

Vanderbilt University Medical Center: Successes and Unexpected Challenges in a Cardiac Valve Replacement Bundled Payment Program

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This January 2016 Q&A is with Brittany Cunningham, director of Episodes of Care at Vanderbilt University Medical Center. She discusses the institution's engagement in the CMMI BPCI program, focusing on the Vanderbilt Heart and Vascular Institute's care-intervention efforts for patients receiving cardiac valve replacements.

Vanderbilt has accepted financial risk under BPCI since January 1, 2014. Can you describe how your care-redesign activities for valve patients evolved once Vanderbilt entered this program?

Our team used to heavily focus on the inpatient setting, ensuring that patients were maximally prepared for surgery and streamlining OR processes. However, under BPCI, we shifted our focus to managing patients throughout the post-discharge period. We redesigned patient education to ensure that patients were able to properly care for themselves post-discharge. Before BPCI, patients with valve replacements might be contacted after surgery, but there was no guarantee that this would happen. This practice is unacceptable under new models of care. Vanderbilt has established partnerships with and expectations for post-acute care [PAC] facilities; these partners are required to provide us with information to help better monitor and manage patients.

Can you expand on these "expectations"?

We have agreements with PAC facilities about the frequency and content of data sharing. For example, we ask facilities to weigh patients daily and to contact Vanderbilt if a patient experiences large fluctuations in weight, since this can be an indicator of heart failure or a more serious cardiac condition. Vanderbilt's care coordinators track this process and typically call the facility to ask for the patient's weight. If a large weight fluctuation is reported, the care coordinator can further assess whether a readmission is necessary or if the situation can be appropriately managed in the PAC setting.

It sounds like care coordinators play a central role in Vanderbilt's efforts.

Absolutely. The care coordinators are excellent. They can tell you every single patient's name, if they have been readmitted, why, and so on.

Bundled Payment for Care Improvement: Examples in Practice

To encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs, the Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payment for Care Improvement (BPCI) initiative. As of January 2016, the AAMC was supporting the efforts of more than 30 hospitals to implement BPCI through the AAMC Facilitator-Convener Group.

The Examples in Practice Series highlights the challenges faced, and strategies followed, by leaders at five health systems while participating in BPCI. These examples offer potential lessons for other academic medical centers pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing these payment-reform programs.

For more information on bundled payments, go to aamc.org/bundling.

What impact has this intervention had on patient care?

I believe that Vanderbilt's greatest success with the cardiac valve replacement population has been in reducing readmissions. During our three-year baseline period (2009–2012), this population's 90-day readmission rate averaged 41 percent. In 2014, this figure dropped to 32 percent.

That is fantastic! However, I know that, financially speaking, Vanderbilt has experienced mixed results with valve replacement under BPCI. In fact, your team ultimately opted to cease participating in BPCI with cardiac valve replacements at the end of 2015. How did you reach this decision?

It was not an easy choice. Vanderbilt dedicated significant time and resources to BPCI. We hired two care coordinators and spent a good year and a half setting up processes and teams, along with significant dedicated resources during the implementation period. Even after we were live, it took another 6 to 12 months to feel completely organized. You can't just flip a switch and be in this program. That being said, we felt we had strategically tackled areas for improved efficiency and savings and pursued most of our opportunities. While we continue to vigorously review readmissions, we usually conclude that the readmissions were clinically appropriate and could not have been prevented. We determined that in order to generate Medicare savings, we would have to invest resources we just didn't have. We'd be unable to generate a return on our investment, and the effort would be unsustainable.

While cardiac valve replacement may not have been the optimal bundle for Vanderbilt, Vanderbilt is still highly engaged in bundled payment programs.

That is correct! We are engaged in both commercial and Medicaid bundled payment programs. As of January 2016, 8 clinical populations are covered by Medicaid bundles, and the ultimate goal is 75 populations.

And you are still a BPCI participant. Vanderbilt remained in the program by accepting financial risk for two additional episodes in October 2015. Why did you decide to stay in BPCI?

Well, we must be clairvoyant because we chose to select risk for major joint replacement the day before Comprehensive Care for Joint Replacement (CJR), the mandatory bundled payment program, was announced. We are always evaluating which populations are prime for care interventions. Major joint replacement has always been at the top of our list, and we felt that it was only a question of when, not if, bundling for joints would become mandatory.

We also decided to take financial risk for stroke because we had already been proactively engaged with spine and neuro teams. Our stroke center has already done a lot around quality.

We understand that alternative payment models are the way of the future, and we are eager to learn as much as possible before additional programs are mandated.