure Collaborative**

(aka Bundled Payment Project)

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# The Beginning

- Discussions about a CHF project began in 2011
- Initial Meetings facilitated by:
  - Vermont Association of Hospitals and Health Systems (VAHHS)
- Focus on reducing the number of patients coming back to the hospital and being readmitted.
  - 30 day readmission rate

# The Beginning

- Quickly realized, limited improvement if only hospital based improvement project.
- Needed to look at the “big picture” of care in the Rutland area.
- Work together as one team.

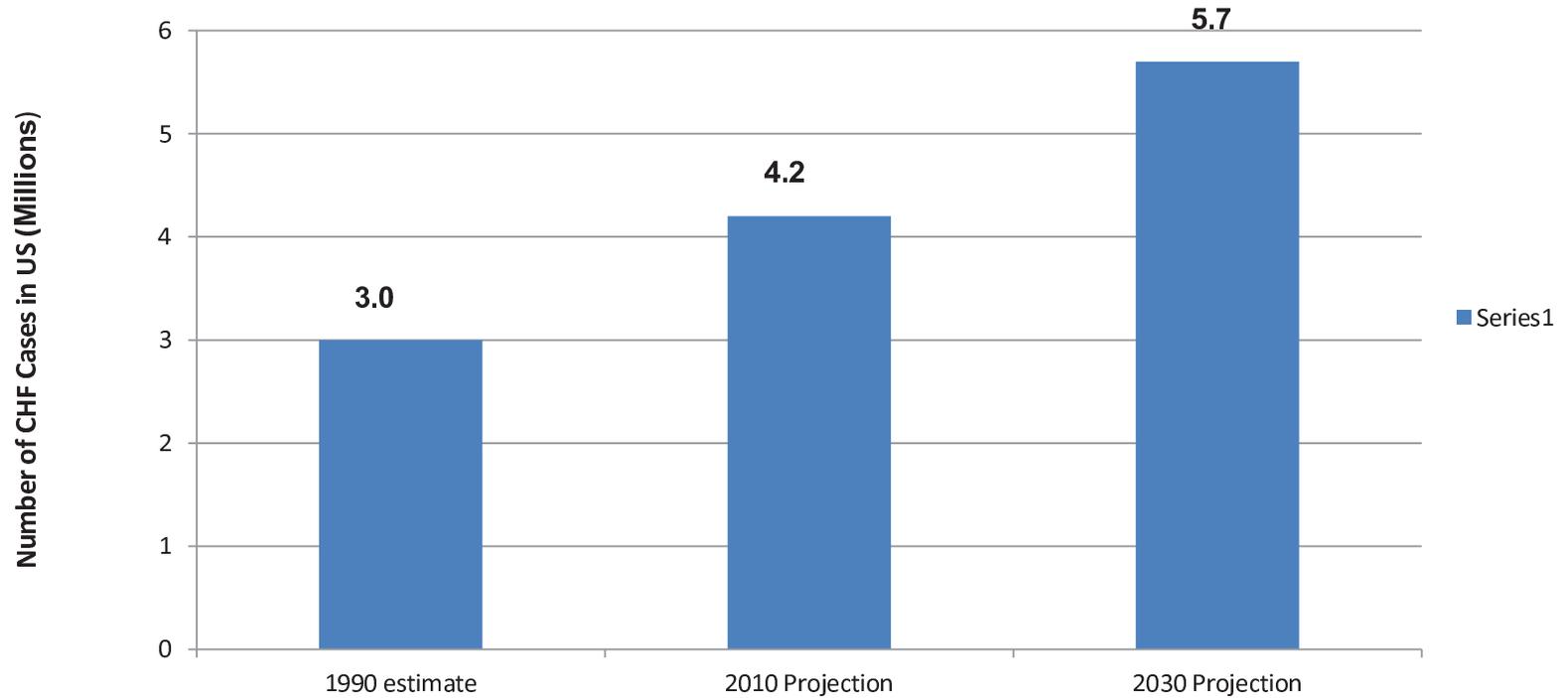
# The Beginning

- Decision made to try to form a Community-Wide Team (“Collaborative”)
- Reached out to Physicians, Skilled Nursing Facilities, Home Health Agencies, Other Agencies to ask for their participation
- Overwhelmingly positive response
- All had same focus: Improving care for patients with heart failure

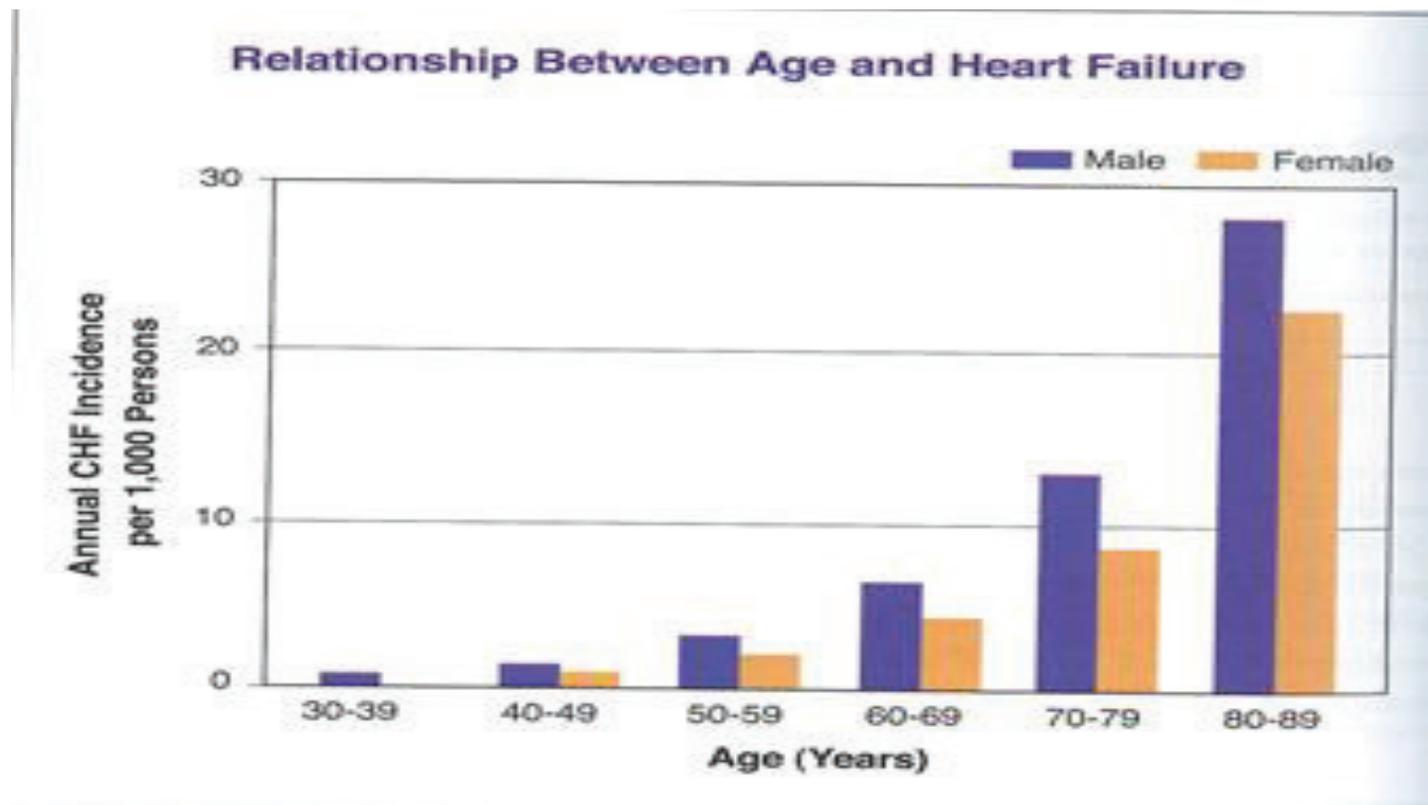
# Why Congestive Heart Failure ?

- 5.8 million people with CHF
- 1 million hospitalizations annually US
- ~27% readmit within 30 days
- \$37.2 billion dollars annually
- Acute in hospital care is responsible for 70% of costs

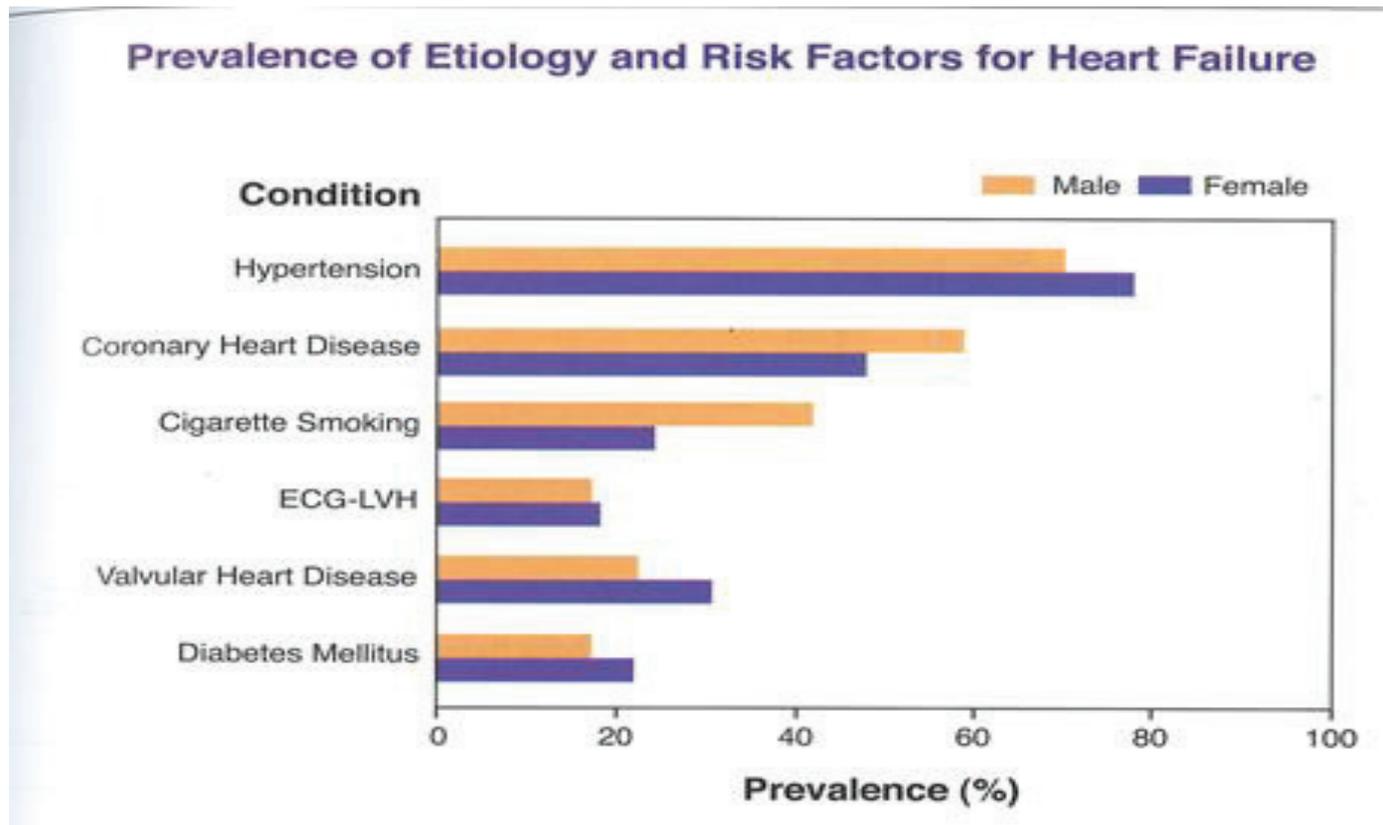
# CHF Prevalence to Nearly Double by 2030 as US Population Ages



# Relationship between Age and Heart Failure

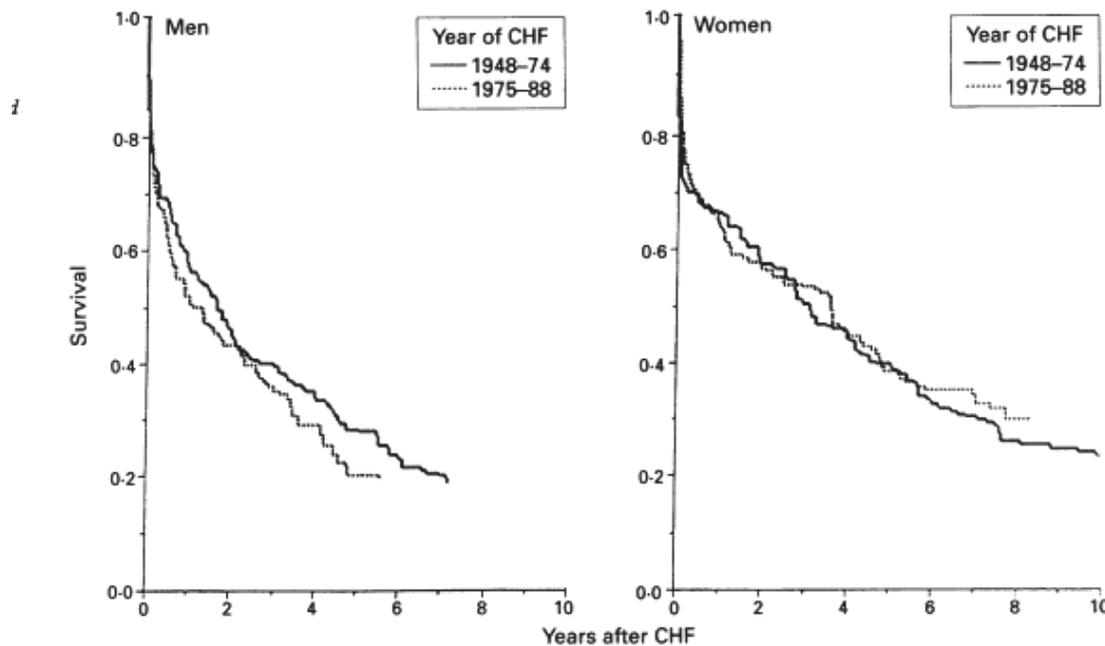


# Prevalence of Etiology & Risk Factors for Heart Failure



# AGE Adjusted Survival Rates after Diagnosis of Heart Failure

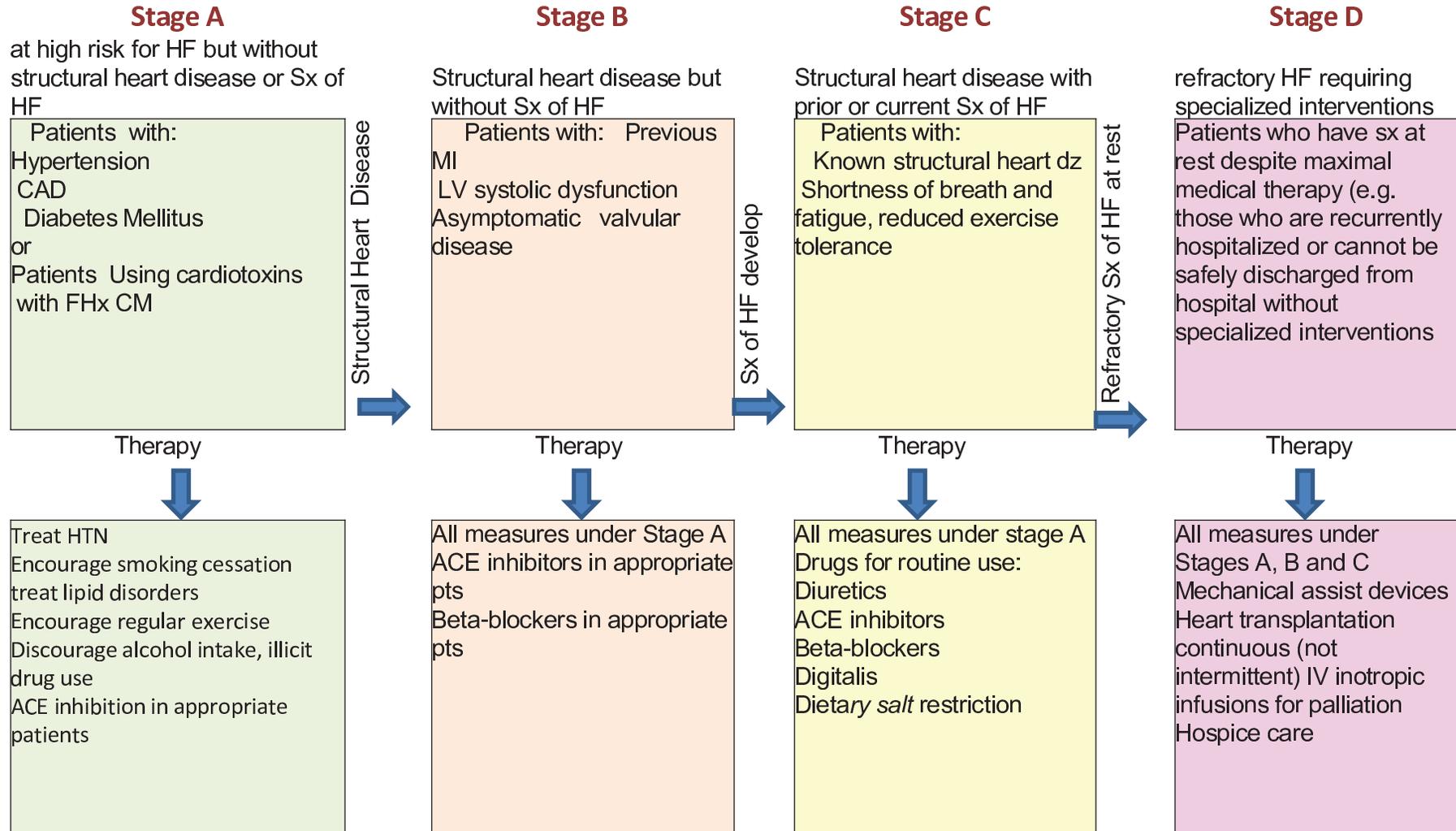
*Kannel, Ho, Thom*



- Age adjusted survival rates by calendar year after the first diagnosis of CHF for men and women in the Framingham Study. No significant change in survival over 40 years of follow-up was found, despite a considerable decline in coronary artery disease mortality

# ACC/AHA Guidelines

## Heart failure diagnosis and management



# Establish Goals

- 1<sup>st</sup> Collaborative Meeting in August, 2011

## “Triple Aim”

- Improve the patient experience of care
  - Quality and Experience
- Improve the health of populations
- Reduce the per capita cost of health care.

# Community Participation

- Community Health Centers of Rutland Region
  - Primary Care Physicians
  - Nursing
  - Care Coordinators
  - Quality Improvement
- Marble Valley HealthWorks
  - Primary Care Physicians
- Rutland Area Visiting Nurse Association & Hospice
- Bayada Home Health Care
- Genesis Healthcare Mountain View Center
- The Pines
- Indian River Nursing Facility
- Rutland Rehabilitation & Healthcare
- VT Program for Quality in Health Care
- Others

# RRMC Participation

- Leadership
- Performance Improvement
- Cardiologists
- Hospital Based Physicians
- Nursing
- Case Management
- Emergency Department
- Social Workers
- Palliative Care Nurses
- Educators
- Dietician
- Clinical Informatics
- Pharmacists
- Blueprint Community Health Team

# Green Mountain Care Board

- Reached out to RRMC
- New model of service delivery: “Bundled Payment” for Care Improvement
- Innovation Center at Center for Medicare & Medicaid Services
  - Achieve Triple Aim

# Bundled Payments Program

- Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment.
- This approach can result in fragmented care with minimal coordination across providers and health care settings.
- Payment rewards the quantity of services offered by providers rather than the quality of care furnished.
- Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.

# Bundled Payments Program

- Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability
- Must apply to CMS and be approved to participate.
  - 3 year agreement.

# Bundled Payments Initiative

- A bundled payment can be thought of as a budget. A target price is established for the episode of care, and the group of providers agree to work together to ensure that care is coordinated and the total cost of an episode is within the target price.
  - Risk and/or Gain Sharing
- To ensure that these financial incentives don't adversely affect other aspects of quality, it is also critical to measure and monitor patient experience and outcomes.

# Bundled Payment

- Chose Model #2: Retrospective Acute Care Hospital Stay plus Post-Acute Care
  - Includes the inpatient stay in the acute care hospital and all related services during the episode.
  - The episode will end either 30, 60, or 90 days after hospital discharge.
  - Participants can select up to 48 different clinical condition episodes.
- For Rutland, primarily a patient care focused decision

# Bundled Payment

- Established a target price for the CHF episode of care
  - CMMI provided Data for Historical Claims by Provider Type
  - The Target for CHF bundle will be updated over time based on actual results
- CMMI Risk Track selection was required to allow Participants to reduce impact of high cost outliers
- Ongoing monitoring of Financial performance is based on beneficiary paid claims

# Bundled Payment

- RPMC is the initiating partner and responsible for financial losses associated with CHF Bundle
- All partner Medicare reimbursements remain unchanged during participation in the BPCI
- Quarterly CMMI reporting will report episode costs and benchmark against the target cost.
- Annually, RPMC will settle with CMS for total costs above target. If costs are below target, a gain sharing payment to partners is made.
  - There is no partner infrastructure or reporting to support verification of claim payments against benchmarks
- CMMI needed IRS and OIG Waivers to clarify activities related to Gain Sharing Agreements.

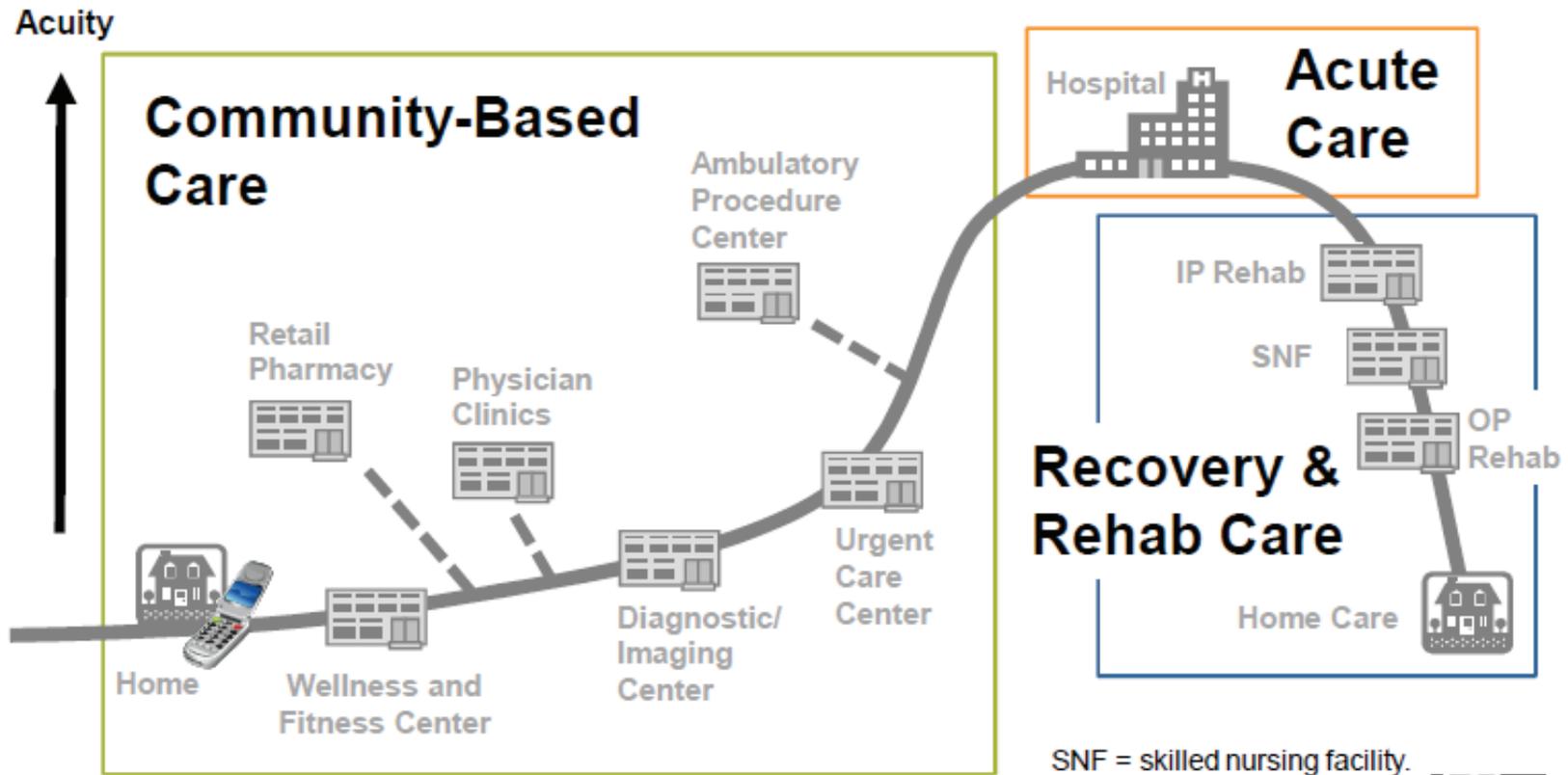
# Bundled Payment

- Ongoing management of the BPCII
  - Manage the BPCII administrative requirements
  - Engage participants
  - Planning & implementing improvements
  - Clinical quality measure data
  - BCARE tool
  - Learning the BPCII process & complying with requirements

# Green Mountain Care Board

- Assisted RRMC in developing our application for CHF for Medicare patients
- Approved by CMS
- Provides structure & oversight
- Opportunities to share and learn from other groups

# Where are the Improvements?



# Summary of Patient Readmit Data

## 2009 CHF Readmissions

- Total # readmits: 31
- # pts readmitted more than once 2;
  - 1 patient 2 times,
  - 1 patient 4 times
- Average age 78, ranging from 48-96
- Breakdown by gender: 12/31-male 19/31-female
- ALOS 4.3 days
  - shortest stay 1 day
  - longest stay 9 days
- # that have PCP 31/31
- # that were d/c to home 19/31
- # with insurance 31/31
- # with Medicare as insurance 28/31
- # with chronic dz other than CHF 31/31
  - COPD 13/31
  - renal impairment 7/31
  - Diabetes 9/25
- # with mental health issues 9/31
- # with palliative care consultation 0
- # with communication barriers 28/31

## 2010 CHF Readmissions

- Total # readmits: 25
- # pts readmitted more than once
  - 1 patient-seven times
- Average age 74, ranging from 57-92
- Breakdown by gender: 7/25 male, 18/25 female
- ALOS 3.5 days
  - shortest stay 1 day
  - longest stay 7 days
- # that have PCP 25/25
- # that were d/c to home 20/25
- # with insurance 25/25
- # with Medicare as insurance 23/25
- # with chronic dz other than CHF 25/25
  - COPD 15/25
  - renal impairment 6/25
  - Diabetes 16/25
- # with mental health issues 11/25
- # with palliative care consultation 2/25
- # with communication barriers 23/25

# Improvements Made

- Made this a priority for all organizations
- Communication between organizations
- Emergency Department resources
- Electronic Health Record
  - Order Sets
- Involvement of Dietitians, Physical Therapists, and Social Workers
- Better engage our patients

# Improvements Made

- Patient Education Information & Materials
- Patient Education Method
- Pharmacist teaching about medications
- Post-Discharge Appointments
  - Primary Care Physician
  - Cardiologist
- Post-Discharge Telephone Calls
- Use of Community Health Team

# Improvements Made

- Increased use of Palliative Care consultation
- Increased referrals for Home Health
- Home Health
  - Increased ancillary services
  - Increased use of Tele-monitoring
  - Patients meet criteria
- Working as a Team and Collaborating to improve care
  - Clinical Case Reviews

# So how are we doing?

- Congestive Heart Failure 30-day readmission rate
- Historical average at RRMC ~ 24-25%
- Target 18.5% or less by end of FY13.
- **2013 Results: below 15%**
- Foundation for the future and making other improvements to our patients & community

# In Conclusion

Questions?

Thank you.