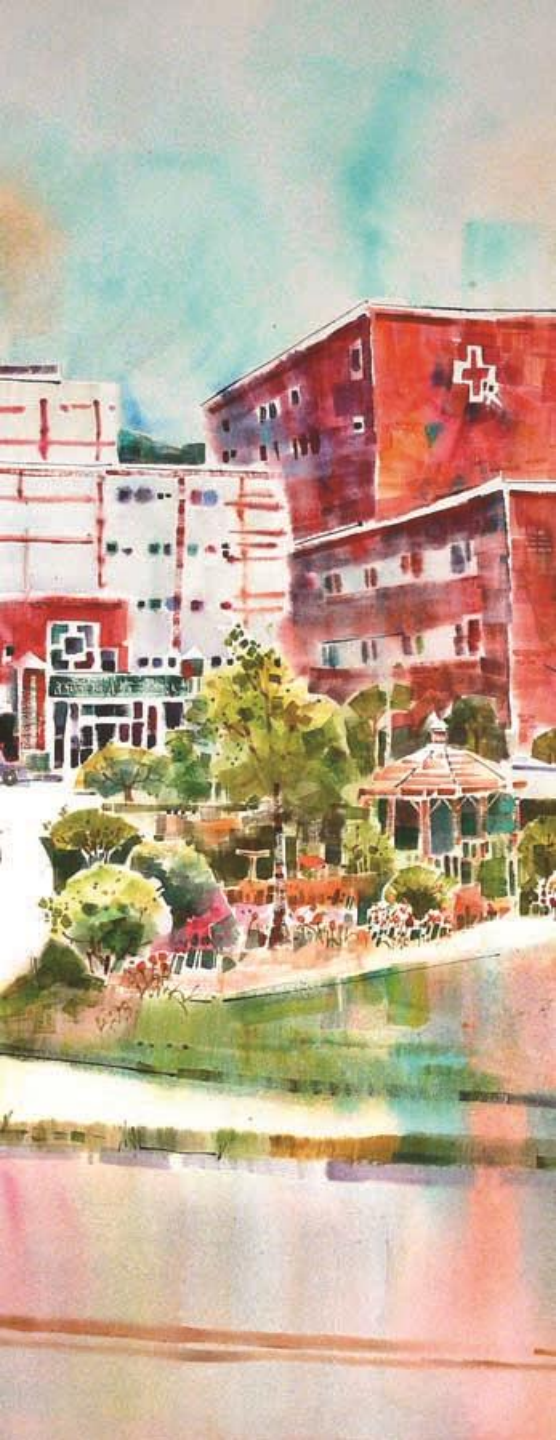


Community-Wide Congestive Heart Failure (CHF) Collaborative

Green Mountain Care Board Presentation
October 17, 2013

Darren Childs, Director Quality Improvement
Stan Shapiro, MD Cardiology Medical Director

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

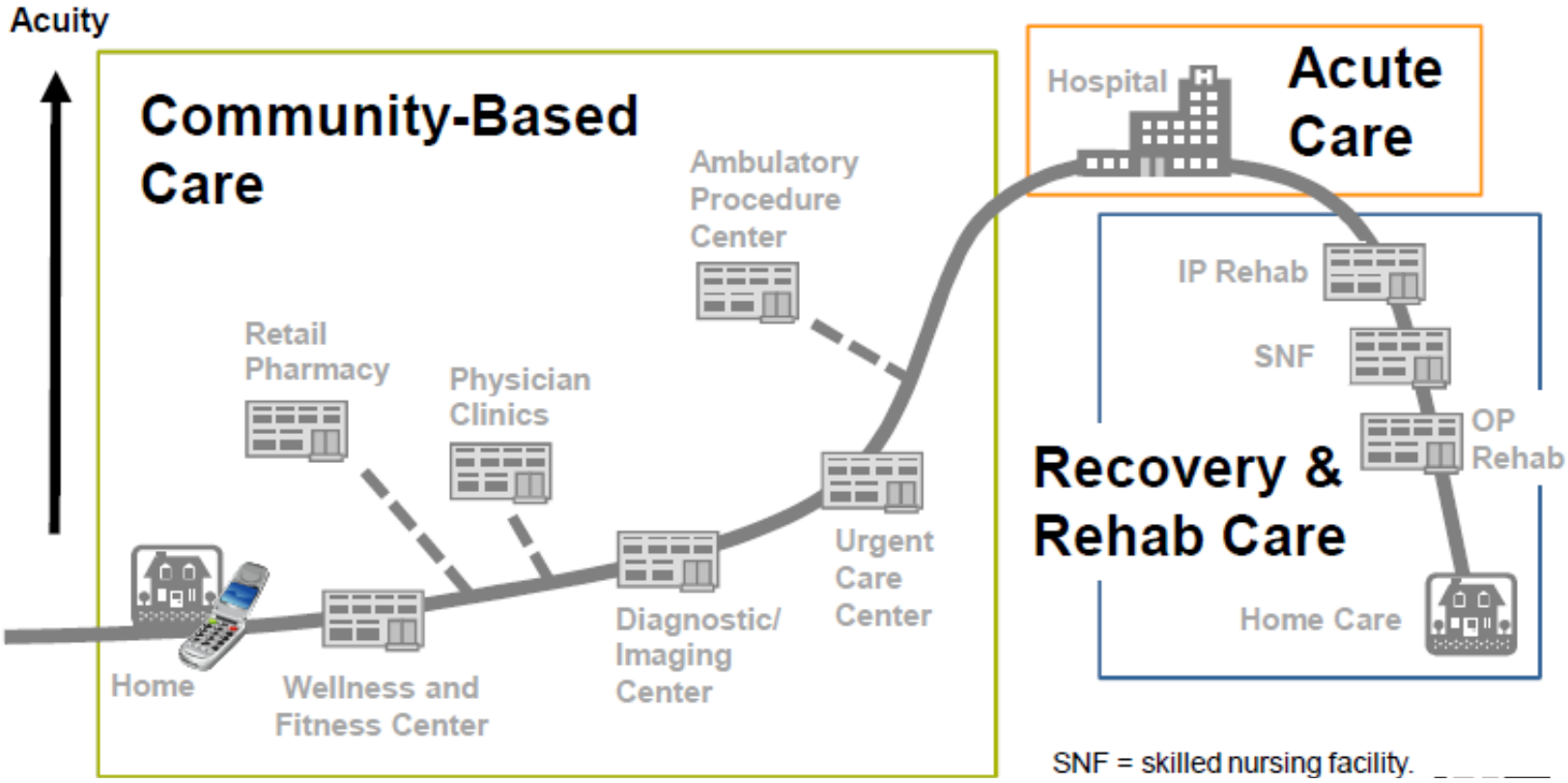
CHF Project: The Beginning

- 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

- Meant to be a rapid cycle improvement project.
- Quickly realized, limited improvement if only hospital based improvement project.
- Needed to look at the “big picture” of care in the Rutland area.

"Systems of Care"



SNF = skilled nursing facility.

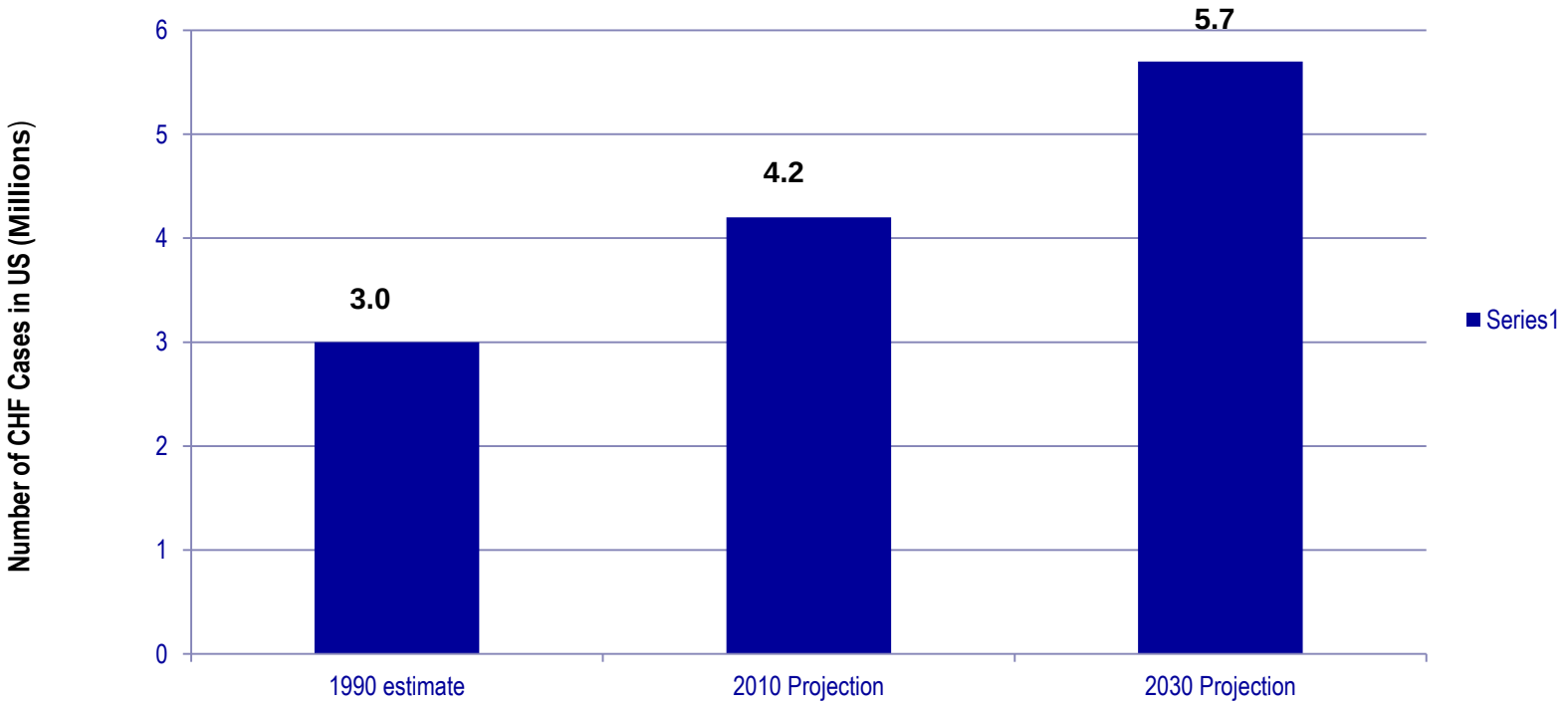
The Beginning

- 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

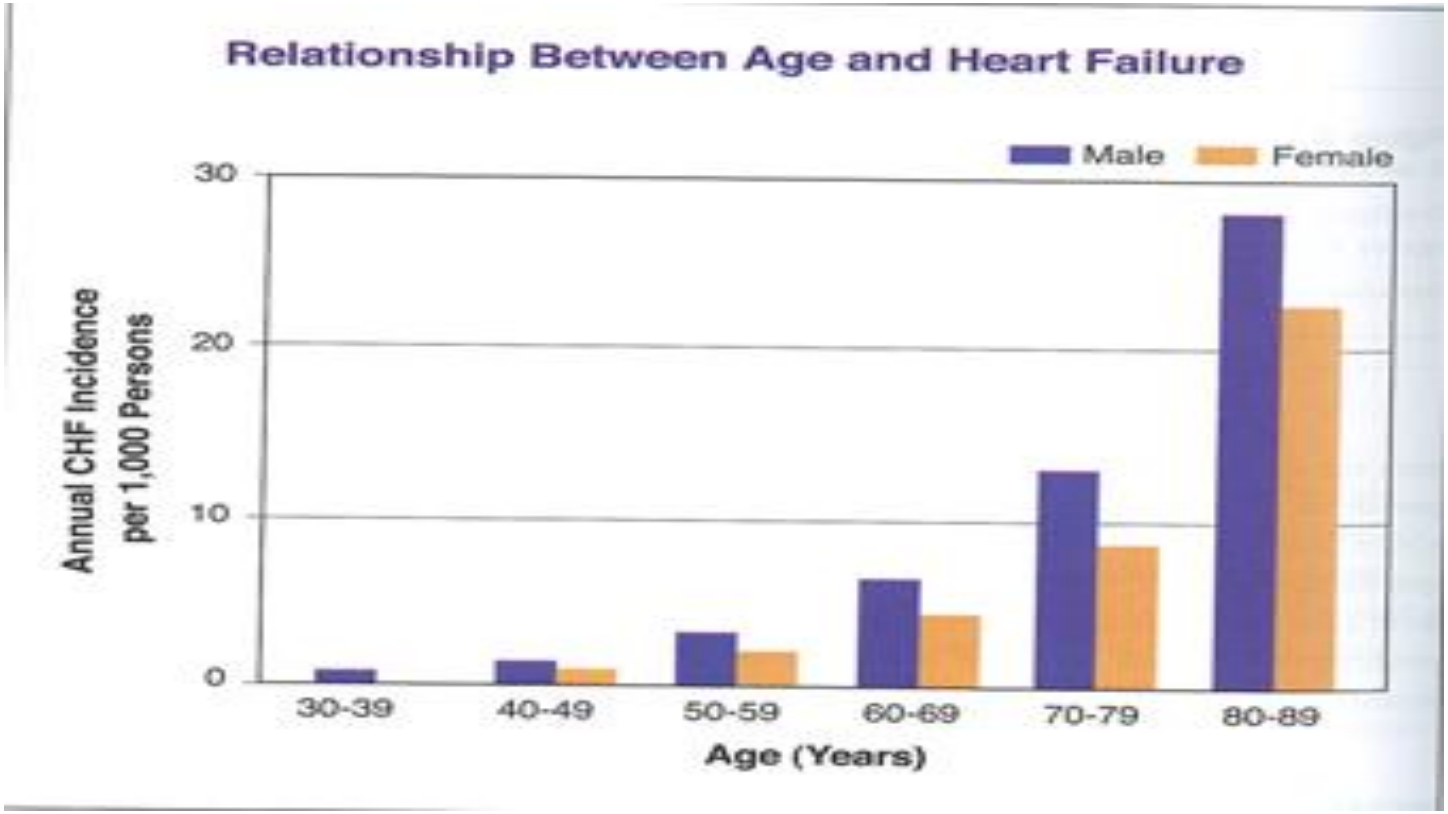
Why Congestive Heart Failure ?

- 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

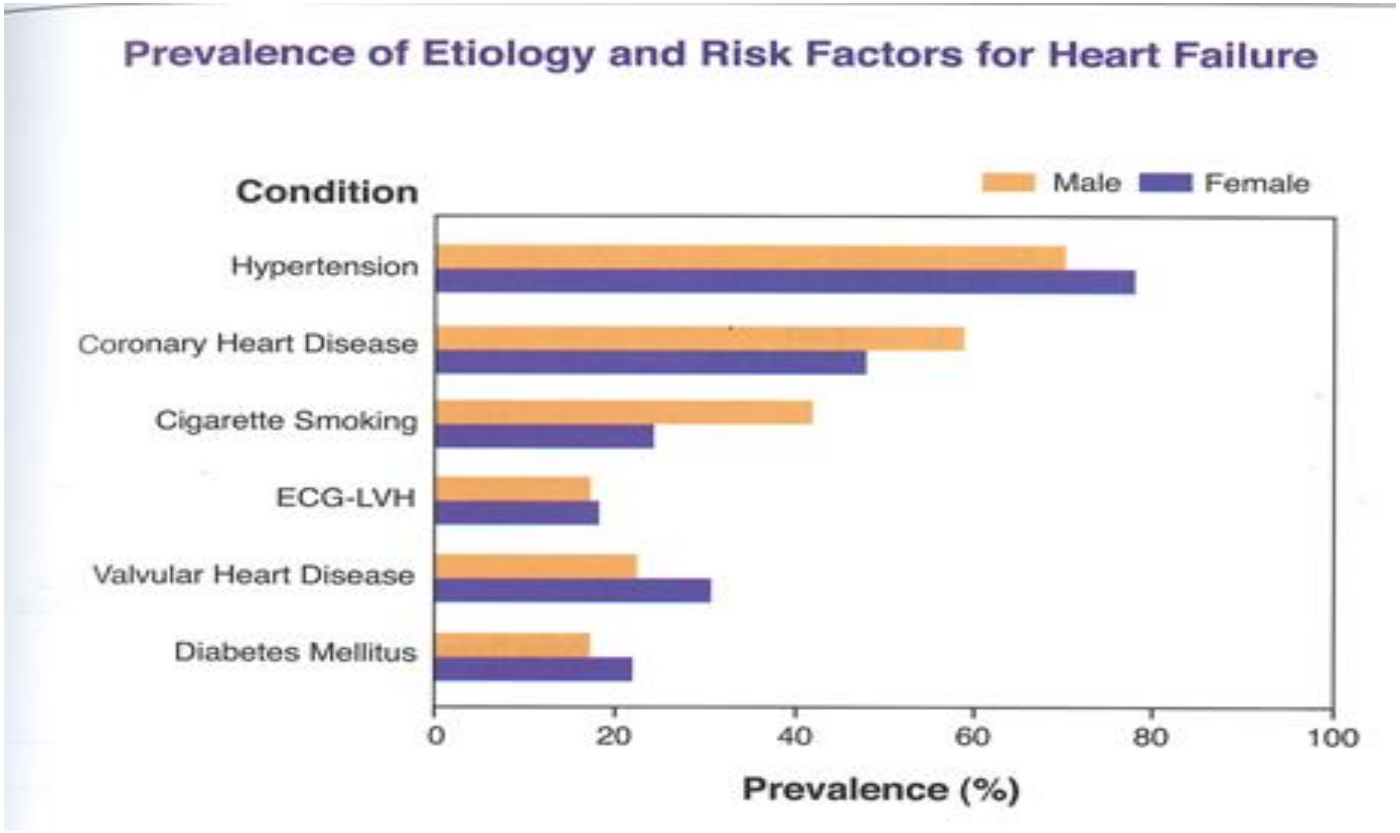
CHF Prevalence to Nearly Double by 2030 as US Population Ages



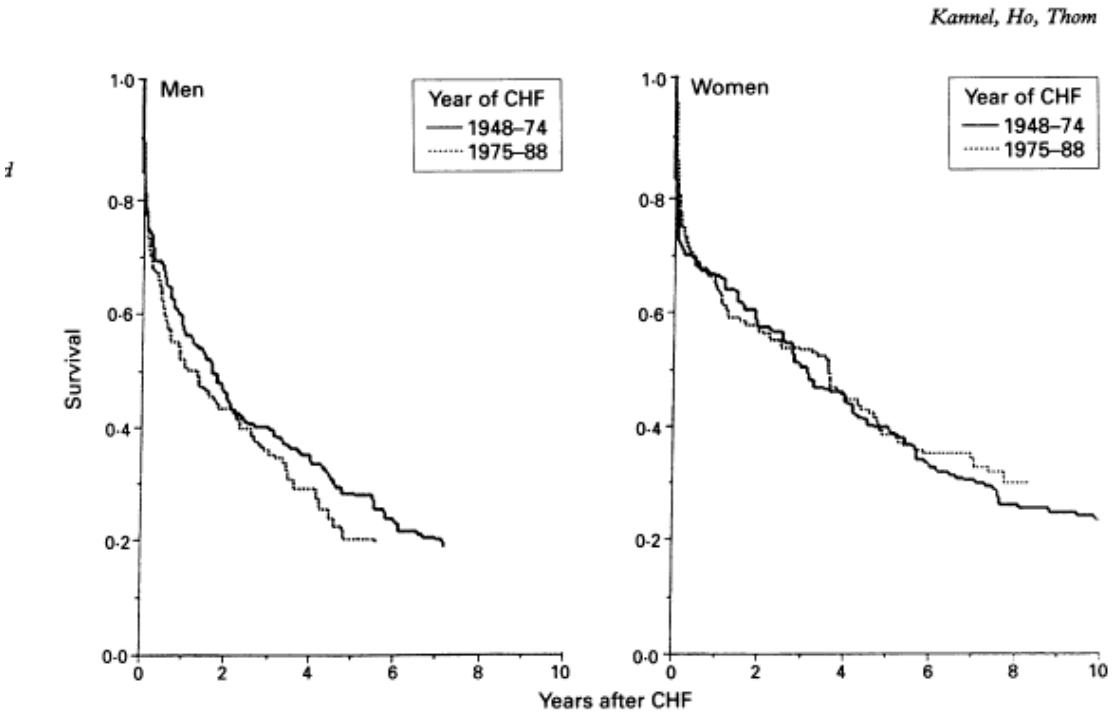
Relationship between Age and Heart Failure



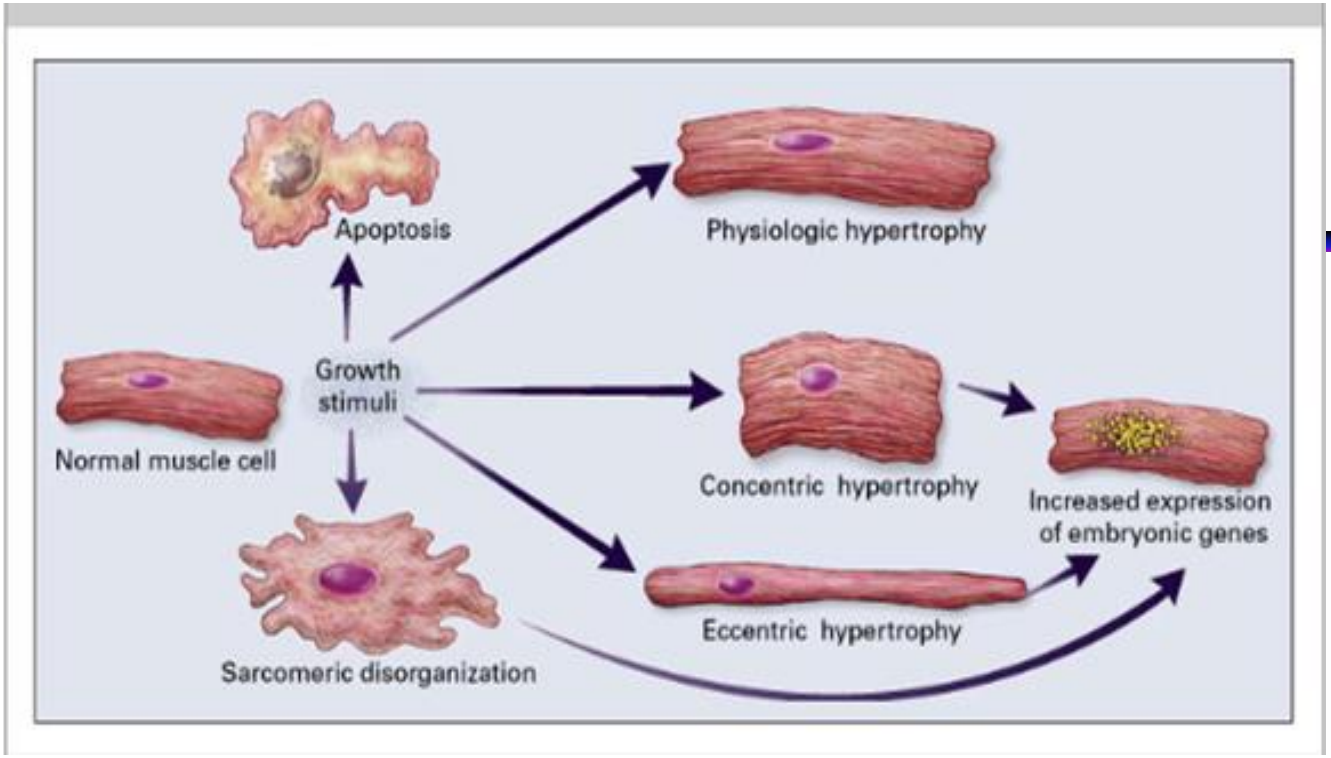
Prevalence of Etiology & Risk Factors for Heart Failure



AGE Adjusted Survival Rates after Diagnosis of Heart Failure

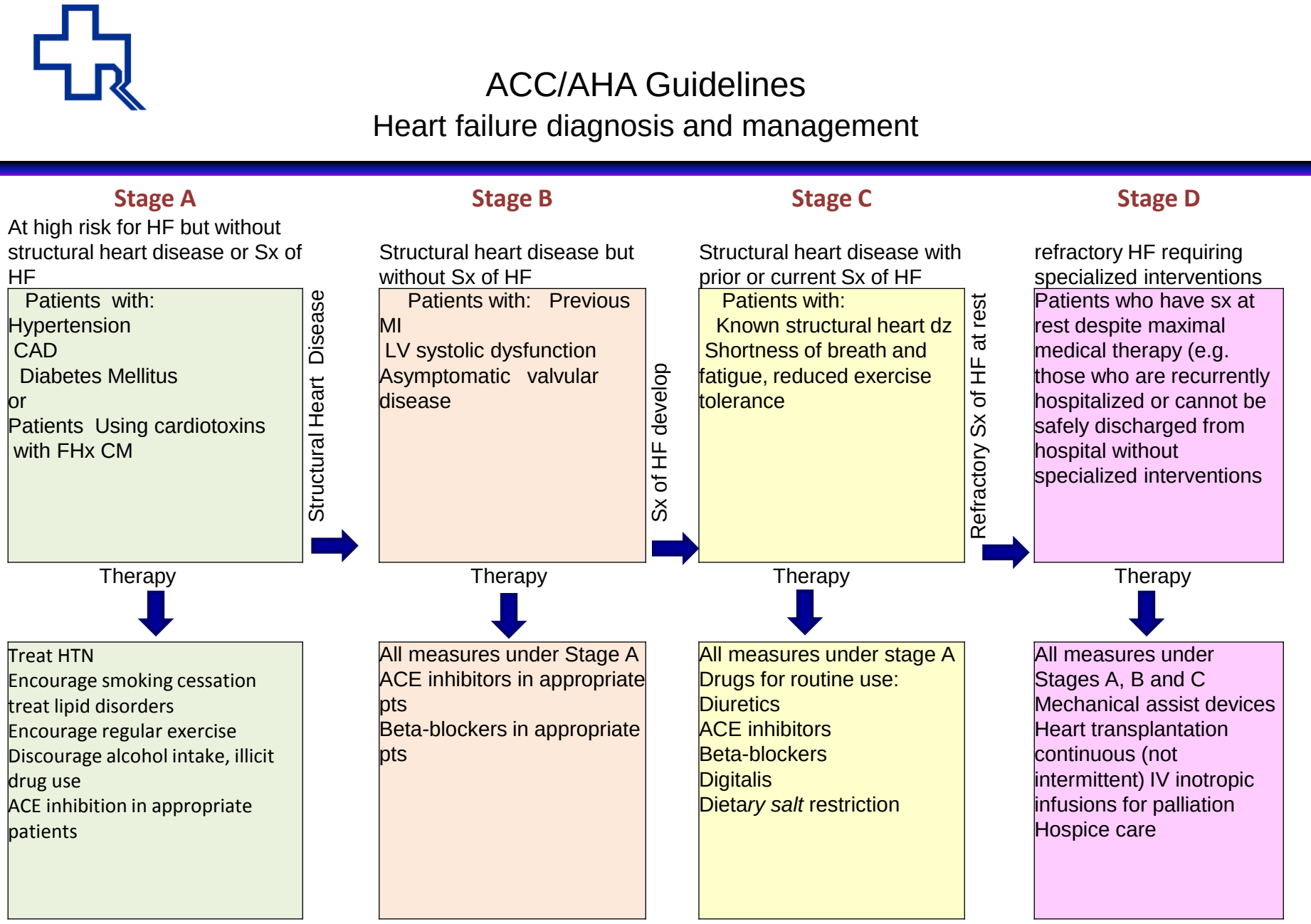


- Age adjusted survival rates by calendar year after the first diagnosis of CHF for men and women in the Framingham Study. No significant change in survival over 40 years of follow-up was found, despite a considerable decline in coronary artery disease mortality



- Morphology of Ventricular Muscle Cells in Cardiac Hypertrophy and Failure
- Phenotypically distinct changes in the morphology of myocytes occur in response to various growth stimuli. The expression of embryonic genes such as natriuretic peptides is increased in both eccentric and concentric hypertrophy, but not in physiologic hypertrophy, in response to exercise. Myofibrillar dissaray (sarcomeric disorganization) is typical of hypertrophic cardiomyopathies; this disorganization is focal and is accompanied by more widespread increases in the cross-sectional area of myocytes

ACC/AHA Guidelines
Heart failure diagnosis and management



Establish Goals

- 1st Collaborative Meeting in August, 2011

"Triple Aim"

- Improve the patient experience of care
  - Quality and Experience
- Improving the health of populations
- Reducing 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 Initiative
- 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.

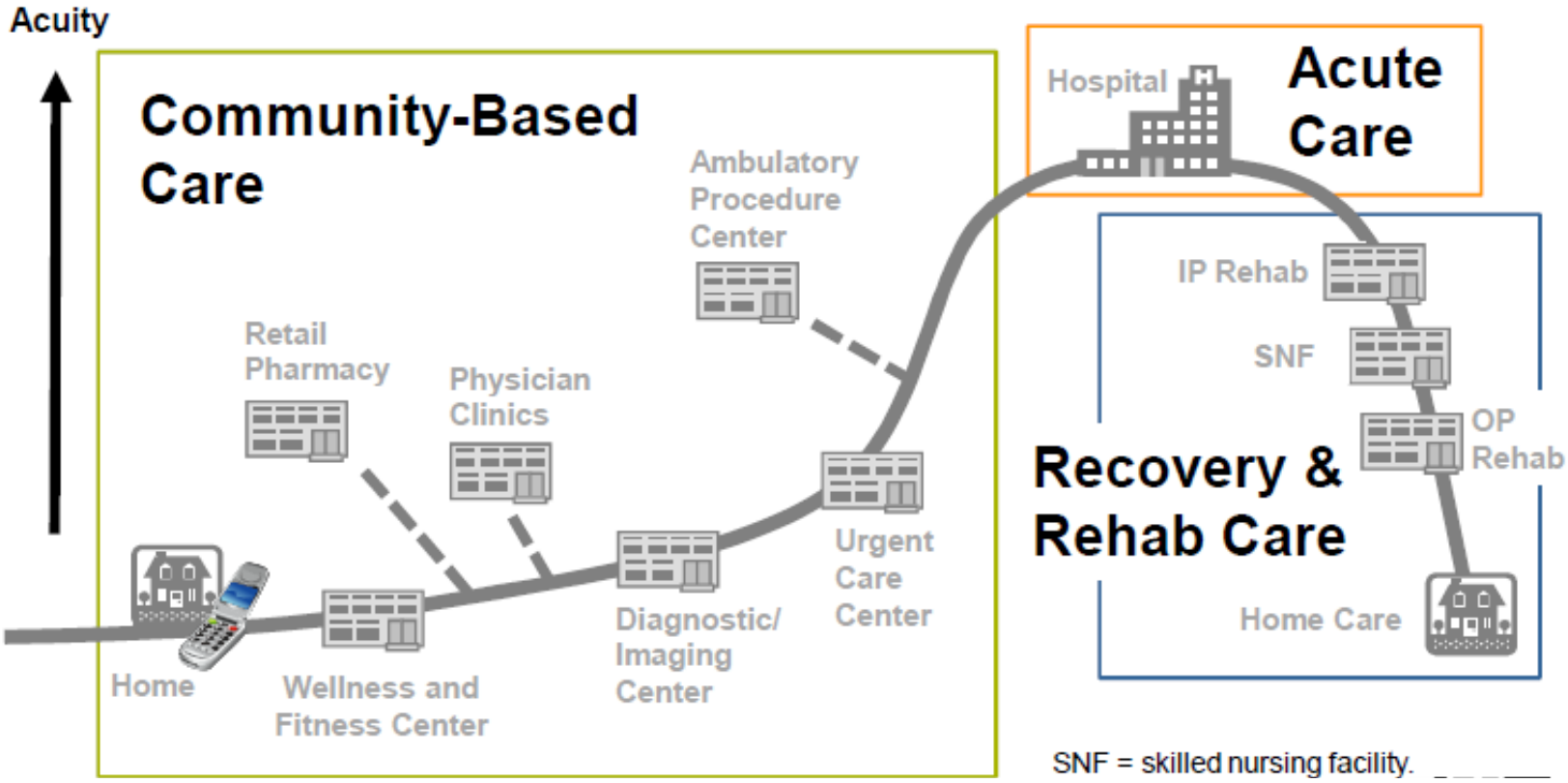
Bundled Payments Program

- 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 agrees to work together to ensure that care is coordinated and that 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.

Green Mountain Care Board

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

Where are the Improvements?



SNF = skilled nursing facility.

Improvements Made

- Made this a priority for all organizations
- Communication between organizations
- Emergency Department resources
- Electronic Health Record
  - Order Sets
- Involvement of Dieticians, 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.