

# VA Heart Failure Network

9/13/2010

# Outline

- Potential VA HF Performance Measures
- Hospital to Home (H2H) Initiative
- Possible Aldosterone Antagonist Campaign

# Potential Heart Failure Performance Measures

- Inpatient (Similar to Medicare)
  - Denominator: principal diagnosis of heart failure discharged alive
    - Excluding consults to palliative care or hospice
  - Numerator -1 Readmission at 30 days (all cause)
  - Numerator-2 Mortality at 30 days

# Potential Heart Failure Performance Measures

- All Heart Failure Patients
  - Denominator: any encounter for heart failure in the prior 12 months
    - Excluding consults to palliative care or hospice
  - Numerator -1 Admission for heart failure during the next 12 months
  - Numerator-2 Mortality during the next 12 months

# Available Data: VSSC Website

## <http://vssc.med.va.gov/>


The screenshot shows the VSSC website in a Windows Internet Explorer browser window. The address bar displays <http://vssc.med.va.gov/>. The browser's title bar reads "U.S. Department of Veterans Affairs - VSSC (VHA Support Service Center) - Windows Internet Explorer".

The website header features the VSSC logo on the left and the text "UNITED STATES DEPARTMENT OF VETERANS AFFAIRS VHA SUPPORT SERVICE CENTER (VSSC)" in the center. A search bar is located on the right side of the header.

The navigation menu includes the following items: [Blog](#), [My Metrics](#), [My VSSC](#), [News](#), [Portals](#), [Support](#), [Training](#), and [User Acceptance Testing](#).


The main content area is organized into several sections:

- Index:** A list of letters from A to W, with '2' as the first item.
- Business Operations:** Contains links for [Metrics](#), [City Profile](#), [S](#), and [Improvement Opportunities Pack](#).
- Capital and Planning:** Contains links for [Capital Reports](#), [Planning Reports](#), [Capital Portal](#), and [Planning Portal](#).
- Clinical Care:** Contains links for [Clinical Programs](#), [Nursing Outcomes \(VANOD\)](#), [Physician Productivity](#), [Primary Care Panel Management \(PCMM\)](#), and [OPES Portal](#).
- Announcements:** A list of recent updates:
  - 9/3/2010 ProClarity Cut Moving - Requires customer action [more»](#)
  - 8/30/2010 Patient Cent Medical Home renamed Patient Aligned Care Teams [more»](#)
  - 6/22/2010 PCP Panel C has been fixed [more»](#)
  - 6/7/2010 High Risk for Suicide Performance Monitor [more»](#)[all announcements»](#)
- Other Service:** A partially visible section.
- Quality & Performance:** A partially visible section.
- Resource Management:** A partially visible section.

	<a href="#">Primary Care Panel Vs Capacity Vs Modeled Panel Size</a>	Displays information about the two performance monitors related to primary management. Details the adjusted observed panel size, adjusted capacity, a capacity. Provides drill through reporting from VISN to provider level with sel include or exclude contract CBOCs in calculations. Reports exportable to Exc
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D OMAIN: Q UALITY AND P ERFORMANCE

P ROGRAM A REA: P ERFORMANCE M EASURES AND M ONITORS

TYPE	PRODUCT NAME	DESCRIPTION
	<a href="#">Chronic Heart Failure Reporting (Pilot EMeasure)</a>	A series of 4 reports measuring Chronic Heart Failure care. This is a pilot m undergoing user testing and data validation. The initial report contains summ all users have access. The remaining reports require SSN level access to wo

D OMAIN: S PECIAL FOCUS

P ROGRAM A REA: T RANSFORMATION I NITIATIVES

TYPE	PRODUCT NAME	DESCRIPTION
	<a href="#">Transformational Initiatives Dashboard</a>	This report will assist the field in tracking progress on the implementation of key Transformational Initiatives. The majority of these are related to the ob funds in the different areas, and also contains the ACP score, PCMM staffing

P ROGRAM A REA: W OMEN V ETERANS H EALTH



[https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/OQP/HeartFailure/CHFMeasure](#)
Live Search

File Edit View Favorites Tools Help

CHFMeasureSummary - Report Viewer

Select VISN: 
 Select Facility:

Select Quarter:

1 of 1 | 100% | Find | Next



## Chronic Heart Failure Measure Summary

\*\*\* Currently in user testing and data validation phase. To participate in user testing, please click here \*\*\*

Last Discharge Included:

- [VSSC Help Desk](#)
[Data Definitions](#)
[Measure Detail](#)
[Risk Score](#)
[Admissions](#)

8/25/2010

The first table addresses the performance measure cohort. Heart failure patients NOT receiving palliative care. Heart failure patients are counted once for each facility/level if they have a heart failure diagnosis in the last year, beginning with the fiscal quarter starting date. A patient may have multiple admissions with a heart failure diagnosis during that period, but is only counted once. If a readmission occurred within 30 days of any CHF discharge, the patient is considered to have a readmission within 30 days of discharge for the entire reporting period.

Unique Heart Failure Patients Not Receiving Palliative Care (Measure Population)	Total	VA Admissions for Heart Failure	Heart Failure Patients Readmitted (All Cause) within 30 Days of Discharge	Heart Failure Patients Deceased in the Past Year	Heart Failure Patients Deceased within 30 Days of Admission
VHA	379,561	32,086 8.5%	7,156 22.3%	28,008 7.4%	2,106 6.6%
V21	13,752	1,242 9%	252 20.3%	1,129 8.2%	112 9%
(V21) (640) Palo Alto, CA	3,076	296 9.6%	48 16.2%	301 9.8%	18 6.1%



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# Hospital to Home (H2H) Excellence in Transitions

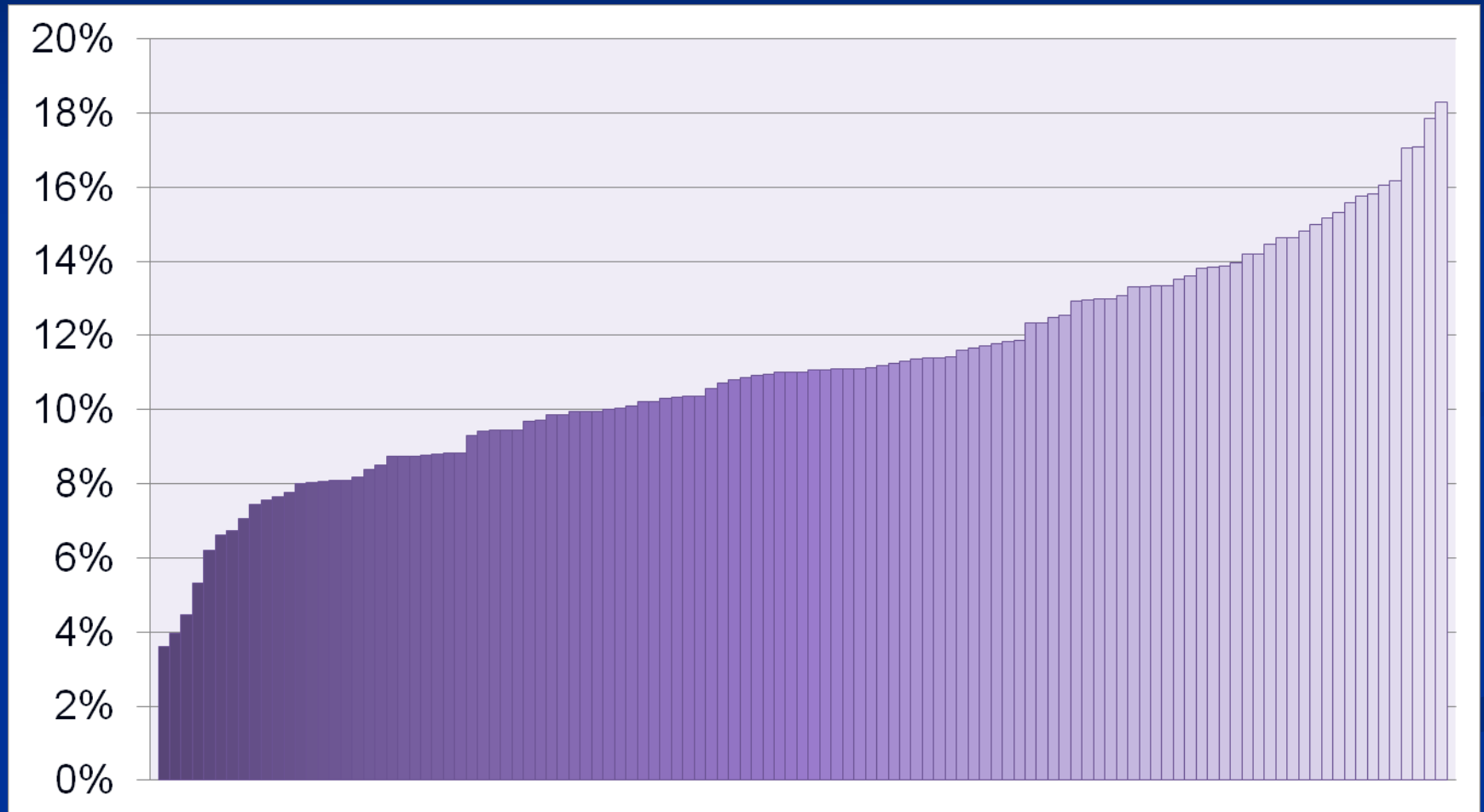
## VA CHF QUERI



## What is H2H?

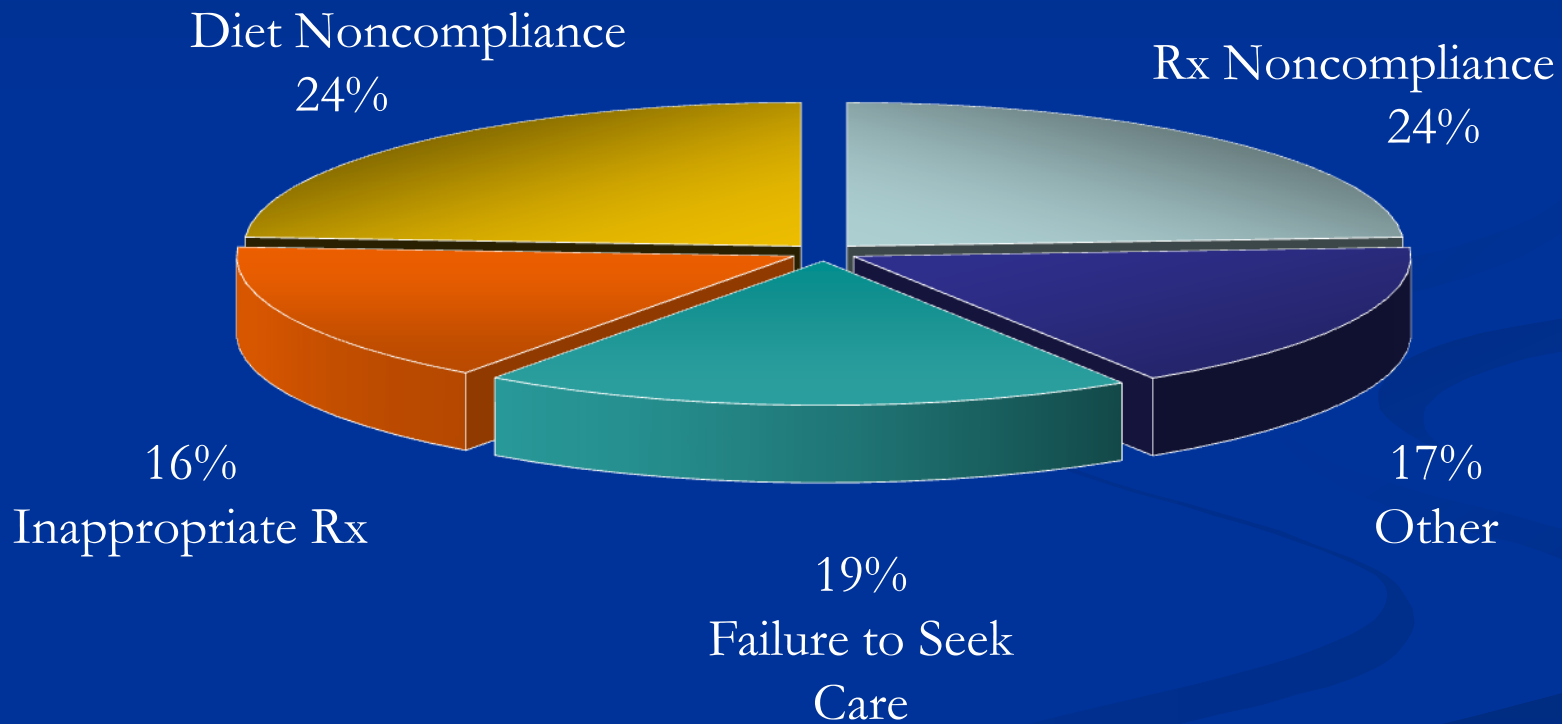
- H2H is a national quality improvement initiative to reduce unnecessary readmissions for cardiovascular patients
- Goal is to reduce all-cause re-admission rates among patients discharged with heart failure or acute myocardial infarction by 20% by Dec 2012

# 30 Readmissions (HF Principal Dx) Distribution for VA Facilities



Excludes Facilities with < 100 HF discharges over 2 years.

# Potential to Prevent HF Hospitalizations



## 3 Question Framework

- **Medication Management Post-Discharge:** Is the patient familiar and competent with his or her medications and is there access to them?
- **Early Follow-Up:** Does the patient have a follow up **appointment** scheduled within a week of discharge and is he or she able to get there?
- **Symptom Management:** Does the patient fully comprehend the signs and symptoms that require medical attention and whom to contact if they occur?

## How is the VA Involved?

- The Undersecretary for Health has signed a letter offering support as a Strategic Partner.
- However, each facility needs to join separately.



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## Who Can Join?

Hospitals are the focus. Our goal is to have each VA inpatient facility involved.

However, anyone committed to reducing unnecessary readmission is a welcome participant.



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# Participant Commitments

- **All Participants**
  - Implementing a quality improvement program
  - Contributing to and learning from the community
- **“ Fully- Committed” Participants (Facilities)**
  - Obtaining Administrative Support
  - Assembling an Improvement Team
  - Developing an Improvement Plan
  - Reporting on Progress



## How Does My Hospital Join?

- A representative goes to [H2Hquality.org](http://H2Hquality.org) and fills out an online form indicating your facilities commitment to reducing readmissions.



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## How Much Does it Cost?

- It is free to participate.
- Your facility will need to allocate resources as needed for any intervention aimed at reducing readmission rates.

# What Are the Incentives for My Director?

- Hospital specific heart failure (and MI) readmission rates will be reported (performance measure)
- Reduced readmission rates should reduce costs.
- Undersecretary for Health has signed the VA up as a strategic partner
- Patient Care Services is recommending Enrollment



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# What Are the Incentives for the Heart Failure Provider?

- Opportunity to have your Director increase funds for heart failure care.
- Involvement with a large community dedicated to improving heart failure care.
- Webcasts and online tools.



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# What is Expected of Participants

- I Obtain Administrative Support
- II Assemble an Improvement Team
- III Develop and Improvement Plan
- IV Report on Progress through periodic responses to brief surveys

# What Can I Do to Encourage My Facility to Enroll?

- CHF QUERI will provide data on your current readmission rates.
- Go to your administration with a list of talking points, ideas for improving care.
  - CHF QUERI will provide a draft talking point list, will be available for consultation
- Agree to lead/contribute to the effort for your facility.

# Potential Campaign to Improve Aldosterone Antagonist Use

- Use is low in those without a contraindication
  - 35% in US registries (similar in the VA)
  - NNT 19 over 1 year to save 1 life
- Indication may soon expand to mildly symptomatic
  - EMPHASIS-HF (Eplerenone in Mild Patients Hospitalisation And Survival Study in Heart Failure) stopped early for benefit
  - NYHA class II, LVEF $\leq$ 30%.



# Potential Resources For Increasing Aldosterone Antagonist Use

- Webinars for interested providers
- Protocol for Initiation/titration
- Slide Set for talks
- Local pharmacist involvement
- Patient Activated Care Team
- Notes placed in Echocardiography Report
- No Industry involvement

# Discussion