Integrated Service Lines in the Age of Bundled Payments: Where Does the ED Add Value?

DESCRIPTION
The ED is the hub of the health care delivery system. Increasingly ED groups are being asked to provide integrated solutions involving outpatient care, Observation care, and Inpatient Hospital Medicine. The successful ED group of the future will be able to add value broadly across the spectrum of care.

OBJECTIVES
- Incorporate into practice disease specific practice guidelines, as opposed to those limited to Emergency Medicine.
- Develop strategies to improve patient outcomes for an episode of care.
- Improve collaboration with other service lines and specialties to improve patient safety, patient outcomes and optimize reimbursement

1/29/2020, 9:45 AM - 10:45 AM, Integrated Service Lines in the Age of Bundled Payments: Where Does the ED Add Value?

FACULTY
Rebecca Parker, MD, FACEP

DISCLOSURE
(+) No significant financial relationships to disclose
Integrated Service Lines in the Age of Bundled Payments: Where Does the ED Add Value?

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Disclosure

- Rebecca Parker, MD, FACEP
- Chief Medical Affairs Officer, Envision Healthcare
- President, Team Parker, LLC
ACEP Course Description

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ACEP Course Objectives

- Incorporate into practice disease-specific practice guidelines, as to those limited to Emergency Medicine.

- Develop strategies to improve patient outcomes for an episode of care.

- Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement.
ACEP Course Objectives

- Develop strategies to improve patient outcomes for an episode of care. **Bundled Payments.**

- Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement. **Enhanced Recovery After Surgery (ERAS) & Peri-Surgical Home (PSH) Programs.**

- Incorporate into practice disease—specific practice guidelines, as opposed to those limited to Emergency Medicine. **Opioid Collaboratives.**
WIIFM?

I’m so excited.

Inform

Teach

Inspire
Bundled Payments

Obj #1: Develop strategies to improve patient outcomes for an episode of care.
Patients are sicker
INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

Iran’s agony
The mystery of Mrs Merkel
Asia’s consumers to the rescue?
The Greeks and those marbles
Evolution and depression

Reforming health care
This is going to hurt
The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.
CMS Target Payments

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

**Historical Performance**

- **2011:** 0% (Alternative), ~70% (FFS), 0% (All Medicare)
- **2014:** ~20% (Alternative), >80% (FFS), >80% (All Medicare)
- **2016:** 30% (Alternative), 85% (FFS), 85% (All Medicare)
- **2018:** 50% (Alternative), 90% (FFS), 90% (All Medicare)

**Goals**

- 2011: 0%
- 2014: >80%
- 2016: 85%
- 2018: 90%

Source: Dr. Patrick Conway, Acting CMS CMO, May 16, 2016
Bundled Payments for Care Improvement (BPCI Classic)

- Began in Apr - Oct 2013 through Innovation Center
- Voluntary
- Arrangements include financial and performance accountability for episodes of care
- Goals: higher quality, more coordinated, lower cost to Medicare
- Align incentives amongst all providers (hospitals, post-acute care providers, physicians, other practitioners)
# BPCI Classic

<table>
<thead>
<tr>
<th>Episode</th>
<th>Model 1</th>
<th>Model 2 *</th>
<th>Model 3 *</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All DRGs; all acute patients</td>
<td>Selected DRGs; hospital plus post-acute period</td>
<td>Selected DRGs; post-acute period only</td>
<td>Selected DRGs; hospital plus readmissions</td>
</tr>
<tr>
<td>Services included in the bundle</td>
<td>All Part A services paid as part of the MS–DRG payment</td>
<td>All non–hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non–hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non–hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td>4/1/16</td>
<td>1</td>
<td>649</td>
<td>862</td>
<td>10</td>
</tr>
</tbody>
</table>

Total 4/1/2016 1552

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BPCI Classic

- Model 1, few participants, ended Dec 31, 2016
- Model 2, 3, 4
  - Two phases: Phase 1 preparation period, Phase 2 risk bearing transition complete by July 1, 2015
  - Most initiated in Model 2, 3
  - Many dropped out of Model 4
  - Model 2, 3, 4
- 48 Clinical episodes
- Ended October 1, 2018

BPCI Classic

Total 1025 7/1/2018

- 255 Acute Care Hospitals
- 485 Skilled Nursing Facilities
- 192 Physician Group Practices
- 43 Home health Agencies
- 9 Inpatient Rehab Facilities
- 0 Long Term Care Hospitals

BPCI Classic

Group experience

3rd Qtr. 2015-2nd Qtr. 2018

Full risk versus partial risk

Partnerships

Local presence
BPCI Classic
Group experience

Medical Bundles

- Cardiac: acute MI, PCI, arrhythmia, pacemaker, CHF
- Pulmonary: COPD, bronchitis, asthma
- Infectious: sepsis, simple pneumonia, cellulitis

Locations

Successful
Bundled Payments

Part 2

AND

THE PLOT THICKENS
“A new mandatory program the CMS proposed...hospitals in 98 markets...financial accountable for the cost and quality...with bypass surgery and heart attacks.”

“In 2014, hospitalizations for heart attacks for more than 200,000 beneficiaries cost Medicare over $6 billion...cost vary as much as 50%...”
2016 Presidential Election
Bundled payments cancelled?

CMS cancels two mandatory pay models and scales back a third

By Virgil Dickson | August 15, 2017
“CMS is proud to announce this administration’s first Advanced APM,” said CMS administrator Seema Verma. “BPCI Advanced builds on earlier successes...move away from fee-for-service and towards paying for value.”

AND: voluntary, qualifies for an Advanced APM.
# BPCI Classic vs BPCI Advanced

<table>
<thead>
<tr>
<th>BPCI Classic</th>
<th>BPCI Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Size</strong></td>
<td>$10 billion*</td>
</tr>
<tr>
<td><strong>Episode Mix</strong></td>
<td>48 episodes</td>
</tr>
<tr>
<td><strong>CMS Discount Threshold</strong></td>
<td>2%</td>
</tr>
<tr>
<td><strong>Price Methodology</strong></td>
<td>Retrospective only; based on 2009-2012 CMS data</td>
</tr>
<tr>
<td><strong>Episode Initiators</strong></td>
<td>Physician Group, Hospital, or Post-Acute Provider</td>
</tr>
<tr>
<td><strong>Reconciliation Frequency</strong></td>
<td>Every 3 months</td>
</tr>
</tbody>
</table>

To be determined - Expected to be larger

- 29 inpatient episodes;
- 3 outpatient episodes

Prospective target pricing with retrospective adjustments (and annual re-basing); based on 2013-2016 CMS

- Physician Group or Hospital
- Every 6 months

## Illustrative Timeline: Bundled Payments Models

<table>
<thead>
<tr>
<th>Year</th>
<th>BPCI Classic</th>
<th>BPCI Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
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<td>2015</td>
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<td>2016</td>
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<td>2017</td>
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<tr>
<td>2018</td>
<td></td>
<td></td>
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<tr>
<td>2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Applications Submitted (March 2018)
- Patient Agreements + Bundle Selection Due (August 2018)
- Program Go-Live (October 2018)
- One-time Opportunity to Add or Drop Bundles (March 2019)
- Go-Live for Second Cohort (January 2020)

## Participants:

- Convener vs Non-convener

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BPCI Classic vs BPCI Advanced

Participants:
Convener vs Non-convener

**BPCI Advanced**

**Anchor Admission** 40%

**Skilled Nursing** 20%
**Readmissions** 14%
**Part B / DME** 10%

**Long-term Care** 2%
**Home Health** 6%
**Outpatient Care** 5%

**Anchor admissions are not targeted** for cost reduction.

**Inpatient Clinical Episode Triggers**

29 Clinical Episodes are triggered by the submission of a claim to Medicare FPS by an EI for the inpatient hospital stay, identified by Medicare Severity-Diagnosis Related Group (MS-DRG).

**Operational Levers:**
1. Next Site of Care Decisions
2. Post-Acute Stay Duration
3. Patient Readmissions

"BPCI-A is a new iteration of CMS Innovation Center’s continuing efforts in implementing VOLUNTARY episode payment models... to improve quality and reduce expenditures. Program runs from 2018 to 2023; with a second cohort beginning in Jan 2020."
How Are We Changing Behavior?

Earliest Possible Discharge to Available Bed

Evidence-Based Clinical Decision Support and High Value Post Acute Networks

- Independence
  - Can the patient perform activities of daily living?
  - Can the patient ambulate?
  - How is the patient’s cognition?
  - Does the patient have a caregiver who can help them at home?

- Therapies
  - Does the patient need Physical Therapy, Occupational Therapy, and/or Speech Therapy?

- Skilled Nursing Services
  - What clinical skilled nursing services does the patient need to receive post-discharge?
    - Ostomy
    - Tracheostomy
    - Wound care
    - Injectable meds
    - Catheter
    - Tube feeding
    - Oxygen
    - Venipuncture/blood testing
  - How much clinical nursing oversight does the patient need?
  - How much clinical teaching and training does the patient need?

CARE will propose one of the following care settings:
- Home with Limited Services
- Home with Home Health Agency
- Post-Acute Facility
Group Early BPCI-A Success

Programs Operationalized
BPCI Advanced

Role of the Emergency Physician?

- Hospitalist/PC driven
- Identification
- Quality measures
- Care coordination
- Reduce variation
- Hospital gatekeeper
BPCI Advanced

Role of the Emergency Physician

Quality Measures for Episodes

• NQF #0268 Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin

• NFQ #0326: Advanced Care Planning

• NQF #1550: Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty

• NQF #1798: All-cause Hospital Readmission Measure

• NQF #2558: Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery

• NQF #2881: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction

• PSI 90: CMS Patient Safety Indicators

ERAS & PSH Programs

Obj #2: Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement
Early Recovery After Surgery (ERAS)
Group ERAS Program

MARCH 2019
(47/262) = 18%
8mo → 3x

NOVEMBER 2019
(152/262) = 58%

- Lower LOS
- Lower costs
- Decreased re-admit

<table>
<thead>
<tr>
<th></th>
<th>ESR Case Volume</th>
<th>LOS Difference (Days)</th>
<th>Complication Rate Difference</th>
<th>Variable Cost Difference</th>
<th>30-day Readmission Percentage Difference</th>
<th>90-day Readmission Percentage Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 Outcomes</td>
<td>3980</td>
<td>-0.99</td>
<td>0.15%</td>
<td>$ (4,580.67)</td>
<td>-2.76%</td>
<td>-4.58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Opioid Days of Therapy</th>
<th>Opioid admin / Encounter</th>
<th>Patient Pain Goals Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 Outcomes</td>
<td>-0.87</td>
<td>-2.65</td>
<td></td>
</tr>
</tbody>
</table>

* Mixed payer data
ERAS History & Review

Features

- Created in 2001
- “Open source”
- Evidence Based
- Meets the Triple Aim (4th not measured)
- Decreased variability
  - Decrease health disparity
- Multi-modal

https://jamanetwork.com/journals/jamasurgery/fullarticle/2595921
https://insights.ovid.com/pubmed?pmid=28594746
Enhanced Recovery After Surgery (ERAS) Flowchart

A typical ERAS flowchart overview indicating different ERAS protocol items to be performed by different professions and disciplines in different parts of the hospital during the patient journey. The wedge-shaped arrows depicting each time period move into the period to follow to indicate that all treatments given affect later treatments. No NPO indicates fasting guidelines recommending intake of clear fluids and specific carbohydrate drinks until 2 hours before anesthesia; PONV, postoperative nausea and vomiting. Reprinted with permission from Olle Ljungqvist, MD, PhD.

<table>
<thead>
<tr>
<th>Preadmission</th>
<th>Preoperative</th>
<th>Intraoperative</th>
<th>Postoperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preadmission nutritional support</td>
<td>Selective bowel preparation</td>
<td>Minimal invasive surgery</td>
<td>Early removal of drains and tubes</td>
</tr>
<tr>
<td>Cessation of smoking</td>
<td>Preoperative carbohydrates</td>
<td>Minimize drains and tubes</td>
<td>Stop intravenous fluids</td>
</tr>
<tr>
<td>Control alcohol intake</td>
<td>No NPO</td>
<td>Regional analgesia</td>
<td>Multimodal opioid-sparing pain control</td>
</tr>
<tr>
<td>Anesthesia:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical optimization</td>
<td>PONV prophylaxis</td>
<td>Opioid-sparing anesthesia</td>
<td>Early mobilization</td>
</tr>
<tr>
<td>Nursing:</td>
<td></td>
<td>Regional analgesia</td>
<td>Early oral intake of fluids and solids</td>
</tr>
<tr>
<td>Preoperative information</td>
<td>Balanced fluids</td>
<td>Temperature control</td>
<td>Postdischarge follow-up</td>
</tr>
</tbody>
</table>
### Table 3. ERAS Society Guidelines

<table>
<thead>
<tr>
<th>Procedure and Topic</th>
<th>Year of Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonic resection</td>
<td>2012</td>
</tr>
<tr>
<td>Rectal resection</td>
<td>2012</td>
</tr>
<tr>
<td>Pancreaticoduodenectomy</td>
<td>2012</td>
</tr>
<tr>
<td>Cystectomy</td>
<td>2013</td>
</tr>
<tr>
<td>Gastric resection</td>
<td>2014</td>
</tr>
<tr>
<td>Anesthesia protocols</td>
<td>2015</td>
</tr>
<tr>
<td>Anesthesia pathophysiology</td>
<td>2015</td>
</tr>
<tr>
<td>Major gynecology (parts 1 and 2)</td>
<td>2015</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>2016</td>
</tr>
<tr>
<td>Liver resection</td>
<td>2016</td>
</tr>
<tr>
<td>Head and neck cancer surgery</td>
<td>2016</td>
</tr>
<tr>
<td>Breast reconstruction</td>
<td>2017</td>
</tr>
<tr>
<td>Hip and knee replacement</td>
<td>Under production</td>
</tr>
<tr>
<td>Thoracic noncardiac surgery</td>
<td>Under production</td>
</tr>
<tr>
<td>Esophageal resection</td>
<td>Under production</td>
</tr>
</tbody>
</table>

**Abbreviation:** ERAS, Enhanced Recovery After Surgery.

*a* For updates and free download, go to http://www.erassociety.org.
Peri-Surgical Home (PSH)
Including and Expanding ERAS to the Beyond
The practice of medicine was variable and fragmented

Surgery often disconnected patients from their usual care

Surgical patients often experienced lapses in care, duplication of tests, and preventable harm

As a result, costs were rising, complications were occurring, providers were frustrated, and patients were enduring a less-than-optimal care experience
The Perioperative Surgical Home (PSH)

- A patient-centered, physician-led, interdisciplinary and team-based system of coordinated care

- Spans the entire surgical episode from the decision of the need for an invasive procedure - surgical, diagnostic or therapeutic - to discharge and beyond

- Designed to achieve the quadruple aim of improving health, increasing provider and patient satisfaction, and reducing the cost of care
Perioperative Surgical Home (PSH) Model: A Coordinated System of Perioperative Care

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The PSH Model Achieves the Quadruple Aim

- Better Outcomes
- Improved Clinician Experience
- Lower Cost
- Improved Patient Experience
The heart of the Perioperative Surgical Home is Care Coordination! PSH team members include:
- Care Coordinators: Case managers, patient navigators, and social workers
- Emergency physicians
- Health IT/EMR staff
- Hospitalists
- Hospital administration
- Nurses
- Physician anesthesiologists
- Quality
- Surgeons
Benefits of the Perioperative Surgical Home

- Improves surgical outcomes
- Eliminates silos and the fragmented care process
- Decreases unnecessary testing and utilization of healthcare resources
- Assures appropriate cost-effective post discharge care
- Provides cohesive management of surgical patients beginning with the preoperative period and ending 30/60 days after discharge
- Enhances patient and family experience
Perioperative Surgical Home Learning Collaborative Outcome History, 2014-2020

PSH Learning Collaborative 1.0
Launch of Learning Collaborative 1.0
44 Organizations
Ends November 2015
Sample Outcomes
- 73% of participants launched PSH Pilots
- Reduced Length of Stay
- Reduced 30 Day Readmission Rate
- Improved Discharge Disposition

PSH Learning Collaborative 2.0
Launch of Learning Collaborative 2.0
57 Organizations
Ends March 2018
Sample Outcomes
- All participants launched PSH pilots
- Reduced Length of Stay
- Reduced 30 Day Readmission Rate
- Reduced Surgical Case Cancellations

PSH Learning Collaborative 2020
Launch of Learning Collaborative 2020
41 Organizations
Ends April 2019

Preliminary Findings
- Expansion of PSH Pilots to new service lines
- Development of patient education tools
- Improved HCAHPS Scores
- Reduced Length of Stay
- Reduced 30 Day Readmission Rate
- Reduced Surgical Site Infection rates
- Reduced Oral Morphine Equivalent use
- Implementation of Multimodal Pain Management
- Reduced Surgical Case Cancellations
- Reduced Surgical Case Complications

Sample Outcomes
- Reduced Length of Stay
- Reduced 30 Day Readmission Rate
- Reduced Surgical Case Cancellations

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PSH Pilot: Hip Fractures

- **Goal:** Reducing Length of Stay

Given the service selected, surgical team knew need to work closely with ED to have success in their primary goal.

For the PSH pilot, ED director with the surgical team looked at ED LOS, time from ER to OR and then OR to discharge.

The ED developed a “Blue Sheet” as part of PSH pilot.
- The Blue Sheet functions as “fast pass” for ED to OR
- Outcomes:
  - reduction in unnecessary testing and duplicate tests
  - Gets hip fracture patients to OR quickly- gold standard within 24 hours

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Opioid Collaboratives

Obj #3: Incorporate into practice disease—specific practice guidelines, as opposed to those limited to Emergency Medicine.
Opioid Task Force: Purpose & Goals

Review current trends and advance evidence-based practices for the service lines most directly impacted by the crisis.

• To share best practices in pain management that involve alternatives to opioids.

• To reduce opioid prescriptions.

• To identify and refer at-risk patients for addiction treatment and support.
Task Force Activities

Phase 1

- Opioid White Paper published
- Assessed current state across Specialties

- Acute Care Surgeons
- Anesthesiologists
- EM
- Hospitalist
- OB & Neonatology
- Pain specialist

Missing: *Radiology
Task Force Activities

Phase 2

- 2019 Quality Measure
- 3 Multi-Specialty Collaboratives

- Including all 7 specialties most effective
- Face to Face meeting
- Prep call & pre work
- Internal facilitators
- Two techniques
  - Nominal technique
  - LEAN technique
Process

> 93 Ideas Shared

> 59 Solutions proposed

Categorized into Groups
Top Opioid Collaborative Outcomes

Sharing of best practices experiences, guidelines and protocols

- Pain management (e.g. multi-modal and ALTO)
- Scripting
- Across specialties

Care coordination technique sharing and creating

- Discharge process
- Recovery handoffs
- Consultation processes
ACEP Course Objectives

- Develop strategies to improve patient outcomes for an episode of care. **Bundled Payments.**

- Improve collaboration with other service lines and specialties to improve safety, patient outcomes and optimize reimbursement. **ERAS & PSH Programs.**

- Incorporate into practice disease–specific practice guidelines, as opposed to those limited to Emergency Medicine. **Opioid Collaboratives.**
Success!

Inform

Teach

Inspire
Questions

Rebecca.Parker@Envisionhealth.com

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