Evolution Of A 90-Day Model Of Care For Bundled Episodic Payments For Congestive Heart Failure In Home Care

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EVOLUTION OF A 90 DAY MODEL OF CARE FOR BUNDLED EPISODIC PAYMENT FOR CONGESTIVE HEART FAILURE IN HOME CARE

Submitted to the Faculty
Yale University School of Nursing

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

APRIL FELD

May 23, 2016
This capstone is accepted in partial fulfillment of the requirements for the degree Doctor of Nursing Practice.

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Evolution of a 90-Day Model of Care For Bundled Episodic Payments for Congestive Heart Failure in Home Care

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The authors declare no conflict of interest and the content of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies

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Acknowledgement

I offer my sincere gratitude and appreciation to Dr. Ruth McCorkle and Dr. Rose Madden-Baer for the deft ways in which you lovingly challenged and supported me throughout the Capstone process. This scholarly project would not have been realized without your guidance and persistent help.

A special thank you to Susan Northover, Dr. John Delfs, Dr. Timothy Peng, and Eni Balkballeshi from The Visiting Nurse Service of New York for each of your additional reflection and contribution to this very important body of work. I would also like to acknowledge Dr. Barbara Turner, Dr. Paula Milone-Nuzzo, Charles Wiggins and Tracey Moorehead for your expertise and participation in this scholarly Capstone work as well.
Abstract

CMMI’s Episode Based Payment initiatives propose a large opportunity to reduce cost from waste and variation and stand to align hospitals, physicians and post acute providers in the redesign of care that achieves savings and improve quality. Community-based organizations are at the forefront of this care redesign through innovative models of care aimed at bridging gaps in care coordination and reducing hospital readmissions. This article describes a community-based provider’s approach to participation under the Bundled Payment for Care Improvement Initiative and a 90-day model of care for Congestive Heart Failure in home care.
Background

The Affordable Care Act (ACA), supports payment reform that rewards coordinated, high value care and encourages expansion for pay-for-performance as a substantial means to move the United States’ fragmented health care delivery system towards ideal performance. Under the ACA, public and private sector payers and health plans play an important role in improving performance through innovative payment systems. This means moving away from the fee-for-service payment structure that maintains little provider accountability for the total care of patients and contributes to fragmentation, unnecessary interventions and high costs. The Centers for Medicare and Medicaid Services (CMS) Innovation Center, known as “CMMI,” is a main engine in driving payment and delivery reform through such performance improvement initiatives.

CMMI supports the development and testing of innovative payment and service delivery models that improve patient outcomes and increase savings through improvements for the health care system (CMS a, 2015). The innovative models tested by CMMI are organized into seven categories: Accountable Care, Primary Care Transformation, initiatives focused on the Medicaid and CHIP population as well as initiatives focuses on the “dual-eligible” population, initiatives customized for rural America, initiatives to speed the adoption of best practices and, finally, Episode-Based Payment initiatives. The Episode-Based Payment initiatives are particularly exciting as they extend across the continuum of care throughout the nation and, although they are specific to CMMI, provide a framework beyond Medicare fee-for-service. Under Episode-Based Payment initiatives is the three-year Bundled Payments for Care Improvement Initiative (BPCI), which includes four new payment models that reach across the continuum of care [Reference table 1]. Participants can select up to 48
different clinical condition episodes to undertake in BPCI. These bundled payments provide an opportunity to reduce cost from waste and variation and stand to align hospitals, physicians and post-acute providers in the redesign of care that achieves savings and improve quality.

Under BPCI, participants will enter into payment arrangements with CMS that include financial and performance accountability for an episode of care (EOC) for a non-managed Medicare enrollee. A target price will be set that will be based on historical fee-for-service payments for the participant’s Medicare beneficiaries in the clinical condition episode and will include a discount for the total cost of care. Payments will be made at the usual fee-for-service payment rates, after which the aggregate Medicare payment for the episode will be reconciled against the target price. Any reduction in expenditures beyond the discount reflected in the target price will be paid to the participant and may be shared among their provider partners (upside and downside risk sharing). The anticipated effect is that these payment models lead to higher-quality, more coordinated care at a lower cost to Medicare (CMS b, n.d.). In response, BPCI participants are re-thinking how care will be delivered. Perhaps nowhere else is the opportunity and responsibility greater than it is in the community setting under BPCI.

In the BPCI model 3 demonstration, for post-acute care only, the EOC is triggered by an acute care hospital stay and begins at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end at a minimum of 30, 60, or 90 days after the initiation of the episode (CMS c, 2015). Services included in
the bundle are Part A and B services during the post-acute period and hospital readmissions. Opportunity rests within strong clinical service organizations, partnerships predicated on information sharing, proven quality and capability. This article describes the evolution of a 90-Day model of care for bundled episodic payments for congestive heart failure in home care at a BPCI model 3 participant.

To ensure the validity of the model description, we undertook a two-step process. Initially the description was documented by the first author (AF) and reviewed independently by the other two authors. Once all three authors agreed on the accuracy of the structure and process, a panel of four experts reviewed the paper. All four experts agreed on 14 out of 17 domains, while at least three of the four agreed on the others. The content was judged on its relevance and clarity. Experts had experience with episode-based payment and value-based purchasing, population health management, and home health. The second step was a review by five organizational leaders with bundle experience in a focus group format. Based on their review and input, final revisions were made to the paper. The following description is based on these combined methods.

**Organizational Setting**

As the nation’s largest and oldest non-for-profit home-and community-based health care provider, where about 65,000 patients and health plan members receive direct or coordinated care on any given day across the five boroughs of New York City, Nassau, Suffolk and Westchester Counties, the Visiting Nurse Service of New York (VNSNY) is poised to be a lead ambassador in the re-design of post-acute care services. Established by Lillian Ward in 1893, the VNSNY legacy stretches for more than 121 years, serving
as a vital part of the New York City’s health care infrastructure. VNSNY entered into BPCI in order to gain experience in risk sharing and value-based purchasing and had the capacity to test this model based on experience and resources. Furthermore, the work of bundled payments aligns with existing VNSNY goals to follow patients through the care process and facilitate care transitions within the greater context of population health management and also potentially apply what is learned from that more locally to New York State’s Medicaid Waiver Initiative, the Delivery System Reform Incentive Payment Program (DSRIP).

**Partnering Up**

VNSNY partnered with Remedy Partners, “The Episode of Care Company”, to develop and operate the best in class bundled payment services. In our partnership, VNSNY is the “Episode Initiator” and Remedy Partners is the “Awardee Convener”. Remedy Partners specifically provides support to VNSNY in the form of quarterly reconciliation and reporting as well as CMS compliance. However, as an “Awardee Convener,” Remedy Partners also assumes financial risk for its BPCI participants’ patients.

**CHF: A Global Problem**

In the U.S. CHF affects 5.7 million people, with approximately 670,000 new cases annually (Center for Disease Control, & Ambrosy et al, 2014). Unfortunately, that number is expected to increase to over 8 million by 2030 due to an aging population and increased life expectancy, according to The American Heart Association (American
Heart Association policy statement, 2011). Subsequently, the total cost of heart failure will increase almost 127% to $69.7 billion (American Heart Association, 2015). Such high cost is largely attributed to the unacceptably high rate of older Americans being hospitalized due to CHF (Center for Disease Control, & American Heart Association policy statement, 2011). In 2010, there were one million hospital readmissions for CHF (US Census Bureau, 2010). Home Health Care is the most common post-acute care service for patients with CHF and data briefs on hospitalizations for CHF suggest that Home Health can expect to care for even more CHF patients in the future (National Center for Health Statistics, 2012).

**CHF and Home Health Care**

National outcomes for the management of CHF in home care are limited to Outcomes and Assessment Information Sets (OASIS) and claims information. Several reviews of these data have been reported.

Madigan (2008)-reviewed OASIS from 2003 on patients with heart failure reveals that 73.9% (N=107,285) of patients entered home health care following a hospital stay, and 86% of these patients had payment under traditional Medicare. The average length of stay (LOS) in home health care was 44 days and less than one-fourth of patients with CHF continue with services beyond 60 days. During the EOC, nearly two-thirds of patients remained at home at discharge from home health care and approximately 15% of patients (21,778) were re-admitted to the hospital during the home care episode (Madigan, 2008).

A review by Riggs and Madigan (2012) of 2005 OASIS confirmed an unchanging LOS in home health for the heart failure patient (44 days) and examined variations in the
LOS. This review concluded 1% of heart failure patients in an initial home care episode expire at home, 63% are discharged to community, and 12% transferred back to the hospital and did not return home. If a recertification was completed, and this is without a transfer/no-discharge to the hospital during the initial episode of care, only 3% of patients are then discharged to community. For patients transferred to the hospital during the initial episode of care and for whom a resumption of care is completed, the 7% are then discharged to the community. However, another 2% of patients post resumption of care were found to have transferred back to the hospital. It can be implied from this review that any history of re-hospitalization for heart failure patients in their initial episodes of care influences service utilization, the trajectory of care and ‘final’ disposition in home care, where it is less likely that the affected patient remains in the community setting.

The problem of high re-hospitalization rates, compounded by variations in LOS, leads to real challenges in the care management of the heart failure patient. An investigation into predictors of re-hospitalization for the heart failure patient in home care is important to inform care delivery. Madigan et al. (2012) identified two patient factors with the strongest predictors of hospital readmission for heart failure patients in home health care; number of prior hospital stays and dyspnea severity. These predictive variables overlap with national risk factors identified for hospitalization for all-population home care patients as seen in Fortinsky et al. (2012) predicated on 2002 OASIS data. Targeting risk for re-hospitalization and adjusting for variations in LOS as it informs the trajectory of care are key areas that home health providers can focus on to improve care for the heart failure patient.
The Significance of Length of Stay

Similar to national averages, the VNSNY’s average LOS in a home care episode is 44 days. This means that while VNSNY could anticipate that up to 10% of its bundled heart failure patients will “live out” the bundle in a home care episode (1 recertification occurred), a high volume of patients who are discharged at/by day 45 remain in the community. In a 90-day risk bearing period, then, nearly half of the time would have traditionally been carried out “unsupervised” by VNSNY. Moreover, a look at VNSNY’s readmission distribution data showed the hospital readmissions percentages were about equivalent in the first 45 days as in the second 45 days of the 90 day period for the CHF clinical episode. This supports the need for ongoing care coordination to mitigate risk for hospital readmission after home care discharge for the CHF patient. Certainly then, innovation is needed from post-home health care discharge through bundle discharge.

Choosing a Clinical Episode

VNSNY is required to have an understanding of the organization’s performance across all 48 clinical condition episodes. A retrospective data collection and analysis of VNSNY’s home care admission data from 2009-2011 was completed to make an informed selection of our clinical condition episode. Analysis was undertaken on; 1) the total Medicare costs to VNSNY broken down per clinical episode type; 2) which clinical episodes predicted to have the most cost-relative opportunity to reduce re-hospitalization rates and therefore increase savings to VNSNY as well as; 3) the re-hospitalization distribution across the 90-day episode of care (all population). Several stakeholder meetings between VNSNY and Remedy Partners followed this analysis in order to make
a final decision. Congestive Heart Failure (CHF) was selected as the first and only clinical episode under BPCI (MS-DRG 291, 292, 293). The final decision to scale to a single selection of a clinical condition was attributed to concerns over effective change management and DRG identification. Top reasons for selecting CHF included the fact that at VNSNY, CHF has the highest prevalence (roughly 969 cases annually), required a relatively “low” reduction in admission rate, approximately 9.3%, to demonstrate impact and potential savings, and represented the highest cohort for readmissions overall. Assuming VNSNY could demonstrate impact and savings in this major clinical condition, this would be a huge opportunity for the organization from a quality perspective in a competitive marketplace as it applies to the potential implications for other clinical conditions and to STARS ratings.

Evidence Base Beyond Home Health for the Management of CHF

A search of databases including Medline, CINAHL, Pub Med, Ovid, Cochrane Library, Scopius and Google Scholar was conducted to identify the models of care, including payment systems, and evidence of outcomes associated with the management of CHF from 2000-2015. Reference lists from selected publications were also examined to identify further publications that meet inclusion criteria. Articles were included if interventions were delivered in community settings, or during the transition from hospital to home, and if studies measure the effect of the intervention on hospital readmission and/or readmission rates and/or reduced hospital readmissions and/or cost/cost savings. Articles were excluded if interventions were delivered in inpatient/ward or unit based settings, did not disclose findings and/or were published prior to 2000 and in languages
other than English. Literature found can be grouped into three domains: Transitional Care (post-discharge programs), Comparative Effectiveness Research (disease management models of care, including care coordination), whereby clinic and home-based interventions are described, and Telemonitoring. Models of care identified vary in design, intensity, interventions and duration of follow-up and all include hospital readmission avoidance as a primary outcome measure. Successes of models vary, an indicator that there is no dominant singular approach for the management of CHF. Rather, the management of the CHF patient is multifaceted; drawing best elements from across all three domains is most appropriate in the quest to redesign care for the CHF patient under BPCI.

Transitional Care

There is considerable evidence that transitional care interventions, as embedded strategies in models of care and/or programs, are successful in the prevention of hospital readmission for diverse patient groups. The most well-known transitional care models include Mary Naylor’s Transitional Care Model, Eric Coleman’s Care Transition’s Program, Community Based Transitions Model, and Brian Jack’s Project Red (Reengineered Hospital Discharge Program). Though each of these approaches differ in design, time period and duration of follow-up, core attributes include: a transitional care role, mixed modality of patient follow-up (i.e. telephonic and face-to-face, or electronic), patient-centric care plan/record, an emphasis on early recognition and response to health care risks and changes, timely provider follow-up and behavior activation to set self-management in motion. Though effective, transitional care programs are not without
challenges, and alone are an incomplete response to chronic disease management, such as CHF. Under BPCI, care redesign would serve to manage all points of care transitions, including the additional transition at home care discharge to our Population Care Coordinators, and promote enhancements to existing transitional care protocols as embedded strategies within a greater approach to care delivery and disease management [See Figure 1].

**Comparative Effectiveness Research**

There is a particularly large focus on comparative effectiveness research for the management of CHF. Examples of this research focus on methods of patient follow-up as well as interventions and strategies deployed to care for CHF patients. Methods of followed-up discussed include: Outpatient heart failure clinic and/or clinical-based interventions which may include nurse lead outpatient telephonic follow-up, a multidisciplinary team providing specialized follow-up but not in a hospital or practice-
based clinic, home-based interventions, case management, and primarily educational-based programs. Findings suggest that overall disease management programs that provide targeted follow-up appear to be effective on reducing hospital readmissions, lowered cost as well as improved quality of life, functional capacity and adherence measures. Programs that emphasized enhanced patient care activities or multidisciplinary teams providing specialized follow up were more effective on all cause hospital readmission. A key takeaway is that specially trained nurses should be core to intervention with a strong emphasis placed on patient and caregiver education related to precipitating factors for enhanced self-management.

**Telemonitoring**

Telemonitoring is unique in that it may serve as a monitoring strategy to alert for intervention within a disease management model of care and/or stand alone as a primary method for patient follow-up. Inglis et al. (2010) investigation of structured telephonic support programs and telemonitoring compared to standard practice for patients with CHF on CHF related hospital readmissions reveals structured telephonic support and telemonitoring are effective at reducing the proportion of patients with a CHF-related readmission, as well as effective at reducing risk for all cause readmission. Yet, more work is required on the business models underlying the cost-effectiveness of telemonitoring in particular, and these business models can help determine how clinical teams use the technology. In a 90-day episode of care, patient interactions may be multi-modal, including electronic, where the deployment of telemonitoring can be an additional safety net for the most vulnerable persons at and for specific intervals of time.
Description of the Model: Co-Care 90 Partnership

The model is named “Co-Care 90 Partnership.” Co-Care captures key dimensions of our care coordination; “continuous,” “comprehensive,” “collaborative,” “coordinated” and “community-based.” The model is a blended model of certified home health care with transitional care and disease management within a true care-redesign framework. Care redesign elements were achieved at various points during the 90-day episode of care, beginning at point of referral to home health care and extending well beyond the traditional home care episode. Chief redesign elements included the new role of Population Care Coordination (PCC) and the Population Health Management team as an overarching strategy in care management. The model schematic shows that in Co-Care 90 Partnership the PCC may deliver and manage care concurrently with other providers and resources over the 90-day episode of care [See Figure 2]. This schematic specifically highlights how different providers are activated into the patient’s care at
different time points along the trajectory of the episode of care and whom may take the lead at such time points, yet all the while the PCC serves as the anchor to the care team.

The model uses an interdisciplinary team, with hybrid care management including mixed-modal patient interactions. PCCs, along with other team members, provide health education, assessment and screenings as well as referrals to community based organizations and other community assets as integral strategies to promote self-management. Evidence-based practices are entrenched throughout and include: strong transitional care practices within the first two weeks of the home care episode, integration and use of risk stratification methodology and predictive analytics to stratify the population, as well as the attention to care transitions throughout the episode. The model also supports the deployment of Telehealth (remote monitoring) for CHF patients who meet predetermined criteria, structured telephonic support and a 24-hour call center, the use of clinical pathways and the deployment of advanced practice nurses. Consultation services, such as pharmacy desk consults, nutritional consultation, a tiered “activity level” fitness program through therapy consultation and paraprofessionals as health coaches compliment the model as well. Seven specific components comprise the platform of this model of care [See Figure 3].

The following sections will describe
each of these components in greater detail as well as their application.

*Predictive Analytics and Risk-Stratification*

Understanding variations in length of stay and discharge dispositions in combination with hospital re-avoidance strategies, including stratification methodologies, is key to improving the outcomes of our CHF patient, thereby reducing the total cost of care. In its simplest form, predictive modeling is a statistical tool, a data-driven strategy, used to target efforts; it intends to predict cost, utilization, and even outcomes when specific variables are applied (Hodgeman, 2008). In this model, utilizing a proprietary risk stratification model that predicts the probability of hospitalization is key. Predictive analytics with risk stratification segments the population into 3 risk-tiers: low, rising and high risk. Stratifying the population into patient groupings is an important tool for informing resource allocation, targeted intervention, and utilization management within care-redesign. This approach allows for a strategy based on the evidence that there is no such thing as a “one strategy fits all risk cohorts” and that care management needs to be driven towards the best efficacy within the context of the lowest cost. Interventions are aligned with the risk groups for targeted approaches. Because we know conditions change over time, a patient is re-stratified at specific intervals throughout the EOC for a best-fit clinical pathway.

*Evidence-Based Tools*

Specific evidence-based tools for patient activation measures (Insignia Health PAM® survey) and a disease registry to drive care management and interventions are also employed in this model. Patient activation is the foundational premise of population
health, often understood as a vital sign. Evidence has shown that activated “consumers” have the knowledge, skill and confidence to effectively take on the role of managing their health and health care. Less activated patients are nearly twice as likely to be re-admitted within 30 days of discharge (Greene & Hibbard 2013, Greene, Hibbard, Sacks, Overton, & Parotta, 2015). Other examples of evidence-based tools include, but are not limited to: Morisky Medication Adherence Scale (MMHS₈), use of readiness and confidence rulers; behavioral health and depression screening tools-GDS/PHQ9, a caregiver strain index (CSI), and a health risk assessment. Motivational interviewing for behavior activation for enhanced self-management is also employed. A patient’s clinical presentation, in combination with outcomes of screening tools, is a trigger for management approach and resource activation.

Patient and Caregiver Centric Design

As always, the patient and caregiver are at the center of care and process. Encounters, whether by telephone or face-to-face, are purposeful and goal directed. S.M.A.R.T. goal setting and monitoring is the very fabric of self-management, and reinforces person engagement. A person-centered care plan with person-stated goals is also essential to move patients through care transitions in settings as well as within the larger context of their goals of treatment.

Comprehensive Assessment and Care Coordination by Registered Nurses

Role redesign for nurses as care coordinators, health coaches and systems innovators is emerging as a strategy to better coordinate patient care. Therefore, the development of this model included the creation of the PCC role as an anchor to our
model of care in order to prepare nurses for emerging roles that are crucial for meeting current and future health care needs. PCCs serve as coaches, educators, coordinators and health advocates, have advanced care management skills and incorporate multidisciplinary models of care. They employ evidence-based strategies to deal with care coordination, patient engagement, medication reconciliation, behavior activation and management of care transitions to help make sure that patients get and stay healthy. They incorporate concepts such as social determinants of health, disparities, health literacy, demography, geographic provider access and personal risk-behaviors into risk stratification and care management strategies to develop a deeper understanding of the impact that these variables have on prevention, management and the overall trajectory of disease. Most importantly PCCs overlay evidence-based practice into these strategies and their care management plans.

*Health Coaching and Support*

A plan was developed at VNSNY to initiate a Health Coach Training Program for Partners in Care Home Health Aides, which will help retain Home Health Aides in the field, provide them with a viable career ladder, and ultimately provide patients with a higher quality of service. The Health Coach model is a community-based intervention for improving the health of “at risk” patients. In this model we are blending lessons learned from several evidence-based coaching models targeted at reducing re-hospitalization in an at-risk population. The Health Coach will address the roles of coach as proposed by Boddenheimer and Eric Coleman: self-management support, serving as a bridge between clinician and patient, emotional support and continuity. Improving health literacy and “demedicalizing” medical terminology with health literacy tools are also areas the Heath
Coach can impact. In the Co-Care 90 Partnership, the PCC deploys the Health Coach to the patient, based on a set of pre-determined criteria. The Health Coach engages with the patient both telephonically and face-to-face.

**Provider Activation and Engagement**

Communication channels and established pathways to “activate” providers into a patient’s care for problem oversight and intervention are paramount to this model. Information flow between the PCC and community providers is critical, particularly in the effort to fulfill early problem identification in order to avoid “ER as medical home.” This includes strong physician or nurse practitioner engagement by the community provider in the plan of care. Early engagement and adoption by the community physician is critical in establishing goals of treatment, transitions in plan of care or in setting, as well as in managing new onset of clinical need. Communication strategies include designated time internals of information sharing, hand-off tools, checklists, as well as structured scripting around clinical message delivery (i.e. SBAR).

**Financial and Clinical Outcomes Reporting/ Data Analytics**

The model must be financially sustainable; if the cost of the model is higher than the gain share and the model is effective, then it is not sustainable. Under BPCI, a proportion of payment to VNSNY is obtained by the reconciliation of CMS total cost of care for the target population based on established benchmarks, less an established percentage to CMS, less an additional percentage in administrative fees to convener organization and then the difference of upside gain sharing and downside risk sharing.
Financial sustainability is determined by measuring this aggregate number against the quarterly budget for BPCI (Cost/Gain share = margin). Therefore, this model needs to be balanced- cost and potential gain share. Total cost of care includes the direct clinical component of cost (service utilization), cost of intervention (model) and other administrative fees. A mechanism by which to produce and share knowledge of present clinical performance against a budget and resource allocation is an essential component of our model’s platform. In this way, work flows and processes are revised to incorporate findings. Using data to inform practice is essential. Clinical and financial dashboards, in combination with regular clinical management meetings, can be an approach to consider as part of an iterative strategy.

Conclusion

It is imperative in the rapidly changing U.S. health care system to work towards the reform of outdated payment and service models to reduce costs and improve patient care. Specifically, utilizing a 90-day model of care for CHF patients in home care under BPCI, with bundled episodic payments, can potentially improve the quality of care as well as reduce total cost of care. This article describes a basic blueprint for this model and may be applicable to other bundles. A description of organizational alignment, community-based partnerships, logistics and technologies engaged in the model is excluded from this article. Next steps in this journey include implementation and evaluation of the model. Evaluation must assess the degree to which the model is clinically effective and financial sustainable. We plan to evaluate the model using two outcome variables: 90-day hospitalization rate and resource utilization. This can be
achieved by reconciling the CMS claims data for the target population against margin (cost/gain share) for one performance quarter.
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