

The VALUE Project Results: The CA and NJ Experience

Transitional Care Weekly Learning Session

March 20, 2008

VALUE Background

- Sparked by Dartmouth Atlas data
- Analyzing claims data together
- Employing collaboration
- Finding opportunities to decrease utilization while increasing quality
- Testing out process changes

A Four State Pilot Project

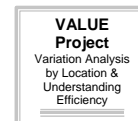
- Colorado
- California
- New Mexico
- New Jersey

The VALUE Project: The New Jersey Experience

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The QIO VALUE Team

- Director, Physician Services
- Director, Special Projects
- Two QI Specialists
- One Analyst
- One Researcher



Issues Unique to New Jersey

- Named as one of the highest utilizing states by Dartmouth Atlas
- The Governor's Commission on Rationalizing Healthcare Resources
- Low occupancy rates in many hospitals



Issues Unique to New Jersey (cont'd)

- Hospitals are closing
- Unique charity care reimbursement
- Expansion of ambulatory surgery centers



Hospital Partners

- Overall, New Jersey is a “high utilizer” state
- Originally recruited six providers; two withdrew due to competing priorities
- Four hospitals participated:
 - Two are “low utilizers” in the state
 - Two are “high utilizers” in the state
 - Paired as high/low in the same hospital referral regions (HRRs)



Recruitment

- Recruitment was relatively easy in New Jersey
- Providers were eager to work on utilization of healthcare issues
- Actually had to turn down providers who wanted to join project in the beginning
- Providers were open to being identified to one another



Strategy

- Created introductory packet containing:
 - Timeline
 - Dartmouth Atlas data
 - Provider-specific data from Medicare claims
 - Sample aim statements
 - Quality improvement plan template
 - Interim reporting reports and tools
 - Sample mortality analysis matrix
 - Supporting presentations and literature



Strategy (cont'd)

- Scheduled meeting with each provider to present packet and provider specific data
- Gave each provider “assignment” to write an aim statement within 30 days of meeting



Selected Aim Statements

- Increase requests for palliative care consults for congestive heart failure (CHF) patients by hospitalists by 25% by September 30, 2007, and by 50% by January 31, 2008
- Increase palliative care assessments in CHF patients by 25% by December 31, 2007



Selected Aim Statements (cont'd)

- Increase the number of appropriate referrals to hospice for patients with a principal diagnosis of HF, Stage IV per New York Heart Association (NYHA) staging criteria, by 25% by December 31, 2007
- To reduce intensive care unit/cardiac care unit (ICU/CCU) patient average length of stay (ALOS) by 0.5 day by December 31, 2007. In addition to this goal, the team will focus on decreasing the number of physician consults for ICU/CCU patients



Early Successes

- Some hospitals were able to combine resources designated for other projects working with the same patient population to bring greater resources to the VALUE Project
- The opportunity to select their area of improvement increased commitment and buy-in
- Increased awareness of Dartmouth Atlas among many providers



Early Successes (cont'd)

- Community education department in one hospital served as a partner by conducting educational programs about project topics
- Two hospitals had palliative care programs
- All hospital team members were enthusiastic and committed to bring about change



Initial Barriers

- While physicians were open to the project, many were looking for concrete parameters, e.g., criteria for appropriate admission and utilization of the ICU
- Some hospitals struggled with capturing and utilizing data
- Some hospitals struggled to find physician champions
- In all projects, the hospital teams faced resistance from physicians, patients, and caregivers



Individual Hospital Results Hospital A

- Focus on increasing palliative care referrals among HF patients
- Goal was to increase awareness, early intervention, and referrals to palliative care and encourage discussion either in the hospital or the private physician's office
- Interventions tested:
 - CHF palliative care and screening tool drafted for patients admitted with HF
 - physician and staff education
 - tested use of brochures, e.g., Aging with Dignity's *Five Wishes*; unsuccessful in hospital setting



Individual Hospital Results Hospital A (cont'd)

- Has a highly diverse patient population; found cultural issues among patients and physicians to be a barrier
- None of the patients referred by the advanced practice nurse (APN) agreed to participate in palliative care
- Hospital had other grants related to HF so it was able to consolidate and maximize resources
- Board approved policy that all ICU patients should be evaluated for palliative care; no referral required
- Results: APN referrals to palliative care—29 appropriate HF referrals September-October 2007 (APN position vacant November 2007)



Individual Hospital Results Hospital B

- Focus on increasing palliative care referrals from hospitalists
- Interventions tested:
 - Surveys of hospitalists and other hospital staff, physician/staff education
 - Thank you notes sent when referrals were received
 - Presentation was made to the Bioethics Committee
 - Defined differences between palliative care and hospice services
 - Added another physician group mid-project
 - Plans to implement Aging with Dignity's *Five Wishes* in March 2008



Individual Hospital Results Hospital B (cont'd)

- Hospital already had a palliative care service
- Results: Referral rates

June 2007—2/3 (66%)	October 2007—0/6 (0%)
July 2007—2/2 (100%)	November 2007—1/6 (17%)
August 2007—0/2 (0%)	December 2007—1/8 (13%)
September 2007—1/8 (13%)	January 2008—1/9 (11%)

- Total referrals were 8/44 HF referrals between June 2007-January 2008 = 18% (7 from hospitalists and one from physician group)



Individual Hospital Results Hospital B (cont'd)

- Other Results
 - Total referrals to palliative care increased by 64% from 2006 to 2007
 - Referrals from palliative care to inpatient hospice increased by 27% from 2006 to 2007
 - Hospital is now expanding home health telemonitoring project for HF patients
 - Contracted with ethicist group to assist Bioethics Committee and to help patients/families with advance directives



Individual Hospital Results Hospital C

- Focus on reducing ICU LOS and reducing number of consults in ICU
- Hospital is one of the highest utilizers in New Jersey
- Took a long time to get focused and had issues with data (had a lot of it, but didn't know what to do with it)
- Recent change of quality improvement (QI) director; brought about focus



Individual Hospital Results Hospital C (cont'd)

- Interventions tested:
 - Revised admission and discharge criteria for ICU and telemetry due to identified delays in transfer out of ICU (approved September 2007)
 - In November 2007 instituted an initiative to reduce LOS and utilization and improve patient satisfaction
- Medical staff education by an ethics professor; included points on role of the consultant physician, when/why it is necessary to have a consultant, and a recent newspaper article on the Dartmouth Data



Individual Hospital Results Hospital C (cont'd)

- The hospital has recommended the use of an “ICU gatekeeper” (intensivist) to streamline care in the ICU; has already received positive medical staff feedback
- Results: ALOS in ICU

June 2007—5.25	October 2007—3.32
July 2007—9.8	November 2007—5.49
September 2007—5.78	December 2007—4.71



Individual Hospital Results

Hospital D

- Focus on increasing hospice referral for Stage IV HF patients
- Interventions tested:
 - Physician/staff education
 - Concurrent medical record review to identify hospice-eligible patients,
 - Two community education programs—one about HF and the second about end-of-life decision making, working with skilled nursing facilities (SNFs) to increase do not resuscitate/do not hospitalize (DNR/DNH) orders among SNF residents
 - Working to gain consensus on the use of ejection fraction (EF) below 30% as trigger; ongoing difficulty obtaining EF rate as part of inpatient documentation



Individual Hospital Results

Hospital D (cont'd)

- Interventions tested (cont'd):
 - Revised nursing assessment to include end-of-life care section
 - In December 2007, hired APN to work with physicians with long LOS; hope to use APN to initiate discussions with physicians and families of ICU patients on end-of-life issues
 - Vice President, Medical Affairs, champions project



Individual Hospital Results Hospital D (cont'd)

- Physicians have long-term relationships with patients and caregivers, increasing barriers related to end-of-life discussions
- Increasing awareness of hospice was difficult; determining Stage IV HF based on documentation proved troublesome and physicians felt it may be too late for hospice referral
- Results: Outcome data pending



Recommendations

- Need to provide education and gain buy-in of physicians and other healthcare providers, as well as patients and caregivers; be prepared for addressing cultural, ethnic, comfort, and personal beliefs in dealing with end-of-life care for chronic disease patients
- This type of work needs to have a focused approach at the hospital level and a strong physician champion; tackle one area at a time



Recommendations (cont'd)

- Consider approaching the hospital administration with the necessary data, including financial information
 - For example, if you can reduce ICU utilization, you could be able to save enough money or resources to reallocate for a palliative care program or disease management education, which could lead to a reduction in admissions for chronic disease patients



Recommendations (cont'd)

- Focus on combining quality of care and overutilization of inpatient services is a new way to look at patient care in New Jersey. Consider addressing the need for collaboration between the medical staff, nursing, utilization/case management, and quality improvement/quality of care



Recommendations (cont'd)

- Need to address and educate the healthcare community that end-of-life care can be applied to chronic disease, such as HF or chronic obstructive pulmonary disease (COPD)
- More effective to have decisions about advance directives made in another setting when not in healthcare crisis

