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Workgroups to Drive Sustainable Success: Preparing for the Evolution of Cardiac Bundles

By Shane Recker

The Cardiac Bundle Program has been a hot-button issue in healthcare for the last several months. With the announcement of its cancellation in September, the Centers for Medicare and Medicaid Services (CMS) have drawn both ire and praise from physicians and hospitals across the country.

Many health systems that were placed in the mandatory cardiac bundle program spent considerable amounts of time and money redesigning processes and changing standards of care in preparation for this new initiative. These progressive hospitals did so in hopes of taking advantage of the bonus repayment (awarded by the CMS) if their region's fixed-cost target and certain quality metrics were met. Understandably, these health systems that are now prepared for the implementation of bundled payment are not pleased with the decision to cancel it. However, in the long run, the systems that began making such changes will ultimately be rewarded; Corazon believes healthcare will continue to move away from the current fee for- service system to some evolving form of bundled payment.

We have already seen successful cost reductions from bundles in joint replacements, and large private payers have taken notice. For example, Humana, a private insurer, has already partnered with several orthopedic groups to set up a bundled payment program.[1]

Meanwhile, the modern consumer is becoming increasingly aware of the value of the product or service they are purchasing. Now more than ever, patients are more likely to look at a hospital or provider's quality outcomes before choosing where to receive care. Those that have been improving their quality scores and lowering their costs will reap the benefits of attracting these patients. The methodology with a cardiac bundle works to ensure better care at lower overall cost, and, although implementation has been cancelled at this time, bundling, in one form or another, will no doubt continue as part of the move to a value-based healthcare system in the United States.

Corazon anticipates private payers beginning to pay based on episodes of care rather than the traditional fee-for-service system in the cardiac realm. This means that even though the most recent proposed bundled payment initiative has been cancelled, preparing for episodic payment models remains vital.

Corazon believes that the most effective way to achieve higher quality while simultaneously lowering costs is by forming a Bundled Payment Steering Committee (BPSC). This committee, consisting of a mix of high-level administrators and physicians, should be responsible for the overall direction and decision-making for the bundled payment preparation. A BPSC operates with the philosophy of "as issues climb up the chain, our guidance flows down." This committee should be tasked with forming three workgroups (as shown in Figure 1) that include more 'boots-on the- ground' type employees in the hospital. The BPSC decides who is a good fit for each workgroup based on a number of different factors, including job titles, responsibilities, and personalities. The workgroups, which should be formed sequentially over a six-month timeline (Figure 2), address specific components that will prepare the hospital for a transition to a value-based system.

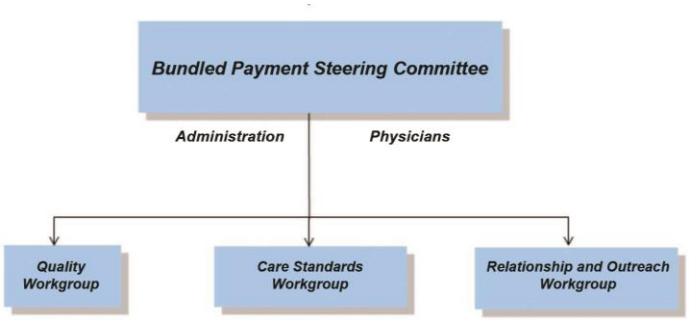

Figure 1. The three workgroups of the Corazon's suggested Bundled Payment Steering Committee (BPSC) address specific components that will prepare the hospital for a transition to a value-based system.

The Quality Workgroup focuses on care delivery and outcomes through analysis of hospital and regional quality and cost data, and identifies any opportunities that may exist to improve. In Corazon's nationwide experience with best-practice standards of care, we often find opportunities for improvement in documentation. It isn't rare that we see a hospital offering quality care, but without reflection in their quality score. Lots of times this is due to a breakdown in communication between the coding department and the abstractors who are responsible for reporting outcomes.

Figure 2. The BPSC workgroups should be formed sequentially over a six-month timeline.

This is one example of why it is critical to form a Quality Workgroup — once everyone is on the same page, they work to achieve the same goal. Otherwise, addressing quality metrics can be difficult and complex. From a cost standpoint, it is important that the group look at controllable measures, such as length of stay and discharge disposition, and then discuss how changes can be made in order to improve these measures. Looking at the cost goes hand-in-hand with quality, especially since the bundle encompasses the entire episode of care.

As previously pointed out, quality is such an enormous factor in the new bundled system, because it is now garnering more attention from consumers than it historically has in the past. Patients are willing to bypass hospitals that might be convenient in order to reach hospitals that provide better care, regardless of distance or other potential hardships. This is certainly a major shift from traditional patterns. With publicly available quality scores produced by Healthgrades and CareChex, it is now easy for a patient to check on a hospital's score, and use that information to decide where to seek care. The reported scores typically have a lag time of several months, if not years, so it is vital for hospitals to avoid delaying any improvements.

Implementing standardized processes across the health system will be crucial to an organization's success. Therefore, Corazon recommends the formation of the second assembly, the Care Standards Workgroup. This workgroup should be responsible for the standardization of the patient care continuum for each episode. Patients should expect to receive the same high level of care, regardless of the facility or provider within the system. By having this workgroup really dig deep into an organization's current processes and protocols, whether it be for acute myocardial infarction (AMI) or coronary artery bypass graft surgery (CABG) episodes, the results can help to ensure confidence in the care that patients receive across the multi-site continuum; thus, any surprises in quality scores are avoided in the short term.

Corazon endorses a strategy of having two patient care coordination plans — one for AMI episodes and one for CABG episodes. These plans should be finalized after current plans are heavily scrutinized by the workgroup. Guidelines such as order sets and care pathways should also be examined to determine if and how improvements can be made. We also recommend that the group look at the discharge disposition of the patients (which will also affect the last workgroup, described below). We often see the Care Standards workgroup face the most opposition, because of attempts to get physicians to be part of a more standardized process when delivering care. Usually this means a physician who has his or her own order sets or protocols must be brought on board with a system-wide process, which can be challenging. Therefore, it is crucial that this workgroup be persistent when addressing any changes that need to be made with physicians.

The third and final group that Corazon advises forming is the Relationship and Outreach Workgroup. As we mentioned above, this group's primary concern is the discharge disposition of the patient, but it also involves the hospital's relationship with the care setting (when patients leave the hospital), such as skilled nursing facilities, long-term care hospitals, rehab facilities, etc. Since the healthcare industry is moving toward episode-based care, the relationships that hospitals have with these facilities cannot be understated.

The Relationship and Outreach Workgroup must develop strong relationships with post-hospital settings that encompass the final phase of care, sometimes for the short term, but other times for a longer duration of care. Not only will this reflect in the quality scores (when it comes to metrics like readmissions), but as long as there is a smooth transition to these facilities and appropriate care is provided, patients will stay within the health system for future care. Thus, that smooth transition from hospital to post-acute facility requires attention from the Relationship and Outreach Workgroup. We recommend forming transfer agreements with each post-acute setting.

Also, a provider model should be created and agreed upon by the hospital and facility, so that the patient will continue to receive care at the facility that is consistent with what they were receiving at the hospital.

With the formation of these three important workgroups, hospitals will be well prepared for the future of the cardiac specialty as it continues to shift away from fee-for-service care. As time goes on, bundling in one way or another will continue…and a lack of preparation will cause a hospital setback in terms of attracting and/or best treating patients. Consumers are much more in touch with getting the best care for their healthcare spending, so future strategies in terms of high-quality; low-cost offerings that span the continuum will grow in importance as the financial landscape evolves.

Kali Klena, of IBM, points out that "Consumers will expect anytime access to the information, products, and services they want. And those retailers that deliver what they demand will thrive."[2] This could not be more accurate for healthcare providers, too, as it will be absolutely critical to keep patients satisfied as a precursor to sustained viability. With growing use of social media for all age groups, and the speed with which news travels — whether good or bad — patient satisfaction should be a companion goal as well. Preparing your hospital for the future of value-based healthcare is a path to achieve these and other important goals for optimizing the cost and quality equation.

References

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