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A Strategy to Meet the Heart Failure Needs of the Community

Mary Meyers-Marquardt, DNP, APRN-BC, ANP
I have no disclosures.

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Acknowledgements

Expert Advisors

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Heart failure (HF) epidemic illustrated by number of Americans with disease:

5.5 million with annual increase 700,000

As Medicare numbers increase so do hospital admissions for decompensated HF

HF admissions translate to increased mortality:

30% in 1st year and 60% at 5th.

Problem

2005-2010 Texas HF Statistics
Number of HF Hospitalizations: 362,000*
Average Hospital Charge: $30,000*
Total HF Hospital Charges: $11,000,000,000*

2007 Bryan/Brazos HF Hospital Charges
$15,000,000*

*numbers rounded (Texas Department of State Health Services
http://www.dshs.state.tx.us/ph/state.shtm)
Problem

St. Joseph Regional Health Center (SJRHC)

2011 HF admissions: 2570

78% of 2011 HF admissions lived in rural areas

(57% in 2012)

Avg. LOS: 3.4 days    Avg. reimbursement: $7000.00

2011 30 day readmission rate: 24.7%    2012: 21%

No outpatient HF program in 90 mile radius
Problem

2012 CMS 30 day HF readmissions penalty:

1%

Will increase in 2014:

2%
Partial Solution

SJRHC Inpatient Heart Failure Unit
Developed and implemented August, 2012
Unit reduced HF readmission rate 2012-2013
Effectiveness Studies: Outpatient HF Management Programs

Meet the following end points

• Increased quality-adjusted life years (QALY)
• Decreased resource consumption
• Improved functional capacity
• Increased compliance
• Prolonged survival

Limited Financial Incentives

“Rural Expansion to Address Chronic Heart failure”

Planned, innovative rural heart failure (HF) strategy

Developed and proposed by:
Mary Meyers-Marquardt, DNP, APRN-BC
ICIC’s Expanded Chronic Care Model

NP Directed Program Development: Necessary Components

Community Needs Assessment

Identification of Stakeholders & Program Champion

Develop Mission & Goals; Choose Service Model; Identify Available Resources

Negotiate with Interdisciplinary Team/Healthcare Members

Development of Pro Forma & Cost Benefit Analysis
Community Needs Assessment

A Systematic process:

to acquire an accurate, thorough picture of the strengths and weaknesses of a community

Can be used to:

collect and examine information about issues
utilize that data to determine priority goals
develop a plan
allocate funds and resources
Steps in Conducting Needs Assessments

1. Clarify the purpose of the needs assessment
2. Identify the population
3. Determine how you will conduct the needs assessment
4. Design a survey instrument or adopt one that already exists
5. Collect Data
6. Analyze Data
7. Use the results
Identification of Stakeholders

1. Identify Your Stakeholders
2. Prioritize Your Stakeholders
3. Understand Your Key Stakeholders

http://www.mindtools.com
Project Champion

A Project Champion:
Has the authority and commitment to ensure the project's success
Leads and directs the overall project environment
Assures the organization understands the project’s value
Is ready to receive and implement the project's deliverables
Negotiation with Interdisciplinary Team Members

Identify Team Members:
- Healthcare Team
- Project Champion
- Stakeholders
- Project Experts

Develop Relationships

Identify Project Needs from Members & the Team
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A Multidisciplinary HF Team

Nurse Practitioner
Nurses
Cardiologists
Pharmacist
Social Worker
Dietitian
Cardiac Rehabilitation Therapists
Home Health & Hospice Agencies

Stakeholders
Project Champion
Project Experts

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REACH® Development

Develop Mission, & Goals
Choose Service Model
Scope of Services
Model of Care
Identify Available Resources
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Mission

Provide excellent Heart Failure care to those diagnosed with the disease throughout the Brazos Valley
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Patient Outcome Goals

50% of participants will experience:
• Amelioration of HF symptoms
• Enhanced quality of life
• Improved adherence to medical therapy

25% of participants will experience:
• Improved functional health status

5% reduction in HF hospital readmissions
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Organizational Outcomes Goals

Increase quality & access to care
  Right Care at the Right Time by the Right Professional

Decrease costs
  Reduce HF readmissions & lessen ER visits
  Avoid or limit CMS readmission penalties
  Decrease RAC denials

Positive Pro Forma
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Implements evidence-based HF guidelines
Develops patient-specific plan of care
Supports patients, families, & significant others

• Incorporates regular, planned in-person clinic visits with scheduled telephone contact
• Promotes self improvement & self management
• Reinforces HF education at every visit
• HF Team available via phone or email
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Evaluates needs of each patient & intervenes to
- Coordinate transportation
- Provide walk in times for emergent care
- Assist in obtaining medical therapies such as scales, & pharmaceuticals
Address Palliation & End of Life issues early
Evaluate program interventions
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Provide rural patients care
“Closer To Home”
Compliments SJRHC Inpatient Heart Failure Unit
Allows for smooth transition from hospital to home
Patient Criteria

• Diagnosed with Heart Failure (Echo or Cath) HFP EF or HFr EF
• ACC/AHA Stage C or D
• NYHA Functional Class II or higher
Referral Sources:

- Hospital Heart Failure discharges
- Cardiology and PCP provider referrals
- Self-referrals
Stakeholder:
Nurse Practitioner of REACH®

NP Project developer with extensive inpt & outpt cardiac experience will:

• coordinate, lead, and manage HF care delivery in collaboration with cardiologists
• provide care for approx. 12 patients/clinic day
• initially function as program manager
St. Joseph’s Regional Health Center (SJRHC)

310 bed regional hospital
Level II Trauma Center
Brazos Valley’s only regional hospital
St. Joseph Health System (SJHS)
  7 rural outpatient clinics
  4 rural hospitals, 2 critical access
St. Joseph’s Regional Health Center (SJRHC)

Mission

“Provide excellent health care and promote wellness throughout the Brazos Valley”
Community of the Brazos Valley

7 counties

Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington

Approximate population

310,000*

Area

5,109 square miles
Central Texas Heart Center (CTHC)

5 cardiologists practicing at SJRHC
Committed to refer patients
Chief of CV Services
Champions of REACH Program
Advantages to SJHS & Providers

Allow for better efficiencies among providers
Improve care coordination & transitions
Provide overall higher quality of HF care
Has “First to Market” advantage
Provide the Right Care at the Right Time by the Right Professional
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5 Year Pro Forma

Developed Best/Worst/Most likely Scenarios Assessments based on “Most likely” Scenario

Initial incremental losses over the 2.5 years.

Positive Net Operating Income (NOI)

Year 4 (2016) $157,000*
Year 5 (2017) $370,000*

Internal Rate of Return (IRR) 22%
# REACH®
## 5 Year Pro Forma

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Likely</td>
<td>996</td>
<td>2,880</td>
<td>5,760</td>
<td>7,500</td>
<td>9,600</td>
<td>26,736</td>
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<tr>
<td>Worst Case</td>
<td>415</td>
<td>1,200</td>
<td>2,400</td>
<td>2,400</td>
<td>2,400</td>
<td>8,815</td>
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<tr>
<td>Best Case</td>
<td>1,660</td>
<td>4,800</td>
<td>9,600</td>
<td>9,600</td>
<td>9,600</td>
<td>35,260</td>
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<tr>
<td>Scenario</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
<td>Cumulative</td>
</tr>
<tr>
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<td>----------</td>
<td>----------</td>
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</tr>
<tr>
<td>Most Likely</td>
<td>(77,352)</td>
<td>(79,797)</td>
<td>(19,046)</td>
<td>156,572</td>
<td>370,138</td>
<td>350,515</td>
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<tr>
<td>Worst Case</td>
<td>(141,521)</td>
<td>(265,346)</td>
<td>(390,144)</td>
<td>(406,703)</td>
<td>(425,073)</td>
<td>(1,628,788)</td>
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<tr>
<td>Best Case</td>
<td>(4,016)</td>
<td>132,260</td>
<td>405,067</td>
<td>388,508</td>
<td>370,138</td>
<td>1,291,957</td>
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</tbody>
</table>
### REACH©

**5 Year Pro Forma**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>2013*</th>
<th>2014</th>
<th>2015**</th>
<th>2016</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>Total Revenue</td>
<td>$113,988</td>
<td>$329,604</td>
<td>$659,209</td>
<td>$858,345</td>
<td>$1,098,682</td>
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<tr>
<td>Total Expenses</td>
<td>$191,340</td>
<td>$409,401</td>
<td>$678,255</td>
<td>$701,773</td>
<td>$728,544</td>
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<tr>
<td>Net Income (loss)</td>
<td>($77,352)</td>
<td>($79,797)</td>
<td>($19,046)</td>
<td>$156,572</td>
<td>$370,138</td>
</tr>
</tbody>
</table>

*Represents 6 months only

**2nd NP & RN added

FY 2016 reflects 3% increase on all line items
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## 5 Year Pro Forma

<table>
<thead>
<tr>
<th>Cash Uses</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Costs</td>
<td>$56,630</td>
<td></td>
<td>$6050</td>
<td></td>
<td></td>
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<tr>
<td>Working Capital Requirements</td>
<td>$39,345</td>
<td>$43,909</td>
<td>$87,139</td>
<td>$83,152</td>
<td>$86,027</td>
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<tr>
<td>Total Cash Used</td>
<td>$95,975</td>
<td>$43,909</td>
<td>$87,139</td>
<td>$83,152</td>
<td>$86,027</td>
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<tr>
<td>Per Period Cash Flow</td>
<td>($163,971)</td>
<td>($75,005)</td>
<td>($52,055)</td>
<td>$164,359</td>
<td>$377,852</td>
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<tr>
<td>Cumulative Cash Flow</td>
<td>($163,971)</td>
<td>($238,977)</td>
<td>($291,031)</td>
<td>($126,673)</td>
<td>$251,179</td>
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</table>
Areas of Revenue Generation Not Accounted for in Pro Forma

Nutritional therapy
Lab procedures
Radiology & other procedures: Echos, CXR, EKGs
Cardiac Rehab
Oxygen therapy
Inpatient NP consults
Nursing interventions
REACH© Service Model

NP Led Clinic with Cardiology Collaboration

NP and two nurses will open the program

Scope of Services:

- NP to see avg of 12 patients/clinic day
- Provide IV diuretics & inotropes
- EKGs, POC testing
Nurses will

• perform HF nurse assessments & provide interventions.
• make “check in” patient calls, act as coordinator of medication assistance & track outcomes

AHA “Get with the Guidelines: HF” & ACC/IHI “Hospital 2 Home Quality Improvement Initiative”


NP & nurse will see patients in SJRHC satellite clinics

Initial target areas: Those with highest HF readmissions

2nd NP & nurse will allow for further satellite clinic expansion
Multidisciplinary Team Approach

- PCP
- Cardiology
- Hospitalist
- Cardiac Rehab
- PT
- Nutrition Support
- Home Health
- Palliative Care
- Hospice
- HF Patient & Family
- Nurses
- Case Managers
- Navigators
- Pharmacy

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REACH® Specifications

SJRHC volunteers initially enlisted to assist as receptionists

MA/receptionist hire projected first or second quarter 2014

Second NP& RN projected January 2015

Addition will allow for expansion to rural sites, home, & assisted living facility visits

Dependent on growth of Program
REACH©: Beneficial Strategies

Provider Based Clinic (PBC): allows for additional revenue/visit

Transitional Care Management for post-hospital discharged patients

Majority of patients Medicare eligible: 70%

NP reimbursement: 85% Medicare physician rate

Average Self-Pay: 5%
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Beneficial Strategies

Provide care to medically underserved & unfunded/underfunded thru FQHC partnership

Capitalize on SJRHC volunteers to lower initial costs
Increase SJHS Visibility

Provide HF education in Brazos Valley
Act as educational site for healthcare students
Conduct & disseminate research and QI
Expand Ancillary Services to rural HF patients
Compliment SJRHC Inpt Heart Failure Unit
Apply & obtain grants to aid operational costs
References


References


References


Thank You!