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Learn
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Lead

National Bundled Payment Summit 2014

Clinical Redesign

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Our Questions

- What barriers to sustainable care redesign have you found in the bundled payment program to date?
- In which areas of the clinical spectrum have you seen the most robust redesign? What are the most robust interventions?

Today's Foci

- Early lessons learned at AAMC
- Care redesign survey and results
- Staffing experience to date
- Evidence base for our next steps

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Early Lessons: What's Making the Difference for Patient Quality and Cost

- Weekly meetings with all heath system providers, identifying both system and case-specific opportunities for improvement
- Stop doing things where there is no evidence (example: OT on all hip replacement patients)
- Consistent pharmacist reconciliation process
- Changes in key processes such as DVT protocol
- Listen to after-hours requests; teams are learning from the nature of the call content and patient needs
- Resident education on the most common post-op complications; mandated attending physician contact prior to resident driven readmission
- Improved emergency room relationships and protocols
- FQHCs and palliative care have become partners
- Standardized risk assessments by episode condition and for all patients

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Questions Asked in the Care Redesign Survey

1. Standard risk screening tool use on ALL patients? Tool?
2. Three interventions most effective in readmission reduction
3. Biggest barriers to reducing readmissions
4. Interventions most effective in reducing overall cost of episode
5. Biggest concerns and barriers to further cost reduction
6. Interventions most effective in managing PAC setting selection based on patient condition
7. Barriers in managing the PAC period

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Survey: Care Redesign Among AAMC Bundlers

Common Effective Intervention Themes:

- Pre-admission screening and risk assessments (including BOOST, utilization of STS score and KATZ for functional assessment, HOOS/KOOS, LACE assessment on targeted inpatients, internal "Bridge Report")
- Pre-admission education for patients and caregivers
- Establishing care pathways and discharging to appropriate post-acute setting
- Advanced discharge planning and shifting discharge patterns
- The effective use of care coordination
  - Post-discharge calls and visits
  - Coordination with PCPs, especially those patients with multiple or complex co-morbidities
- Virtual and in-person meetings with PAC providers on BPCI patients
  - Joint QA forums
  - Readmission reviews
- Reduction of waste and managing costs (cath lab, pharmaceutical review, device costs)

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Survey: Care Redesign Among AAMC Bundlers

Common Barrier Themes:

- Multiple or complex co-morbidities, including psychosocial complexities
- Actions of non-partner providers in other settings; coordination of clinical practices and processes in community support services
- Consistent EMR across care continuum
- Communication with post-acute providers (in hand-offs and throughout the episode)
- Predicting risk and early patient identification
- Organization buy-in to changing care environment; the need to change the setting in which care has typically been provided (shift to care delivery in outpatient setting)

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AMC Themes on Continuum of Care Interventions

	HOSPITALIZATION						POST-HOSPITALIZATION PERIOD							EPISODE WIDE								PRIMARY			
	Standardized processes of care/guidepaths/checklists/order sets	Identification of high-risk patients	Waste reduction/patient safety and error reduction	PCP Connectivity	Readmission reduction interventions	Patient eduction advances	Standardized process of care/guidepaths/checklists	Improved discharge/transition summaries	Patient education advances	Patient compact and engagement	Post-acute care risk assessment	Immediate post-discharge interventions	Miscellaneous interventions	IT systems innovations	Process improvements	Care coordination	Staffing leadership of BPCI	Physician engagement strategies	Patient access and expectations	Staff and broader education	Psychosocial interventions	Role of caregivers/family members	PCP communication	PCP expectations	IT solutions
Org 1						x		x			x	x	x	x	x		x		x							
Org 2	x	x	x		x	x	x	x	x	x	x	x			x			x			x		x		
Org 3	x	x			x	x		x				x	x	x	x	x	x	x		x	x	x	x	x	x
Org 4	x	x			x	x	x	x		x	x	x		x	x	x	x	x	x	x	x	x			x
Org 5	x		x				x					x	x			x									
Org 6		x					x	x	x			x	x				x								
Org 7	x	x	x	x	x	x	x	x	x		x	x		x	x	x	x	x		x	x	x	x	x	x
Org 8	x	x	x			x	x	x	x	x		x	x	x	x	x	x			x			x	x	x
Org 9			x		x										x										
Org 10	x	x		x	x	x	x	x	x		x	x			x	x		x		x			x		

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AAMC Bundler Staffing Survey

1. Number of staff (RN, CC, Admin, MD, etc.) working on bundled payment at any level
2. Approximate FTE count for ALL STAFF working on bundled payment
3. Number of staff for whom bundled payment represents more than 75% of their individual effort
4. Number of unique episodes you are implementing
5. Number of care management staff dedicated PRIMARILY to bundled payment ; our staffing ratio is approximately 1: X

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Bundled Payment Staffing Survey

Organization	# of Staff at any Level	Approx. FTE Count For All Staff	# of Staff for Whom Bundled Payment Represents >75% of Their Individual Effort	# of Unique Episodes Being Implemented	# of Care Management Staff Dedicated Primarily to Bundled Payment	Staffing Ratio
Org 1	7	1	0	1.5	0	
Org 2	12	7.5	6	3	5	240
Org 3	6	1.25	1	2	0	
Org 4	12.5	2.5	2	1	2	55
Org 5	12	2	1	1	1	100
Org 6	14	0.5	0	1	0	
Org 7	18	3	1	3	0	
Org 8	8		0	2	3	100
Mean	**11.2**	**2.5**	**1.4**	**1.8**	**1.4**	**123.8**
Median	**12.0**	**2.0**	**1.0**	**1.75**	**0.5**	**100**

- **Mean # staff at any level =11.2, only 1.4 primary responsibility. Significant variation in staffing ratio for CM. (1:55-1:240). Correlation between dedicated FTE and number of unique episodes (0.6 FTE staff/episode)**

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Items for Further Research

1. What are the most robust interventions for the highest risk patients?
2. How do we quickly disseminate lessons learned for Bundlers?
3. What are the most effective models for linking PCMH-PAC-hospital-community?
4. What are the qualifications/positions of those who spend the most time leading and staffing bundled payment programs?
5. What costs are fixed vs. variable in adding additional bundles and/or beneficiaries?
6. Does the staffing ratio for care management change based on the episodes chosen (i.e., medical vs. surgical bundles) or case mix?
7. Does the staffing ratio and/or staffing mix impact quality of care delivered, patient outcomes, or savings generated?

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