The Physician Organization Perspective: Best Practices in Bundled Payment Implementation

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SIGNATURE MEDICAL GROUP

- Multi-specialty physician group in St. Louis and Kansas City with 165 physicians and 450,000 annual patients
- Awardee Convener in the CMS Bundled Payments for Care Improvement (BPCI) initiative
- Convener for Largest Orthopedic Bundled Payment Initiative
Signature BPCI Awardee Convener Scope

- 26 States
- 60 Cities
- 50+ practice groups
- 50,000+ annual episodes
- 2,000 surgeons
- 385 hospitals
- $1.3 billion annual spend
32%

National reduction in PAC costs for 90-day episodes

BPCI adverse outcome reductions

- Pulmonary Embolism during Index: 80%
- Surgical site infections: 60%
- DVT during Index: 60%
- UTI during acute stay: 60%
- Acute MI within 7 days: 40%
- Readmissions within 30 days: 33%

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Signature Convener Results: PAC costs

PAC Medical Cost Ratio

- Q1 2015: 84%
- Q2 2015: 83%
- Q3 2015: 79%
- Q4 2015: 74%
- Q1 2016: 69%
- Q2 2016: 68%

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Orthopedic Bundled Payment Programs

- CMS Government Bundles
  - BPCI classic: Bundled Payment for Care Improvement initiative
    - Began Q4 2013 and ends Q3 2018
    - Medicare patients and inpatient DRG billed
  - CJR: Comprehensive Care for Joint Replacement model
    - Began Q2 2016 and ends Q4 2020
  - Advanced BPCI: Bundled Payment for Care Improvement initiative 2.0
    - Projected to begin Q4 2018 and end Q4 2022

- Commercial Bundles
  - Provider-Led
    - Emerge Orthopedics with BCBS of NC
  - Payer-Led
    - Humana
  - State-Led
    - TennCare
BPCI overview

• Bundled payments align with CMS goals to reduce costs, improve outcomes, and improve quality of care
• Retrospective bundled payment covering 90 days
• Major orthopedic cases including total joints, spine, and trauma
• Historically orthopedic physicians have not been financially responsible for care beyond the surgery
Myths about Bundled Payments

1) Volume creates savings
   i. Episode annual growth per physician (all episodes) = 1.1%
   ii. Episode annual growth per physician (lower joints) = 3%

2) Patient population differs

3) High benchmarks for success

4) Provider size matters – only large organizations can be successful
No Change in Patient Population

No Difference in Number of Comorbidities per Patient Between Baseline and 2015

- Blue line: Baseline % of total patients
- Orange line: 2015 % of total patients

Count of Comorbidities per Patient

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No Change in Patient Population Co-Morbids

No Difference in Comorbidity Type Between Baseline and 2015

- Baseline % of total patients
- 2015 % of total patients

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## Provider Size & Benchmarks

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<th>Provider Size</th>
<th>Group Size</th>
<th>Physicians</th>
<th>Avg NPRA</th>
<th>MCR</th>
<th>% Episodes Positive NPRA</th>
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Bundled Payment Team: Who is Involved?

- Patient
- Case Manager
- BPCI Manager
- Physicians
- Administration
Bundle Payment Core Program

- Leadership
- Technology
- Physician Alignment and Engagement
- Post-acute Network Management
- Care Redesign

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Physician Alignment and Engagement

- Physician engagement approaches
  - Define a physician champion
  - Establish a physician committee
- Standardization
- Gainsharing
  - Physician designated bundled payment
  - Hospital designated bundled payment

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Physician Champion and Committee

- Physician champion role
  - Lead engagement of physicians in standardizing care, establishing care pathways, clinical thresholds, etc.
  - Work closely with bundled payment clinical team and case managers and intercede with outlier and underperforming physicians

- Physician committee role
  - Establish quality measures
  - Establish and approve care pathways and clinical thresholds
  - Review individual cases especially outlier cases
Meet them where they are

• Tailor approach to physician, group, and/or organization
• Use positive messages and reinforce success and strengths
• Problems and weak areas are “opportunities”
• Share a consistent message supported by data and best practices
• Leverage benchmarking to create competition
• Apply multi-angled approach by standardizing message from convener, administration, case manager, support staff, and other physicians/providers
Physician Engagement and Alignment

Phase One

- Supportive or Neutral
- Champion or Leader
- Medical Director and Peer Network
- Physician Scorecards
- Linking financial incentive to quality outcome

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Physician Engagement and Alignment

Phase Two

- Education and “buy in” from staff
- Quality committee
- Case studies
- Build trust with support team
- Maximizing service opportunities

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Gainsharing on Internal Cost Savings

Funded through a reduction of Hospital costs - Options:

- Direct Costs per Case
  - *Example*: Variable Labor, Variable Medical Supplies, Variable Drugs, Fixed Labor, Equipment Rental, Department Indirect

- Supply Costs per Care
  - Intra-Surgical Supplies
  - Blood Utilization
  - Variable Drugs
  - Other Supplies (outside of OR)

- Discrete Supply Costs per Case
  - Implants and related components

Most Common

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BPCI Gainsharing Program Example

1. Identified Hospital ICS for Targeted Episodes
2. Calculate Cap @ 150% Part B Allowable
3. Hospital Savings
   - 0-1 Metric Achieved = No Gainsharing
   - 2 Metrics Achieved = 25% of Part B allowable
   - 3 Metrics Achieved = 50% of Part B allowable
4. Measure Quality Metrics Achieved at Individual Physician Level
5. Validate Approved Screening List Quarterly
6. Calculate Individual Payments and Submit to Committee for Approval
7. SMG Approves and Distributes to BPCI Physicians
8. Payments Made to BPCI Savings Pool

ICS from BPCI Eligible Patients – First Dollar Funding to Cap
Hospital and Physician Internal Cost Savings Gainshare Best Practices

• Requires physician engagement/leadership
  • May include occasional difficult conversations with vendors
• Construct pricing produces best results
• Sole source relationships producing 20+% savings
• Process and compliance related metrics are preferred
  • Pre-op joint replacement class attendance
  • Blood utilization protocol adherence
  • Prophylactic antibiotics 1 hr. prior to surgery
• Engaged and cooperative hospital partner

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Care Redesign Goals

• Shift paradigm from specific clinical focus (surgery) to comprehensive focus (episode)
• Integrate biopsychosocial care model
• Use evidence-based protocols to reduce overutilization of services, reduce adverse outcomes, and lower costs
• Standardize care pathways while maintaining physician decision making and individualized care plans
CASE STUDY: Cost of an **Unmanaged** TJR Surgery

- **Pre-Bundle Testing:** $670
- **Acute Care:** $11,595
- **Home Health - 15 Visits:** $4,275
- **Outpatient Physical Therapy - 15 Visits:** $1,275
- **Physician Fees:** $1,295
- **SNF Stay – 21 Days:** $10,500
- **DME:** $150
- **Specialty Visits:** $800

**TOTAL BUNDLE COST 90 DAY EPISODE:** $30,410

*Estimated Cost

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CASE STUDY:
Cost of a **Managed** TJR Surgery

Pre-Bundle Testing: $670

Outpatient Physical Therapy - 8 Visits: $680

Specialty Visits: $800

Acute Care: $11,595

Physician Fees: $1,295

SNF Stay - 5 Days: $2,500

DME: $150

**TOTAL BUNDLE COST 90 DAY EPISODE:** $17,690

*Estimated Cost

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Case Management

- Pre-Operative
- Intra-Operative
- Post-Discharge
- Patient-Centered
- Evidence-Based (Best Practices)
Case Management Attributes

• Risk stratification with defined care pathways transitions and predictive outcome measures
• Individualized care pathways supported by evidence-based medicine
• Care coordination throughout the continuum of care
• Work within the preferred networks
• Community resource development
• Beneficiary waiver utilization “outside the box thinking”
• Management of chronic and comorbid conditions
• Ongoing case studies and reviews
Case Management Model

• Case management throughout a 90-day episode

- **Pre-operative phase**
  - 2-8 weeks
  - Risk assessments
  - Care plan development

- **Acute phase**
  - 1-4 days
  - Surgery
  - Discharge plan

- **Post acute phase**
  - 90 days
  - Care coordination

• Comprehensively address patient biopsychosocial needs through a physician-led approach

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Pre-Operative Phase: Patient Assessment

• What is your current pre-operative patient assessment process
  • Risk assessment tools
  • Stratification

• Discuss pre-operative assessments which have successfully improved patient care
  • What should be assessed
  • Who should perform the assessment
  • How is the assessment similar or different than current H&P

• Building the communication process to disseminate patient information
  • Who needs to receive the information
  • How is the information dispersed
  • Who is responsible

• Multidisciplinary team
  • Who are the team members
  • How is the team engaged and how do they interact for patients and providers
Pre-Operative Phase: Patient Optimization

• Clinical indication for surgery vs patient optimization for surgery
• What does patient optimization mean
• Successful LEJR patient optimization strategies
• Interventions to improve patient outcomes
• When is a patient optimized
Pre-Operative Phase: Patient Care Plan and Case Management

- Pre-operative care plan and coordination
- Shared decision-making process
- Patient optimization needs
  - Who coordinates
  - How is information collected and reported
  - When is the patient ready for surgery
- Aligning post-operative care plan to address pre-operative assessment and interventions
- Establishing patient care expectations during acute and post-acute phase of care
- Case study reviews
  - Learning how to improve
  - Executing recommended improvements
Acute Care Phase

• Care Redesign (Hospital)
  • Patient education standardized across all hospitals by physicians
  • Engagement with acute care discharge planner
  • Maintaining established care plan
  • Clinical documentation (chronic and co-morbid conditions, complications) to support appropriate index DRG designation
  • Standardization of supplies
  • Establish order set which keeps orthopedic physician in control of the episode
Discharge Planning
Acute Care Phase: Discharge Barriers and Challenges

- Altered care pathways
  - Inpatient Rehab and SNF admissions
- Physical limitations
- Lack of community resources
- Biopsychosocial needs
- Cultural impact
- Family needs/impact (social isolation, new family member, etc)
- Aligning patient level of care with patient choice of care
  - Physician determines appropriate level of care while the patient selects the location of care through shared decision making
Post-Operative Period

• Align patient care plan with the appropriate care setting
• Case management follows patient for 90 days post discharge
  • Triage protocols during the post-acute phase
  • Readmission management
  • Physician monitoring of transition of care throughout the 90 day episode
• Utilize high quality and engaged preferred post-acute care (PAC) providers
• Address readmissions
Success in Episodes of Care is dependent upon an understanding of the goals of patient-centered managed care and a willingness to change culture/behaviors to incorporate a holistic approach to care for the entirety of the episode across all care settings.

Biopsychosocial care model designed to comprehensively address patient needs through a physician-led care management process.
Readmission Overview

• Reason for readmission
  • Which readmission types are impacting LEJR patients
  • Are they surgical or medical
  • Is the readmission avoidable or unavoidable
  • Singular vs multiple readmits

• Cause for readmission
  • Is there a variance between physicians
  • Is it driven by patient stratification/population
  • Is communication poor or overwhelming
  • Does the patient have the correct care plan
  • Are there non-medical reasons

• Source of readmission
  • From where is the patient being readmitted
  • Is there a variance between PAC providers
  • Who is driving the readmit; the patient or a provider
  • What underlying factors could be contributing to the readmission

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Readmission
Care Pathways, Protocols, and Orders

- Pre-operative
  - How can pre-op pathways impact readmission
  - How do you identify readmission risk
  - Who identifies the risk and provides risk mitigation management

- Discharge planning
  - How to and who will determine appropriate discharge disposition
  - How does discharge disposition impact readmission risk
    - Variance in patient care plan
    - Are care pathways aligned and is patient care plan being followed

- Post-operative
  - What care pathways can impact readmissions from each care setting
  - Treat in place options
  - Alternatives to hospital readmission
  - Variance between preferred and non-preferred PAC provider
  - Which processes and protocols can continue to minimize readmission risk
Readmission Communication and Engagement

- Hospital staff
  - Who is engaged with the patient during each phase of care and how does their engagement impact;
    - Identification of readmission risk
    - Ability to mitigate and manage potential risk
    - Address readmission before it happens
    - Address singular readmission to prevent multiple readmits
  - ED visits – observation vs readmission
- Post-acute providers
  - How are PAC providers identifying patients with readmission risk
  - Who is disseminating patient information and to whom
- Physicians
  - Role, responsibility and accountability for;
    - Orthopedic surgeon
    - Hospitalist
    - Emergency physician
    - Primary Care
  - How do you identify what went right/wrong
Post-Acute Care Network

• Influencing factors
  • Physician or provider preference
  • Business or personal relationships
  • Financial relationships and/or risk sharing

• Post-acute care network
  • Preferred and non-preferred network
  • Quality ratings
  • Protocols/pathways for IRF, SNF, HHA, and OPT
  • Reports and scorecards
  • Ongoing management and engagement

• Community resources
  • Beneficiary incentive waivers
  • Current network and resources (internal and external)
  • Geographic needs

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PAC Network Development Strategy

• Identify preferred provider network
  • Considerations: past performance and quality ratings
• Facilitate onsite meetings and education with episode initiators and PAC providers
• Establish consensus care protocols and reporting metrics based on our standardized pathways
• Identify opportunities for specialized program development
• Develop collaborative relationships
• Review and update PAC protocols quarterly
• PACs reviewed continuously and held accountable for protocol adherence

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Technology and Data Analytics

• How do you track patients across multiple providers?
  • Early stages of development so most effective systems have been identified
  • System allows the key care management person to access and record information about the patient
  • Develop care plans and track the patient across the episode

• What data, reports, and key performance indicators drive success?
  • As much data as possible
  • Reports need to provide actionable detail and information
  • Benchmark physicians and providers
  • Established KPIs
Key Performance Indicators

• Categories - incident rate and frequency
  • IRF (inpatient rehab facility)
  • SNF (skilled nursing facility)
  • HHA (home health agency)
  • OPT (outpatient physical therapy)
  • Readmit

• Incident rate – the percentage of patients utilizing a service

• Frequency – the number of occurrences when a service is used
## DRG/Episode Analysis

<table>
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<tr>
<th>Provider</th>
<th>Total Cases</th>
<th>Total Spend</th>
<th>Avg Spend</th>
<th>IRF Incidence Rate</th>
<th>IRF Average LOS</th>
<th>IRF Average Cost/Case</th>
<th>SNF Incidence Rate</th>
<th>SNF Average LOS</th>
<th>SNF Average Cost/Case</th>
<th>HH Incidence Rate</th>
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<th>Readmit Incidence Rate</th>
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<td><strong>2,876.02</strong></td>
<td><strong>9.6%</strong></td>
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## Compare Physicians

- Compare KPIs to determine differences
- Review patient episodes
- Deeper dive and case studies of specific patient episodes

<table>
<thead>
<tr>
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<th>Total Cases</th>
<th>Total Spend</th>
<th>Avg Spend</th>
<th>IRF Incidence</th>
<th>IRF Average LOS</th>
<th>IP Rehab Average Cost/Case</th>
<th>SNF Incidence</th>
<th>SNF Average LOS</th>
<th>SNF Average Cost/Day</th>
<th>HH Incidence</th>
<th>HH Average LOS</th>
<th>HH Average Cost/Case</th>
<th>Readmit Incidence</th>
<th>Readmit Average Cost/Case</th>
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<td>40.9%</td>
<td>38.6</td>
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<td>36.4%</td>
<td>14.1</td>
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<td>10.6%</td>
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## Review Physicians

### Patients

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## Compare PACs

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<th>Ave LOS</th>
<th>Cost per Case</th>
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*(Proprietary & Confidential)*
SMG Support Capabilities

1. Program Development and Management
2. Network Development and Management
3. Care Navigation and Management
4. Medical Management
5. Education and Training
6. Proprietary Technology, Tools and Analytics
Key Lessons Learned in BPCI

1. Transition from Volume to Value requires committed leadership
2. Physician engagement and participation is central to success
3. A high quality performing post-acute provider network drives success
4. Care redesign is critical to a successful bundled payment program. If you deliver the best comprehensive care you will achieve the best results both clinically and financially. Patient-centered care delivers the best outcomes.
5. Technology is a tool in bundled payment however understanding and knowledge gives value to the data
6. The ability for your organization to learn and improve continuously is essential to succeed in value-based payments
Matt Civili
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BPCI Awardee Convener
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