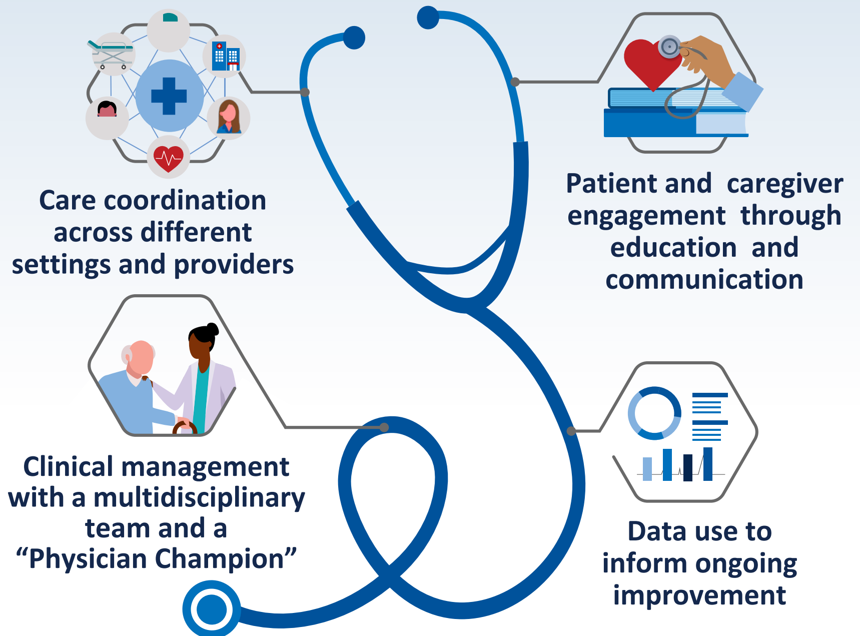
Strategies for Success in Bundled Payments

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is an episode-based payment model that aims to bring a coordinated approach to a beneficiary's needs during a 90-day Clinical Episode. A Participant in the BPCI Advanced Model is the accountable party in this total-cost-of-care concept.

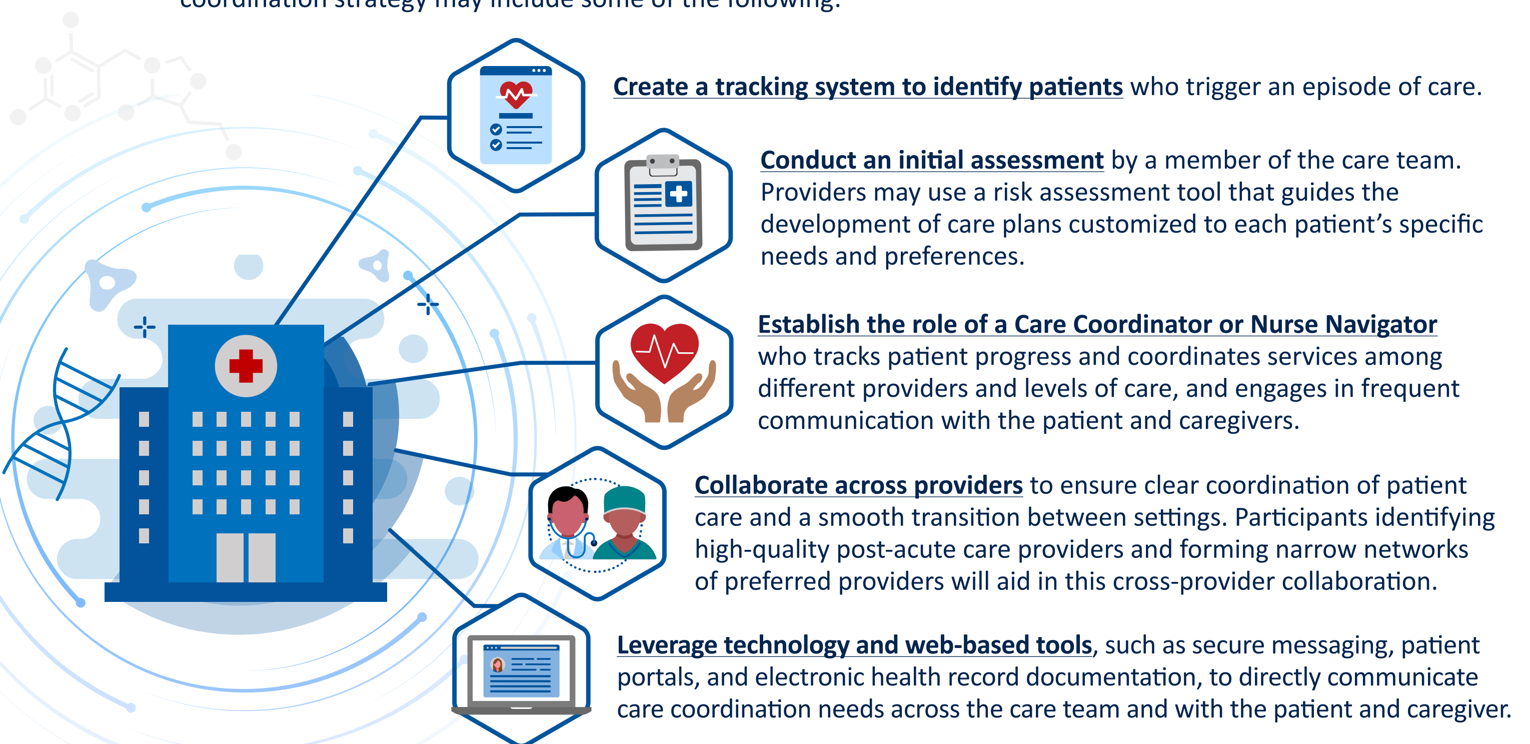
The CMS Innovation Center has been testing episode-based payment models for more than ten years. During that time, CMS has gained valuable knowledge related to the factors that may contribute to success for organizations invested in practice innovation and care redesign. This infographic presents a collection of strategies and tactics with the hope to provide Medicare beneficiaries with coordinated care while improving quality and decreasing costs.

Four strategies that may drive strong performance within episode-based payment models are:



1 CARE COORDINATION ACROSS DIFFERENT SETTINGS AND PROVIDERS

Care coordination is highlighted by BPCI Advanced Model Participants as one of the most impactful efforts for sustaining patient care improvement processes when transitioning to value-based care. An effective care coordination strategy may include some of the following:



Create a tracking system to identify patients who trigger an episode of care.

Conduct an initial assessment by a member of the care team. Providers may use a risk assessment tool that guides the development of care plans customized to each patient's specific needs and preferences.

Establish the role of a Care Coordinator or Nurse Navigator who tracks patient progress and coordinates services among different providers and levels of care, and engages in frequent communication with the patient and caregivers.

Collaborate across providers to ensure clear coordination of patient care and a smooth transition between settings. Participants identifying high-quality post-acute care providers and forming narrow networks of preferred providers will aid in this cross-provider collaboration.

Leverage technology and web-based tools, such as secure messaging, patient portals, and electronic health record documentation, to directly communicate care coordination needs across the care team and with the patient and caregiver.

2 CLINICAL MANAGEMENT WITH A MULTIDISCIPLINARY TEAM AND A “PHYSICIAN CHAMPION”

Another strategy that aids in the successful implementation of care redesign efforts within an organization is the addition of clinical management. A valuable clinical management strategy may include some of the following:

Build a multidisciplinary team of diverse professionals that collaborate to deliver patient-centered and coordinated care.

Identify a “Physician Champion” that will engage with fellow physicians to make collaborative decisions on clinical approaches and create buy-in and support for the care redesign processes.

Implement care pathways or protocols that standardize care from beginning to end for patients and care team members.

Educate all team members on targeted conditions and treatment to ensure standardized care protocols are understood and followed.

Use alerts in the electronic health records to notify team members if a specific criterion or need is highlighted.

Deploy a rapid response team for select, high-risk clinical conditions that understands and adheres to Participant protocols on clinical approaches and patient-centered care.

3 PATIENT AND CAREGIVER ENGAGEMENT THROUGH EDUCATION AND COMMUNICATION

Participants have also found that education and frequent communication empower patients and caregivers to take an active role in their care journey and support shared decision-making to achieve desired health goals. When possible, Participants are preparing patients to recover at home and are re-setting provider expectations to encourage a “Why Not At Home?” mindset. Tactics for engaging patients and caregivers may include:

- **Understand patients’ needs and set expectations up front** to promote patient choices. This enables care teams to create realistic care plans for optimal outcomes for the patient and meet the individual’s preferences.
- **Identify a family member caregiver or community resources** to provide support pre- and post-discharge. If a patient does not have a caregiver, consider how to connect the patient with additional support services such as social workers, mobile health teams or community paramedics to conduct home visits.

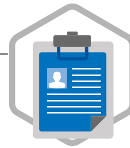
- **Share educational materials with patients and caregivers** to inform discussions about procedures, care plans, and post-acute care. Provide educational resources to patients and caregivers in a variety of formats and languages to meet their preferences.
- **Make services easily accessible and provide patients with care team contact information** to improve patient access to care. This allows patients and caregivers to receive the care and support they need when they need it.

4 DATA USE TO INFORM ONGOING IMPROVEMENT

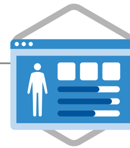
Data tracking and analysis have been an integral part of the improvement process for Model Participants in sustaining change and achieving care redesign goals. Data-driven improvement strategies include:

Develop a data-informed culture by keeping data at the forefront of decision-making and process improvement discussions.

Analyze CMS claims data for Clinical Episodes triggered in the Model to gain insights into cost and quality of care and help inform areas of improvement for managing high-cost episodes and readmissions.



Collect process and outcome measures at the individual and provider levels to track the quality of care and patient outcomes.



Use data tools such as dashboards, reports, or scorecards to visually display analysis outcomes, such as length of stay and readmissions, and identify performance gaps and ultimately sustain positive change.

Stand up clinical steering committees or workgroups to review data, define relevant metrics to measure impact, and sustain engagement in care redesign efforts.

BPCI Advanced aims to provide Model Beneficiaries with efficient, coordinated care during a 90-day Clinical Episode. The four strategies outlined above offer strategies for successful implementation of this approach. Organizations may focus on different tactics at different times based on patient populations, local community needs, and care transformation goals.