

# Getting Bundled Payments Right in Health Care

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Bundled payments — single payments that cover all the care for a patient’s medical condition or treatment over a specified time-frame — are increasingly being deployed to motivate the delivery of better patient outcomes at lower costs. To date, bundled payments have been utilized on a voluntary basis in the United States. Examples include the Bundled Payments for Care Improvement (BPCI) initiative for Medicare patients, arrangements between commercial insurers and providers, and increasingly, in direct negotiated contracts between large employers such as Boeing, Lowes, and Wal-Mart and leading providers for complex medical conditions.

Building on the BPCI program, the Centers for Medicare and Medicaid Services (CMS) in July 2015 announced a proposal called the Comprehensive Care for Joint Replacements (CCJR) program to mandate the use of bundled payments for knee and hip replacements in 75 metropolitan areas beginning in 2016. Under the proposed rules, hospitals would be financially accountable for not only the cost of the surgery and subsequent hospital stay but also the payments to the physician performing the surgery and all subsequent medical costs in the 90 days after discharge.

Providers contemplating entering into bundled-payment contracts can learn from the experiences of Hoag Orthopedic Institute (HOI), a specialty orthopedic hospital in southern California, and the Rothman Institute (RI), a private-practice physician group in metropolitan Philadelphia. They have successfully used bundled payments to capture the value created by cost-effectively delivering superior patient outcomes. Their experiences reveal three keys for successful bundling: excellent data on outcomes and costs, pro-

active management of the patient, and alignment between physicians and hospitals.

## Data on Outcomes and Costs

Consistent with Value Based Health Care principles, HOI and RI measure and track their outcomes and costs for every patient’s cycle of care. Both organizations measure and excel at standard quality metrics such as length of stay, infection rates, readmission rates, complication rates, and HCAHPS patient-satisfaction scores. But both extend their outcomes measurement far beyond these common measures to include pre- and post-operative patient outcomes specific to the medical conditions they treat (e.g., knee and hip osteoarthritis).

RI co-developed an outcomes-reporting software tool and is now able to seamlessly integrate this information into each patient’s medical record. HOI worked with a private vendor to create a website for patients to provide periodic outcomes data. HOI publishes its outcomes data online and has become the largest contributor of patient-reported-outcomes data to the California Joint Replacement Registry. This transparency has proved useful in pricing discussions with payers and employers who value that HOI’s superior outcomes enable employees to return to work faster and healthier. Going forward, having compelling outcomes data will likely become even more important since, in the absence of being able to demonstrate superior outcomes, payers will continue to put pressure on payment rates.

Both RI and HOI utilize time-driven activity-based costing (TDABC) to measure their costs across a patient’s care cycle. This knowledge helps HOI and RI negotiate or accept bundled payment contracts that cover all their expected costs for care delivery. Supple-

mental analytics software allows them to identify process-improvement opportunities by examining detailed information on care-process flows and on the utilization and costs of personnel and supplies within their organizations. They also identify possible new improvements by comparing their performance against national TDABC benchmarks. Rothman has addressed the typical provider challenge of measuring the costs incurred after a patient has been discharged by acquiring utilization data from its commercial payers. RI uses the utilization data to impute an estimated expense for post-acute care based on publicly available Medicare payment data.

Driving cultural change is probably the most difficult challenge that health care leaders face, especially when a new payment mechanism is introduced. Excellent data has helped create a patient-centered culture at both institutions. RI and HOI share comparative cost and outcomes data directly with physicians, allowing the physicians to see their core strengths and opportunities. HOI displays quality and cost metrics on physician scorecards and links employee incentives to achieving targeted performance goals. Valid, relevant data motivated clinicians at both providers to seek and adopt best clinical practices, the subject of the next section.

## Proactive Management of Patients

Both RI and HOI have found ways to maintain or improve patient outcomes while simultaneously lowering costs by improving process flows, changing discharge protocols, using a lower-cost mix of staffing, adopting better pain-management regimens, and lowering supplies and implant costs. At RI, patients are assessed as low, moderate, or high risk pre-operatively based on clinical factors that will influence the operation itself (e.g., whether the patient has diabetes), and psychological or social factors that will impact the post-acute-care recovery. For example, younger patients with healthy spouses are safer returning to home than elderly ones, with some mental impairment who live alone. Following assessment, nurse navigators at RI work with patients during the pre- and post-

operative periods with protocols developed for each of the three risk levels.

RI also uses information in its risk assessment to guide the decision about the clinically-appropriate facility — academic medical center, community hospital, or orthopedic specialty hospital — for the patient's operation. Similarly, HOI performs some of its joint replacements for low-risk patients on an outpatient basis at one of two affiliated ambulatory-surgery centers.

Beyond influencing where the operations are performed, both HOI and RI take a proactive approach to setting expectations with the patient around his or her expected discharge status. Discharging a higher percentage of patients to home health care, when medically appropriate, represents a huge cost-savings opportunity relative to discharging them to a skilled-nursing facility or other post-acute-care provider. HOI and RI surgeons make a preoperative recommendation that is communicated to the patient, his or her family, and the hospital so that all parties are aware of the plan. If the hospital prefers to change the discharge plan, it must consult with the surgical team. RI and HOI also educate their post-acute-care providers directly, who come to learn that following the surgeon's protocols allows them to continue to receive referrals. These procedures help RI and HOI to discharge over 85% of their joint-replacement patients directly to their homes.

### **Alignment of Physicians and Hospitals**

This is important since both the physician and the hospital must coordinate and integrate care to achieve superior, low-cost outcomes for their patients. Beyond coordinating on the discharge plan, another important dimension of alignment is around which supplies — in particular, which prosthetic implant(s) — are used. Our research shows that the extent of physician-hospital alignment is a significant predictor of how much hospitals pay for their implants, which is typically the single-largest inpatient expense for joint replacements.

Since RI is a private physician practice, HOI physicians own 49% of it, and both have dedicated facilities for most of their orthopedic patients, the hospitals have a natural

interest in achieving alignment with the physicians. Cleveland Clinic, Mayo Clinic, and MD Anderson Cancer Center achieve alignment in a different but still effective way: by directly employing their physicians. Not surprisingly, these institutions are also among the leaders in offering bundled payments for complex medical conditions. Physicians and hospitals that do not already have such organizational alignment can use their participation in the Medicare BPCI or CCJR programs to create financial arrangements between the parties that produce shared economic interests and accountability.

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Bundled payments represent a significant opportunity to align the health care system around delivering high-quality care cost effectively by making providers accountable for the full episode of care. With the right data, a proactive approach, and alignment of facilities and care givers, providers will be able to succeed with bundled payments and deliver higher-value care to their patients.

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## SPONSOR'S PERSPECTIVE

# Improving Outcomes by Erasing the “Integration Deficit”

*How the Application of Technology and Use of Data Will Lead to Gains in Patient Outcomes While Reducing Costs*

We live in a world where our personal devices—whether they're in our pocket, car or home—can seamlessly share real-time data with each other. But the same cannot be said for a much more important area of our lives—healthcare. That's because many of the systems that record and store healthcare data across the care continuum are not integrated. Erasing this so-called integration deficit is a critical next step in healthcare's evolution as we transition to value-based healthcare.

While many stakeholders see the potential for improved collaboration, the misaligned incentives of many healthcare systems make the prospects for integration a significant challenge. Repeated tests, recurring readmissions, and an incomplete picture of a patient's overall health are often the result. By working together to manage patient care holistically, the healthcare industry can improve clinical and financial outcomes.

So if the lack of integration is the problem, how do we start working toward a solution? More connected medical technologies—implanted and otherwise—can and should play a crucial role, as will better use of data to help healthcare professionals see a broader view of their patients. Today, many of Medtronic's technologies are actively generating data, and we are working with the global healthcare community to take our technology, services, and insights and fashion them into solutions that either augment the delivery of care through better patient care management or improve overall system efficiency.

In the spirit of progress and partnership, our work includes:

- Utilizing insulin pump technology, sensors and mobile applications to better manage patients outside of the hospital setting in the Netherlands,
- Combining implanted heart failure technologies, diagnostic sensors, and nursing support to keep heart failure patients out of VA hospitals,
- Collaborating with IBM Watson to identify better care management for diabetes patients by using the patient's own data,
- Working with hospitals to allow quicker patient discharges by giving doctors and nurses the ability to monitor patient care and progress remotely,
- Partnering with hospitals to manage their cath labs for better patient throughput and outcomes, and
- Working on-site at hospitals to drive improvements in efficiency, quality, clinical outcomes, and patient experience, all within an outcomes-based payment model.

As we've seen in our efforts, the successful integration of patient care will require collaboration between providers, suppliers, physicians and payers. At Medtronic, we believe we have an important role to play in the integration of healthcare. There's an opportunity to harness the data and insights our technologies produce to create a more integrated, patient-centered healthcare system—one that ultimately is set up to achieve and reward the long-term outcomes that are central to a value-based healthcare system.

Learn more about our perspective on integrating care and value-based healthcare [here](#).

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