

NYU Langone Medical Center: Filling Data Gaps— How NYU Harnessed Internal Data to Successfully Implement Medicare Bundled Payments

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This Q&A, from February 2016, is with Lily Pazand, director of Managed Care Payment Reform at New York University (NYU) Langone Medical Center. She discusses how NYU dealt with the time lag in Medicare data by building new reports in Epic. NYU is currently accepting financial risk for major joint replacement of the lower extremity, coronary artery bypass graft (CABG) surgery, and cardiac valve replacement under the BPCI initiative.

As part of BPCI, NYU receives Medicare claims data about its BPCI patients. However, NYU has invested a great deal of time and resources in creating customized reports in Epic about BPCI patients. Why did NYU undertake this work?

While the Medicare-provided data are extremely useful, BPCI participants generally do not receive claims data for a service until three to six months after the delivery of care. This time delay presents major barriers to implementing timely care interventions and to adequately engaging physicians by allowing them to track their own clinical and financial progress. We needed to track patients in real time, so we engaged our Epic team to build reports that would help clinical care coordinators identify and track BPCI patients.

How did NYU develop a system for patient tracking?

The first step is to identify the patient prior to surgery—either preadmission, if elective, or at admission, if emergent. However, since BPCI patients are defined by their inpatient DRG [diagnosis-related group], this is not a simple task. We examined Epic scheduling reports that document every patient scheduled for a given procedure, and we identified the procedures that most often fall into the BPCI episode DRGs. Now, each day, Epic sends NYU's BPCI team an email listing all patients scheduled for these identified procedures, as well as all patients currently in-house for those procedures. In addition, these patients appear on care coordinators' home screens daily. We have found that our predictive model is able to identify 96 percent of BPCI patients.

Bundled Payment for Care Improvement: Examples in Practice

To encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs, the Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payment for Care Improvement (BPCI) initiative. As of January 2016, the AAMC was supporting the efforts of more than 30 hospitals to implement BPCI through the AAMC Facilitator-Convener Group.

The Examples in Practice Series highlights the challenges faced, and strategies followed, by leaders at five health systems while participating in BPCI. These examples offer potential lessons for other academic medical centers pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing these payment-reform programs.

For more information on bundled payments, go to aamc.org/bundling.

That is fantastic! How do care coordinators use this patient list?

Well, the other change Epic implemented was keeping patients in the care coordinators' registry for 90 days post-discharge. This was a foreign request—our Epic team had never programmed a 90-day end date. Once this task was complete, care coordinators essentially had a working call list. Epic would ping care coordinators with a reminder like, "It's been a week. Time to call this patient." Epic also listed the patient's location and corresponding contact information so the care coordinator would know to call either the patient's home or a particular nursing facility.

The final piece was readmissions. While it's obvious when a patient has been readmitted to NYU, care coordinators tracked readmissions to outside facilities. We built new documentation sheets in Epic for such instances that include readmission fields—date of readmission, reason for readmission, etc.

How is the data translated to frontline clinicians and executive leadership? How have the data affected care delivery?

Managed care analysts extract the data from Epic and make them more visually appealing. We create color-coded charts and tables that allow physicians to quickly recognize key trends. Such trends are not immediately apparent in Epic, so there is definitely an extra step on our part.

Often, surgeons are surprised to see that their patients readmit at a higher rate than they expect. We use this information to help focus physicians. They are now more

engaged in preventive activities such as infection prevention and managing cardiac conditions. Also, care coordinators will approach physician leadership if they identify problematic trends, such as an increase in readmissions after day 40 post-discharge.

It appears that care coordinators are integral to this effort and that a lot of their time is spent tracking patients through phone calls. That seems like a big shift from serving as a nurse providing clinical care. Is that accurate?

Yes. Our care coordinators spend much of their time speaking on the phone to patients, post-acute providers, surgeons, and others on the care team, as well as ensuring that all calls are well documented in Epic, and this is quite a change for most of them. We hired five care coordinators for our major joint replacement episode and one care coordinator for cardiac episodes. I believe that they are excited to be engaged in a new initiative that requires enhanced engagement with surgeons and post-acute care providers.

Does NYU intend to build any additional BPCI-specific Epic reports? Has your team incorporated risk-identification capabilities?

Our current BPCI-specific Epic reports are always evolving as we decide to add new fields or data elements based on feedback from care coordinators and the analytics team. There are no current plans to build any additional reports. However, our team has incorporated risk-identification capabilities. We have built a readmission-risk tool that highlights patients on the BPCI patient registry within Epic who are at high risk for readmission. The intensity of services we provide for that patient, especially post-discharge, is greater than for lower-risk patients. We believe that identifying high-risk patients is key for succeeding in alternative payment models, because providers have finite resources and need to strategically target services to those patients in greatest need.