Bundling for success

Vizient's Improving Value-Based Care for Cardiac Patients Collaborative

$1.1 trillion

The expected cost of treating cardiovascular disease in the United States in 2035, a jump from $550 billion in 2016.[1]

Vizient Performance Improvement Collaboratives program

Vizient© brings together interested members to collaborate on focused performance improvement initiatives. We offer health care collaboratives and benchmarking studies as opportunities to network with like-minded members, access subject matter experts and work on common issues vital to the delivery of health care. We offer collaborative projects, webinars and archived web resources that combine expert-led knowledge with leading practice insights to help you realize top-tier performance in quality, safety and cost effectiveness.

Opportunity

Bundled payments, and other forms of value-based care, are not new to the health care marketplace but continue to be challenging to implement successfully. Pilots around bundled payments and other value-based care models date back to the early 1990s. In 2016, CMS reported a six percent increase in the use of alternative payment models, and 29% of health care payments made by the agency that year were under alternative payment models, including bundled payments.[2] Private insurers have also pushed models that reward quality over quantity. As more payers push for value, health care organizations must learn to implement bundled payment models successfully.

Project overview

Vizient aligned its work in this collaborative with the original episode payment model (EPM) focused on the following patient populations: Acute Myocardial Infarction (AMI) and Percutaneous Coronary Intervention (PCI) with AMI diagnosis, Coronary Artery Bypass Graft (CABG) with or without AMI diagnosis and the Cardiac Rehabilitation (CR) incentive payment model. Participants tracked readmissions, length of stay (LOS) and process metrics around improving discharge and care coordination between inpatient, outpatient and post-acute settings. Goals of the collaborative included:

- Increase knowledge and understanding of cardiovascular bundles and move towards readiness for value-based care
- Track and analyze data to improve quality and care redesign
- Identify strategies across the care continuum to achieve better outcomes and reduce costs under cardiovascular bundled services

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[1] RTI International. Projections of Cardiovascular Disease Prevalence and Costs: 2015-2035 Technical Report. 2016. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf. Accessed on August 3, 2018.

[2] American Hospital Association. Issue Brief: Medicare's Bundled Payment Initiatives: Considerations for Providers. 2016. https://www.aha.org/guidesreports/2016-01-19-issue-brief-medicares-bundled-payment-initiatives-considerations-providers. Accessed on August 3, 2018.

How to get started

Access to the Performance Improvement Collaboratives program is limited to participants of the Vizient Member Networks.

Enroll in a project

For more information about upcoming Performance Improvement Collaboratives, participants can contact picollaboratives@vizientinc.com or their network director.

Learn from past projects

Participants can learn from past projects by:

- Reading knowledge transfer final reports
- Viewing the recordings of knowledge transfer webinars

Key learnings

Key learnings from the collaborative include:

- Restructure your organization to hardwire support for implementing alternative payment models, such as cardiac bundles
  - Consider dyad or triad team structures that pair nurses, physicians and administrative champions to serve as change agents and drive education and awareness of the bundle components
  - Develop multidisciplinary operational and clinical committees to map out care workflows and patient populations
- Use data to identify care redesign opportunities, such as modifying care pathways to streamline discharge planning processes and identify post-acute care partners.
  - Organizations should formalize the post-discharge process, targeting 10-14 day follow-up telephone appointments with case managers or nurse practitioners
  - Develop criteria elements, such as quality ratings, leadership stability and volume of referrals to rate possible post-acute partners
- Develop communications and education, such as fact sheets and training materials, to build organizational support for changes needed for success
  - Condense regulatory guidance into brief and easy-to-understand communication materials

Overall results

Participants aligned their readmission reduction efforts across the three patient population cohorts. Overall results of each cohort are detailed below. Some organizations participated in more than one cohort:

- AMI cohort (16 participants): 30-day readmission rate was reduced from 17.2% to 14.9%, avoiding 67 readmissions and estimated costs of more than $965,666
- CABG cohort (14 participants): 30-day readmission rate dropped from 9.3% to 8.9%, avoiding four readmissions and estimated costs of more than $62,317
- AMI w/PCI cohort (16 participants): the 30-day readmission rate increased slightly from 8.71% to 8.86%, with an increase of four admissions and increased estimated costs of $57,338

To learn more, please contact picollaboratives@vizientinc.com.

As the nation's largest member-driven health care performance improvement company, Vizient provides network-powered insights in the critical areas of clinical, operational, and supply chain performance and empowers members to deliver exceptional, cost-effective care.