Preparing for Bundled Care: What Our Future Report Cards Will Look Like

Michael Suk, MD JD MPH FACS
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To understand the drivers of change

ECONOMICS AND VARIATION ARE DRIVING HEALTHCARE REFORM

The State of Healthcare Today

Healthcare spending 20% of GDP by 2020

Yearly growth estimates 4.8 to 8.3%

GDP growth rate ~ 4%
Inconsistency In Healthcare Delivery

The Quality of Health Care Delivered to Adults in the United States

Elizabeth M. McGlynn, PhD, Steven M. Safer, MD, MPH, John Adams, PhD, Andrew McGlynn, MD, MPH, Jennifer K. Kees, MD, MPH, Karen Delano, MPH, and Louis D. Weiss, MD


- Adults in the US received 54.9% of recommended care
- Acute care – 53.3%
- Care for chronic conditions – 56.1%
- Preventive care – 54.9%

No Correlation Between How Much we Spend and Quality/Outcomes

MD Longitudinal Cost Efficiency Index
(totals cost per case mix-adjusted treatment episode)

MD Quality Index
(outcomes or % adherence to EBM)

High Efficiency
High Quality
(Dream Suppliers)

Low Efficiency
Low Quality
(Nightmare Suppliers)

50th %ile

Lower Efficiency/
Higher Cost

Higher Efficiency/
Lower Cost

Cost Inefficiency In Healthcare

PriceWaterhouseCooper $1.2T

Institute of Medicine $765B

Accountable Care

Key Issues
While We Operate in a Financially Challenging Environment

Where We Are Now
Unjustified variation
Fragmentation of care-giving
Adversarial payor-provider relationships
Perverse payment incentives
Patients as passive recipients of care

Where We Want To Be
Payment for value
Coordinated care
Continuous improvement/innovation
Patient activation
National health goals, accountability

IHI Assumptions

Focus changes from paying for units of service to rewarding quality and outcomes.

To understand the market environment:

NATIONAL LANDSCAPE IS SHIFTING FROM VOLUME TO VALUE
Why Governmental Attention

Total joint replacements

Fractures

Hip

4,250,000 orthopaedic procedures in 2012

How Did We Get Here?

Medicare Modernization Act of 2003
• first time linked Medicare payments to the reporting by hospitals of the quality of their services.

The Tax Relief and Health Care Act of 2006
• physician self-reporting by providing a 1.5 percent Medicare incentive.

SGR Repeal Creates Two Tracks for Providers
Providers Must Choose Enhanced FFS1 or Accountable Care Options

Merit-Based Incentive Payment System

Advanced Alternative Payment Models

2015-H2 – 2016: 0.5% annual update

2016: Last year of separate MU, PQRS, and VBM penalties

2019: Combine PQRS, MU, & VBM – 2019 -1% to -5% at risk

2015-H2 – 2016: 0.0% annual update

2018 – 2019: Frozen payment rates

2020 and on:

2020 and on: 5% participation bonus

2021 and on: Ramped up Medicare or all-payer revenue requirements
New Law Strengthens Move To P4P Incentives

Builds on Trend of Increasing Provider Accountability Even Within FFS

Merit-Based Incentive Payment System (MIPS) Summary

- Succeeds current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories

APM Bonus Rewards Participation in New Models

Option Signals Policymakers’ High Expectations for Risk-Based Models

Advanced Alternative Payment Model (APM) Summary

- Requires significant share of provider revenue in APM with twosided risk, and quality measurement; or in some cases participation in certified patient-centered medical homes (PCMHs)
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

DEFINITIONS

What exactly is a “bundle?”
Clinical "Bundles"

Structured way of improving the processes of care and patient outcomes
Evidence, execution and consistency
A package of interventions that people know must be followed for every patient, every single time.

Implementation

All elements are necessary and sufficient,
• It's a cohesive unit of steps that must all be completed to succeed.
Based on the highest level of evidence
Focuses on how to deliver the best care — not what the care should be.
All-or-nothing measurement.
• "Yes, I did this step and that one, no, I did not yet do this last one."
• "Yes, I completed the ENTIRE bundle, or no, I did not complete the ENTIRE bundle."
• There is no in between, no partial "credit" for doing some of the steps some of the time.
Specific time and in a specific place, no matter what.

Bundle ★ Checklist

Elements of a hip fracture bundle...
High Level Elements

Radiology
- AP/Lat v. AP/Lat/Pelvis v. AP/Lat/Pelvis/Traction View

Timing of Surgery
- 24h v. 36h v. 48h

Anesthesia
- Regional v. General

Intra-capsular Fractures
- ORIF v. Hem v. THA

Extra-capsular Fractures
- SHS v. CMN

Co-Management
- Hospitalist v. Geriatrics v. Trauma

Evidence?

High Level Flow

Pre-op  OR  Postop  Post-discharge
- Patient Activation
- Preoperative eval.
- Disposition Planning
- Blood Conservation
- Antibiotics
- Confirmation of component position
- Antibiotics
- Physical Therapy
- VTE Prophylaxis
- Delirium Precautions
- Disposition Planning
- Blood Conservation
- Occupational Therapy
- PC clinic visits
- Physical Therapy
- VTE Prophylaxis

BUNDLED PAYMENTS IN HIP FRACTURE

Linking clinical bundles to payments
**Shift from Fee for Service**

**Risk sharing: Payer → Providers**

**Bundled Payment System**
- Patients in each DRG are clinically similar
- Similar use of resources
- Same Reimbursement per DRG (90 day postop)

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**Leveraging the “Sweet Spot” to Drive Innovation**

**Aligned objectives between the health plan & clinical enterprise**

- Health Plan
  - Population analysis
  - Align reimbursement
  - Engage networks and employers
  - Share to market

- Clinical Enterprise
  - Care delivery
  - Identify best practice
  - Design systems of care
  - Interpret clinical reports
  - Continually improve

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**GHS Receives “All In” Global Fee**

One fee for the ENTIRE 90-day period including all surgery-related care:
- ALL surgery-related pre-admission care
- ALL inpatient physician and hospital services, including orthopaedic surgeons, anesthesia, consultants, etc
- ALL surgery-related post-operative care
- ALL care for any related complications or readmissions

Aligns incentives across provider, patient and payor
ProvenCare® Acute Orthopaedic Programs

THA  TKA
Hip Fx  Spine

The “Warranty”

All inclusive fee
- Surgery-related pre-admission care
- All inpatient physician and hospital services
- Surgery-related post-operative care
- Any related complications or readmissions

Shared risk
- Across provider, patient and payor

Hip Fx Improvements

Decreased LOS
- 3.6% reduction

Decreased 30 day readmission rate
- 58% reduction

Decreased DVT rate
- 49% reduction

Decreased PE rate
- 67% reduction
Evolution of Bundled Payments on Orthopaedics

- **ACE**
  - 2009-2011 (3 hospital experiment)
  - All three hospitals reduced the overall cost per episode between 10% and 15%
  - Savings from implant cost and LOS reduction

- **BPCI**
  - 2013-2016 (Voluntary participation over 48 episode groups)
  - Retrospective reconciliation of all Medicare Part A and B (-3 to 90 days)
  - Guaranteed 2% savings to CMS

- **CJR**
  - April 1, 2016 (Mandatory participation 75 geographically identified MSAs)
  - Retrospective reconciliation of all Medicare Part A and B (-3 to 90 days)

Hip Fracture Hemiarthroplasty in Total Joint Bundles?

- 2.5x post acute $$
- 1.5x total cost $$
- 2x readmission rate
- 5x SCU/ICU
- 1.5x LOS

**Economically Not Viable**

Bundled Payment versus Population Health

- Bundled payment strategies are consistent with growth in clinical programs.
- More surgery is still better economically for hospitals in a world of bundles.
- Incentives can be aligned improve care coordination across the continuum of care and reduce waste and redundancy.
QUALITY SCORECARDS

How we will get measured…

Quality Measure Domains

Structural
- Adoption of EMR (e.g., Meaningful Use)
  - Easy to define
  - Difficult to manipulate
  - Correlation with quality, outcomes?

Process
- SCIP measures (e.g., Abx, DVT prophylaxis)
  - Easy to define
  - Actionable
  - Allow feedback
  - Clinical relevance
  - Correlation with quality, outcomes?

Patient Experience
- HCAHPs, Press Ganey
  - Patient-focused
  - Influenced by patient expectations and engagement

Efficiency
- Utilization of services, LOS, margins
  - Easy to measure
  - Correlation with quality?

Outcome
- Complications (e.g., infection, readmissions, reoperations)
  - Best measure of quality
  - Difficult to measure
  - Risk adjustment
  - Limited feedback
  - Lag time

Which Outcomes are Important to Measure?

Survival
- For example
  - Hr, age, co-morbidities
  - Overall survival
  - In-hospital death
  - 30-day mortality

Physiologic
- For example
  - Blood pressure
  - Heart rate
  - Oxygen saturation

Cataract
- For example
  - Visual acuity
  - Intraocular pressure

Caregiver
- For example
  - Caregiver burden
  - Caregiver satisfaction

Patient
- For example
  - Patient satisfaction
  - Health perception
  - Functional status

Factors
- For example
  - Age
  - Gender
  - Race

For example
- In-hospital death
  - 30-day mortality
  - 90-day mortality
Conclusion

Value-based payment strategies such as bundled payments offer both risk and opportunity for orthopedic surgeons.

It is important to develop an understanding of the historical experience of bundled payments and the current payments models that are being tested.

THANK YOU