

LAN Summit Session Transcript

9A: Improving The Delivery of Cardiac Care Via Episode Payment: Opportunities and Challenges

[Presentation begins at 4:46]

[Jason Wasfy]

Yea... uh sure yea.

I can talk about it, its fine, I can just advance this way, is this on, and I can start?

Um...Hi, good morning my name is Jason Wasfy I'm a member of the Task Force on Clinical Episode Payment for Cardiac Conditions. Thanks so much for coming, my day job I'm a cardiologist, I specialize in cardiac intensive care, I'm a cardiologist at the Mass General Hospital in Boston. I'm also an academic cardiologist, I do a lot of research especially regarding hospital readmission and outcomes research um... and I am a hospital administrator too. I'm the Director of Quality for the Mass General um... Heart Center and thanks so much for coming to our talk.

Um... I am gonna hopefully be relatively brief. I'm going to talk a little about our work group's charge and activities. Um... I'm going to give a little bit of a preview of our work group recommendations for using episode payment to deliver care to patients with Coronary Artery Disease. I am going to introduce two of our content experts on how this alternative payment model is being used right now to improve the care delivery for patients with Coronary Artery Disease. And then we're in a period now where we very much want feedback, so we're going to leave a good amount of time to get feedback and questions from the audience about our evolving recommendations.

So this is just our schedule, um... our group is chaired by Lew Sandy who you saw in the last session. He is the SVP of Clinical Advancement for United Health Group. The charge of our committee um... was to the charge of the clinical episode payment workgroup generally was to develop models for implementation of bundles for 3 key conditions elective uh... Arthroplasty, for maternity episodes of care, and for the care of patients with Coronary Artery Disease and I am going to talk more about Coronary Artery Disease in this session. You can see there's 18 of us, there are broad of variety of different stakeholders that were on our workgroup you can representatives from government, from payers, and from providers. I'm not sure we're doing so much ACO stuff now, I don't know any more whether if I'm payer or provider, I'm a doctor, so I think of myself as a provider. But as you know the world is changing real fast. Um... Just to talk about a little bit about the timeline of where we are in our work group, we are sort of at the tail end of a development phase that started in February 2016 and will end next month. We anticipate a draft white paper to be released from our work group in mid-May. There will then be a period of public comment, an opportunity for us to revise based on that feedback and then there will be a final release of the report at some point in the summer of 2016. The reason why I'm saying this very explicitly is because we definitely want feedback. So please feel free to give us feedback based on what I articulate here. The components of our recommendations will have design elements for how to construct a cardiac care bundle, a recommendation and discussion about operational issues that will need to be worked out for these bundles to be operationalized.

Umm... We aim to uh... in some ways a bit of a creative tension I think between these bundles do exist to think about how to um... approach the design of these bundles knowing that they already exist and, and incentivize going forward the opportunity to innovate in the creation of these bundles. So we sort of will acknowledge that creative tension and sort of deal with it in, in the report. But we both want to learn from what has happened already and provide opportunities to innovate in the delivery of these bundles uh...going forward.

Ultimately just to reiterate I know that you probably, this is probably been something, I don't want to spend too much time on this, if this is something you heard already. Just in terms of the motivation for episode payments, we want to breakdown uh... existing silos of care, remote coordination, and, and, and communication between different types of providers that typically have not uh... coordinated well outpatient physicians, nurses, inpatient care, procedural care versus non procedural care, improved care transitions for patients between these health care settings. And to fundamentally set up bundles in ways that will allow providers and payers to respond to data and feedback about the course of illness and clinical outcomes for patients. And what we think ultimately, is that this will better align payment with the way that patients receive care. So patients don't think about ya know the interventional cardiologist, the surgeon, the intensive care doctors, and the outpatient doctors. They think about how they experience uh... care. And I'll say in advance this will be sort of a theme you'll hear more about it that it's real tricky with Coronary Artery Disease right? Because Coronary Artery Disease can be from a 50-year-old who is totally healthy or things are totally healthy and then has a cardiac arrest, ends up in an intensive care unit or mechanical circulatory support. This is something I deal with I'm a clinical cardiologist who specializes in intensive care. So we see these patients all, unfortunately all the time. We get lifesaving interventions that need to be deployed in an emergent situation followed by long periods of rehab. But, then there's also the type of patient who has stable symptoms, chest discomfort, maybe seen by their primary care doctor, perhaps referred to a cardiologist, the stress test is ordered. Based on abnormal results of the stress test decisions have to be made about angiography and decisions about revascularization. We have tried very hard to submit recommendations that acknowledge that heterogeneity of effect. That in some cases patients are very stable, there is time to think, time to make decisions and in other cases this is, this is a lethal disease uh...that can come up in emergencies.

And ultimately I know this slide has been shown um... before um... just to reiterate we, the reason why this disease condition was chosen and the reason why maternity was chosen and hip uh... hip and knee Arthroplasty was chosen um... that it felt, we felt it consistent with all of these goals. So these are areas where we want to empower patients, these are areas where shared decision making, these types of things are very well established and well validated. We also think about the health care system. These are areas that are very common in America, Cardiac Disease is extremely common in the United States and is provided at high cost, 15 billion dollars in the United States every year on an all pay prospective. This is also this is something I feel strongly about because all my research has to do with this too is to demonstrate unexplained variation and patterns of care. So even after risk adjustment there are places in America where cap is done a lot of more than in other places. There are places where mortality for AMI is much higher than in other places even after risk adjustment for patient characteristics. There are places where patients are readmitted much more than they are at other places. The fact that, that variation exists after risk adjustment suggests that quality and, and care process's and implementation of care process plays a role of outcomes for these um... patients. Coronary Disease is also an area where there is a clearly defined trajectory of care, where things should happen at certain times so that was

another thing that got this into um... the focus of the committee. This is also an area where quality metrics are not only available but have been well validated.

Um... like for all the work groups, we operated on kind of two levels. One is to define the episode, define relevant quality metrics. But we also sort of realistically understand that there are many operational considerations that would that, that, that interdigitate with the definition of these bundles. So we simultaneously tried to define parameters for bundles while acknowledging that there are specific data needs and implementation needs that have to be realistic in the setting of the bundles that, that we defined. Um... So I mentioned this previously, but Coronary the care of patients with Coronary Disease is extremely expensive. Uh... 15 billion dollars per year in the United States and unfortunately its highly fragmented outcomes in the United States when you consider where how, the, the amount of spending that is deployed are, are substantially worse than they could be. Um... with enormous variation within the country and that's both with variation within regions and variation between regions. There are probably way too many adverse drug events for patients with this uh... disease condition. Again hospital readmission varies tremendously even after risk adjustment suggesting quality issues between care providers. And there is often lack of follow up testing you know the kind of way that I say this is ha... I can say this as a cardiologist. We are pretty good at opening vessels we are little less good at like making sure that people are followed properly and make sure they really understand their disease condition. And part of that to be blunt is that existing payment models don't really incentivize that type of coordination of care. So that's something we really want to break open, in terms of designing these bundles. We want to reward providers just as much for making sure that someone goes to cardiac rehab than they are for successfully performing the PCI empowering patients to understand. Because so much of the outcomes in this area, have to do with um ... things like quitting smoking and sort of the blocking and tackling of the care of these patients has to do with these types of things, maintaining a normal body mass index, those sorts of things, those sorts of things in the present system are relatively undervalued. Um... and that's why a lot of these patients get uh... disjointed, uncoordinated uh... care experiences. So by designing these bundles we've tried to increase the rate of providing the right care, the right time, and the right setting and what that means is being judicious about the utilization of high cost imaging and, and catheterization, cardiac surgery. Um... there are some areas in which this will be underutilized, so we want to simultaneously incent the utilization of underutilized high value services. Whereas we want to dis-incentivize things that are inappropriate, things that are low value um... and high volume um... and incent things that again the blocking and tackling things that are extremely, we know from, from observational research and clinical trials are extremely effective. Things like improving diet, exercise, med compliance, med adherence. This again is the sort of activity that is critically important to our patients, empowering them to understand their disease. But is relatively under incentivized in traditional payment models. And we want to create payment models that ultimately improve outcomes for patients. We would like to see the more inpatient mortality rate from acute Myocardial Infarction decline, we know that even after risk adjustment its different in different places uh... their public policies are relevant we know that, from analysis of different states where there's risk reporting, things like that. We know that public policies can change outcomes for these patients. And we're determined to propose parameters for bundles that, that acknowledge that and, and sort of help drive better outcomes for uh... these patients. So our goals for both patient level and system level. The patient level goals versus what I've been talking about improving people health status, reducing mortality, making sure that we personalize treatment to individual patient preferences, and needs and the circumstances of their lives. But also on a system level we wanna increase the, the rate of high value

services whereas relatively decreasing the sorts of things that are inappropriate or relatively low value. I've sort of talked about this before, but just to be explicit about this, again this is my bias as a clinical cardiologist, but I think this is actually tougher for Coronary Disease. Than it is for Arthroplasty and Maternity. I think because of this heterogeneity of how people present. So um... you can have a heart attack, you can be totally healthy and all of sudden have a heart attack. There's certain things clinically, that need to be done in emergencies that, that, that need to be done clinically. Which is very different than the kind of patient that's experiencing some ambiguous symptoms, needs evaluation, um... needs stress testing, and then there's some patients that the optimal care trajectory is to have symptoms and then have a stress test and then catheterization, so as to not over utilize catheterization. But the other higher risk patients that probably should go that their pretest probability is so high for Coronary Disease they should probably go right to catheterization. That that's the tricky thing about it, how do we make sure to the best that we can, that the payment system is aligned with not only the high risk patient that probably should go right to cath or the catastrophic cardiac arrest in the fields of resuscitation and emergency revascularization. Whereas we're also trying to incent proper care for much more stable patients. It's an extremely difficult challenge and that's ultimately why we chose thought about nested episodes of care. So a 12-month period of preventive care and disease management that's directed more at primary care and ongoing cardiology care in the outpatient setting. But nested eh... um... would be uh... A procedural um... uh... element, so that there would be a separate payment for the procedural episode of care. We think that this balances these two goals although, I acknowledge it's a tricky problem that we're happy to take feedback on it. Uh... this is sort of our hope is by creating a nested bundle that you can simultaneously incentivize cooperation between primary care and outpatient cardiology on one hand and a procedural you know something more like what I do in intensive care unit, that sort of thing. Um... uh... you know that the second element is more hospital based and the um... the first element is more outpatient based. So the hope is that if you put both elements of the care system at risk that it will incentivize collaboration between those types of providers. Because they're both at risk and effectively for the cost of care. Um... so this kind of reiterates this nested uh... disrested, nested, concept. Part of the concern of course is that if someone has a really horrible looking left main lesion and its having Angina. We want the patient to have CABG, we don't want uh.. disincentivize appropriate uh... care. There are situations in stable patients, there are actually relatively few, but there are situations for stable patients where revascularization uh... reduces the rate of Myocardial Infarction death going forward. We would never want to disincentivize procedural care for those patients. So in this way the 12-month part of the nest, disincentivizes poor care for these patients because it incentivizes the right decision. Which is to go ahead with an elective CABG because that reduces the rate of, of, of uh... Myocardial Infarction that would be unsuspected going forward. So that's how we try to deal with uh... this tension just basically based on the recognition that for a disease condition that may or may not include procedural care. That we're addressing both the chronic element and the procedural element of care.

So the way that we've done it and again this is a developmental sort of proposal again, we really want feedback and we have sometime before even the draft report is released. Is that the starting point will be uh... variable based on the presentation. So, in an acute event that would be a starting point in a situation where someone starts to develop symptoms and has testing that's upstream of potentially in geography of revascularization. The symptoms would start the, the episode of care. And for the procedural part of the nest. Uh... it would be preoperative period, so again in this sort of dramatic cardiac arrest example. The preoperative period is actually not every long at all or shouldn't be very

long. The procedural care and the post discharge care, and we struggled a little bit, with the definition of the post procedural episode of care. We kind of decided on 30-90 days, but again there's some ambiguity about what the right deadline is. I think that it acknowledges that ultimately the proceduralist shouldn't be on the hook for things that happen substantially downstream of the procedure. Although I acknowledge that's a tricky, tricky deadline um... the 30-90 days comes out of a lot research especially regarding re-infarction and readmission. You could imagine a late complication of a procedure that would be after 90 days. So I acknowledge that there is some ambiguity of what the right set point is.

Just in terms of the episode design recommendations you can similar a slide for the disease conditions. We defined the episode as 12 months of active Coronary Disease management. There are situations uh... my, my I grew up 10 minutes away from here. I was visiting my parents last night, my dad had a heart attack in 1991. He's still doing fine, but there is a point at which Coronary Disease does become quiescent. Active Coronary Disease is a definition that we define as sort of needing the ongoing care of cardiologists if there is re-infarction and repeating revascularization. The episode timing, I addressed earlier, it'd be parallel to the benefit year but then for the procedure would be uh... pre-op through either 30 to 90 days' post procedure uh... the patient population or patients with Coronary Disease and for procedures, it's those patients who need revascularization procedure either PCI or bypass surgery. The services would be the core services needed for uh... management of Coronary Disease that includes things like procedures but it also includes things like cardiac rehab and counseling. Potentially even things like meeting with a nutritionist, which is really important and underutilized. We want to push the issue of patient engagement, both patient self-education but also engaging family. We recognize things like quitting smoking, and maintaining a normal body mass index, and diet are critically important, med adherence, and often is better with um... the family involved. The accountable entity for the condition part, will be the outpatient cardiologist and PCP accountable for the condition and then for the procedure it would be that anyone involved in the inpatient episode of care and or the procedural which can be that same person in some cases and in other cases it's not. Payment flow would depend on characteristics of the specific market but could be either upfront fee for service or prospective payment. And then with episode price we recognize that there's probably, what we know for sure their existing differences in provider systems with efficiency and cost. So we don't want to penalize, if we do um... bundles that are based on historical norms for that provider, you're punishing providers for being more efficient, so that's not an optimal solution. So probably should combine some element of local norms and local costs and, and historical cost with changes over time. We acknowledge the potential for both upside and downside risk in these bundles and we think it's critically important to include quality metrics include proms and um... uh... measures of functional status in addition to traditional to quality metrics like in patient mortality. Which is sort of the ultimate outcome measure. So I at this point will hand it over, I think first to Sarah um...so I just have a little introduction um... Sarah is the project manager for HCI's ECR analytics software that is responsible for ongoing development of the program. While ensuring that it continues to meet its end user's needs. And it's the subject matter for ECR analytics rule sets. So um... I think she's going to provide feedback based on our committee's work. And I look forward to hearing your comments.

I took both.

[Sarah Burstein]

Better? For those of you who don't know um... about HCI3 and the um... Prometheus analytics. Um... We provide a; the Prometheus analytics are a claims based processing software developed by HCI3.

Very feedbacky

Um... to help payers and providers create, analyze, and implement um... episodes of care. So going through claims database to actually trigger those episodes to find them and give you useable data to actually use in implementations. So the Prometheus episodes are all um... similar to you know the episode um... definitions discussed here, time based, um... patient centered, clinically vetted by expert panels within each field umm... and look at all clinically related services um... for discreet conditioner procedure based on the entire continuum of care down from, ya know from management of the chronic condition through any surgery provided, ancillary services, lab service, pharmacy services, um... within the episode timeframe.

Um... so our model um... for episode definitions really very closely um... reflects what the work group has established in term of their episode definitions as well. We have a fixed period of time begin and end date, a trigger which is for Coronary Artery Disease based on the first diagnoses that shows up um... in an office visit or some sort of evaluation of management service um... often requiring a second signal to confirm the diagnose, but also can be based on an inpatient stay or um... or um... an ER visit. As well as in some cases as we said Coronary Artery Disease doesn't always present itself you know with signs and systems you may end up in the Emergency room or AMI you may end up a CABG may end up with a PCI um... so all of those even presents of those episodes for PCI, CABG or AMI can also be used to our model to trigger a Coronary Artery Disease episode. Um... it includes all relevant services so there are co definitions to make sure that things like if you're in a car accident does not get included it's not just everything that includes within that period of time. And the episode window is set around that trigger so um... we usually use a 30 day look back for procedures like CABG and PCI. We have a 90 look forward as our default but it is modifiable by the user based on um... Contractual you know negotiations. And it does include all of, as we see here the inpatient as well as outpatient and professional pharmacy services one of the more unique for um... aspects of our models is we do differentiate and break out typical or routine services from potentially avoidable complications. Um...so everything you see in blue here would be your typical services your office visits your prescribed pharmacy things that are you know clinically based guidelines care that you would expect to see in management of these conditions and procedures. Um... versus potentially avoidable complications like ER visits um... potentially AMI's and patients with known Coronary Artery Disease and then again you obviously see things in yellow are irrelevant that where their costs would be pulled into the episode.

Um... one of the other defining aspects of the Prometheus logic is that we have this overarching clinical logic where it is completely patients centered. So at the center of our analytics is each plan member. Um... And each plan member can have multiple concurrent episodes. So episodes are then, you know services are assigned based at based level for each of those episodes and the management of that condition where the performance of um... that procedure or intervention. Umm but then the episode can actually be related back to one another through defined clinical associations. Um... for example if you know two PCI episodes in a very close timeframe we don't consider those as two separate PCI episode that would receive two septate budgets and two septate bundles, but its treated as a staged procedure. And then episodes can also be classified as typical or complication in relation to each other.

Um... so a PCI performed or CAPG performed following an AMI would be considered a typical intervention for that um... for that AMI and for that Coronary Artery Disease patient. Um... but you know the AMI itself on top of a patient with Coronary Artery Disease might be seen as a complication and those dollars would get included as complication dollars.

And finally everything in that model is adjusted for payment severity. Um... those were discussed earlier obviously every patient is different and certainly at sometimes, sometimes things are considered medically appropriate um... and sometimes they are not and a lot of that depends on the individual factors surrounding the patient.

Um... so we do as part of this have several different, um... what we consider levels of associations so there are different viewpoints that you can look at an episode. At level 1 we have all of our episodes that would trigger as of you know that this patient has um... and each of this would contain kind of those direct services provided around each of these conditions or procedures. Um... so in this case we have a patient that has Coronary Artery Disease they have actually have two AMIs but there is an AMI it's not nearly as complicated as it looks I see some faces. Ha... but we have they do have they do have an AMI which results the patient having a CAPG followed by a PCI procedure. They also do have a concurrent diabetes episode as well as total knee replacement that you know unrelated to the Coronary Artery Disease and an AMI directly resulting from and following the total knee replacement. So looking at it at level one the patient has a lot of things going on but when we start to look at the patient from a clinical perspective in terms of how we can interrelate these episodes. They start to move together a little more into smaller set of episodes that we would contract for. So the AMI that results from the knee replacement actually rolls into the knee replacement that would be a complication that would not be part of the Coronary Artery Disease episode it's not considered a direct impact to that but the other AMI the freestanding one would be considered a complication on the Coronary Artery Disease, potentially avoidable. And the CAPG and the PCI that are used to treat it would roll into the AMI which would then ultimately nest within um... the Coronary Artery Disease episode. It also then gets actually split though with diabetes cause its Coronary Artery Disease is not the only chorionic condition at play here. Um... but what's important to note from this is that all the dollars at every level remain the same. So it's very simple from an accounting stand point, and it's a true you know real accounting model that can be implemented. Um...and practiced because you know the total dollars are the total dollars there's no double counting you're not wondering how you know things overlap so, things don't get split between conditions to make sure that you don't have any double counting. Um... so depending of the goal of your implementation and, and implementing an episode pilot um... or program. You can look at different levels to see kind of what's going on and this is where that nested um... that nested concept comes into play you know at level three we might look at the procedures because that is where those are considered complete. And that's where you would potentially engage um... a cardio thoracic surgeon or the interventional cardiologist. Um... whereas you know looking at the um... you know if you want to take into account the full picture with the chronic medical condition as well as then um... you know the prevalence of the complications and procedures that occur as a direct result of those conditions. Then we would look at the level 5 to make sure that we're taking in that full view of the patient.

This is just a couple of other um... important things around our model and the way it works. We talked about the fact that we break out the typical from complication potentially avoidable complication services. Um... our patiently avoidance complication measures um... for some of our chronic conditions including Coronary Artery Disease and some of our acute events. That have been actually endorsed by

the NQF as um...comprehensive outcomes measures. Um... and then the next couple of bullet points actually speak I think kind of directly to what was said earlier around, certain services being medically necessary for some patients but medically necessary for others. So depending on how the patient presents and whether you're in an um... acute emergent event versus um... versus whether they're coming in with just kind of some moderate signs and symptoms and the path you're going to take. So services can be considered potentially avoidable and we do track potentially avoidable services to make sure. We're not seeing overuse of the system and that every patient is not receiving something like a cardiac cath. Um... and we, we identify those um... through those that identify though the choosing wisely campaign. Um... but on the flip side, we also identify core services to make sure that they appropriate number of core services are being provided; and that there is an underuse or gaps in care. So we really look at it from both sides to make sure that um... the approximate level of care is being provided. So those are done by looking at counts of claims and um... the codes that are on those claims to ensure that you know based on your, on your case mix and your patient um... severity what would you expect to see in terms of potentially avoidable services as well as core services; and that's how we go about identifying those um... kind of in, in the you know, looking at the claims data to be able to identify, you know are there, is there overuse of player is there an underuse of in making sure that we strike that appropriate balance. Um... and then we talked about the clinical associations um... in terms of making sure that they are um... you know that the treatments and the um...complications are nested within the chronic conditions to make that; as you say brings together kind of the full spectrum of care for that patient and all of the providers involved in the care and management of that condition.

Um... lastly um... it's you know we make sure that um... in terms of your budgets that you're actually, you can track through our system um... perspective budgets to the actual spend for the patient. Um... and the most important part of that is really making sure you're comparing apples to apples. So... we find that um... A lot of times people, who are defining episodes get bogged down in terms of; what's included and what's not included in a lot of negotiations and you get kind of stalled in um... analysis paralysis determining exactly, what should be pulled in and what should be pulled out. It's less important to worry about you know whether or not you have the exact bundle of services right and to make sure that whatever you're doing at the beginning is what you're comparing to the same thing at the end. As long as you are comparing apples to apples then you know you are going to see the same um... services included you know in terms of your definitions. So you know making sure that um... people being you know what, what is included in your budgets is what's included in your actual spend at the end when you're doing reconciliation.

[Jason Wasfy]

Thank you very much ha-ha. Um... Next I'd like to introduce Dr. Bassin, who's the chief analytics office for Archway Health. Thank you so much.

[Ed Bassin]

Thank you can you hear me ok? Hopefully my voice last, April is not a kind of month for those of us with allergies. Um... I gotta give you a heads up or a little warning before I even get started. I have planned remarks I been sitting in a conference for the last day and a half and they're changing. So, such it goes, so it goes um... a little bit of background I have a PhD in Sociology with a minor in mathematical statistics um... I spent the last, in 1994 I was the statistician for Symmetry, when they were developing up as a treatment groups. Um... built a software company around episode based analytics back, um...

starting in the 90's, I sold that Thomson and Reuters about six years ago, and then I worked on ironically the main competitor to ETGEs. Working on the medical episode group, or for what's now Truman Analytics. Spent the last 6 years now working on um... episode based bundled payments. I come at this in some ways from the perspective of a sociologist and of who and what I am. Let me move this down here. Let me give you first two words, I'm going to be really brief, Archway health is the company I now work for. Archway focus is on trying to make bundles something that our customers can understand. We realize there is a lot of complexity out there, we don't make them simple that's a nice buzz word. You can't make something this complicated simple. But we try to simplify them so that people can understand what's going on and work with them. We work in various Medicare programs, we do some commercial work we got actually – got about 75 different clients and everything in covering all 48 bundles, all the different provider types. Um... in CJR, in OCM anything that has acronyms that we can somehow sign up for; we're there. Um... I'm gonna skip that slide; like I tell ya I'm changing my mind um... I wanna start out with somebody who's smarter than I am. Um... so I figure I'd start with Einstein and talk about a little about what he said; and this is the premise. I've been on the bundled payment work group from the beginning, when we were working on hips and knees, until now we're working on maternity and uh.... When we're working on maternity and CAD. boy I had trouble saying CAD in this session. Um...one of the perspectives I've always tried to bring to the group is emphasize keeping it simple. The KISS principle if you want to call it that, in science we used to call it the principle of parsimony, in software engineering they call it elegance, we all have different names for it. But the basic point is that when we design things that are simple. They make it easier for us to learn and they make it easier for us to adjust. And so to the extent that we can develop bundle specifications that are as simple as possible and in the early days they used to complain about how simple BPCI definitions were. I don't anymore, because they gave us a chance to learn, to begin with a position of simplicity, communicate a few things, and move on. Einstein makes another comment that I'm going to now put my medical sociologist hat on, to react to. Einstein says If you can't explain it simply, you don't understand it well enough. I'm going to use two words that I am shocked I haven't heard very much at this conference. Number one, economic and number two rational. The premise of an alternative payment system is the providers will act in manners which are economically rational, given the incentives that are baked into the system. And that's something that we just don't think about a whole lot. We almost take for granted, we don't make it explicit in our discussions. But there's a second part that goes to that as a social scientist and that is people act on their understanding, not on the objective reality. So if providers don't understand the incentives that they're given, then our systems aren't going to effect change in behavior. We have to make sure that our systems that we develop, our payment systems are ones that providers can understand. And to the extent that we call somebody the quarterback, the accountable entity, whatever term we want to use for that poor person who actually bears the risk. We want to make sure that, that entity is passing the risk down to others who are acting in value based manners. I say that and it seems so blatantly obvious right? We're gonna create an incentive based system. Don't we want the incentives getting down to the point of care? And yet for the past two weeks I've had a chance to meet strangely, I don't spend a lot of time in the ACO world, but with the two different practice leaders, who are under ACO based payment structures. It was interesting to me to find out they were bearing no risk within their groups, none. it was all being kept at the hospital ACO corporate entity level. It wasn't being passed down to the physician in practice and then I found out; I was asking one of them, well what do you actually get paid for? What are the incentives? Anyone care to guess what the number one incentive was within those system?

Already used volume; nop, network leakage! They were being paid to keep heads in beds and that's really what the program was being used for. So we think about these value based programs whether they're ACOs, whether they're bundled payments, whether they're PMPM payments. The question we need to ask is whether they're filtering down to the person at the point of care, whose making clinical decision? If we don't do that, if the incentives aren't filtering down and they're not understood. We aren't going to behave in ways that are economically rational, given the incentive system that we're trying to create. So when we claim that we're making 30, or 50, or 70 percent of our patients, of our payments are value based. I think the question needs to be very different, what percentage of the provider at the point of care decision making; is being driven by value. Because that's what's going to change patient care in America.

Ops wrong one, I moved the wrong one.

Complicated systems inevitably create unintended, unanticipated, undesired consequences. Everything we ever do in life creates undesired consequences. I guarantee you, Eliot Fischer when he was coming up with the idea behind an ACO. Wasn't thinking we would be creating incentives to reduce network leakage, so we can keep heads in hospital beds. That wasn't part of it, but as I look at this particular bundle and I admit I been somewhat been a voice of decent within the work group on this one. I have some concerns that we should all be watching for. As we do a program like this and we try to integrate cardiac care, are we going to separate cardiac care from the care of other chronic conditions. How do we make sure, that the patient who has CAD who also has GI problems, osteoarthritis, who has dementia, and who has; as we know I could on and on although I couldn't remember them of the top of my head right now. How do we make sure that care remains integrated? And how do we make sure that we keep patient in there. How do we make sure PCP work with cardiologists, as oppose to against cardiologists in this model? How do we make sure that they're on one team? When we are talking about the person in the last session from the American Association of Hip and Knee Surgeons mention this threat. How do we make sure that physicians who take on the most, physicians are disincented to take on the most complication patients? That's one of my biggest concerns that we have, I am statistician, I have been practicing this for 20 years, risk adjustment ain't perfect folks. Ask anybody who had a, an exchange based plan. Risk adjustment doesn't work perfectly and were talking about small end here at the individual physician level, how is it going to work? I worry that there will be coding changes and that will be gets a patient into a bundle. Oh I didn't ya know look at what HCCs have done. I now look at claims data that comes in from provider practices and you see hyper tension on every claim. I've worked with ETG grouper, how many of you know what the ETG group is? About half... I've worked with ETG grouper for over 20 years, oh my god I'm getting old. Um... but I worked with the thing for over 20 years, I used to love how it had this logic. That said if you had an ongoing episode it would add the claim into that episode otherwise it would add a new one. What I found more recently with it, is that patients would end with all their costs being attributed to hyper tension because the physicians were being told to code the chronic condition on every claim. Coding changes happen when we create financial incentives to do them. Like you I live in Boston, this is one of my favorite signs that I've ever seen in Boston folks, Bron won again. This is a sign that used to be up, how many of you ever were in Boston during the big dig?

[Jason Wasfy]

It wasn't pretty.

[Ed Bassin]

It wasn't pretty; I almost drove into a tunnel once passed the guards. But that was the new guy from Ohio moving to Massachusetts. This is a sign, I know it's a little blurry, um... Rome wasn't built in a day, if it was we would have hired their contractors. Ha, I love this sign, I love the message it gave me; 30 years old I remember being starting out, in doing my work in physician profiling. And I had a medical director I worked with, he used to say if we can just get the physicians to change one thing out of every report, one part of their practice will have been a tremendous success. An inpatient 30-32-year-old. I don't remember exactly how old I was then, I thought oh my god how slow. 20 years later now, I had my 50th birthday last summer. I think, oh my god if I could have spent my last 20 years and have physicians changed one thing in their practice every quarter, improve one aspect of their practice every quarter, each one would have improved 80 things. We need to both accelerate what we do and be patient. Realize that physicians are very busy, that they don't have the time to spend on episode based payment that we do. That we need to enhance their understanding so they can succeed and make sure that our incentives are clear and that they really do incent what we want them to you. So... I am going to leave my comments at that. Mm...and I guess open the floor.

[Jason Wasfy]

Yea, no I, I um Thank you both so, so much. These were such provocative talks; I have a lot of questions of my own. So I will have to restrain myself, so I can get to audience questions but I guess, let me just open up by saying. Giving you an example that I think combines both of your talks. So um... we've heard a lot from Sarah about excluding unrelated conditions and heard a lot of from Ed about simplicity and unintended consequences. So I'll tell you when I was a cardiology fellow, I was interested in sort of redesigning ya know thinking about how to re-change cardiology delivery care. And I did, I did, uh... I asked a relatively simple, thought relatively simple question which was, how many readmissions hospital readmissions after PCI are preventable? Pretty simple question but it hadn't been asked before. So we had multiple doctors to chart view, so this is higher level than coding it's, it's real data. It's like doctors going through medical charts to figure out whether something happened that was 4preventable or not preventable. I thought it would relatively straight forward and we get a number like 50 percent. We had two doctors do it, the doctors rarely agreed. I mean there were 10 percent of the cases where they both agreed it was preventable. And then there was all these things in-between I mean, there was some agreement that there with some vascular access complication that said both said preventable. But it's very hard and we wrote a paper on it. That was mostly about the physicians disagreeing rather than the number that I was looking for. So if doctors can't agree on even when they are looking at a chart. Whether something was preventable or not, how can we reliably exclude things that are unrelated so obviously if someone needs a hip replacement after a PCI its totally unrelated, but there's much that's greyer. So if you agree with me, which I would love to hear yes or no. Should we just include everything like literally everything even if it's totally unrelated, just to make a simple algorithm. I'd love to hear from both of you.

[Ed Bassin]

You want to go first?

[Sarah Burstein]

No I mean I think; I think it goes back to like I said, you can't, you don't want to get too bogged down in the actual definition of the episode. Cause that's where we find everybody gets very paralyzed and the

physicians say well, I don't think this should be a potentially avoidable complication it's not a ya know. That's why we do say potentially avoidable complications, sometimes they are, sometimes they are aren't; obviously it's not that black and white. Um... but if you can reduce that by ya obviously some of them are, so if you can reduce that by even a fraction then you're making progress. Um... but making sure ya know, again the most important thing is that whatever's in your episode definition is just your episode definition is constant throughout and that. It's not even ya know it's, it's making sure that what's in your budget is what's in your actual. So you know that, yes you're not going to include a car accident and something like that but you know we do it based on um... obviously based on the codes on the claims cause that's all we have to work with at this point; down the road our plan is to hopefully include medical record data. Um... the systems aren't there yet um... but that's, that's the end ya know the end goal is to be able to bring both data sources together. Um... and be able to do that but even then it's not as black and white. So It is based on the codes on the claim, we do see as you said ya know certainly over coding of things and ya know our, our reports you can drill down to that level and certainly the physicians aren't necessarily going to do that but. Um... the payers and things take a look to see ya know we, we have seen that where we've said um... ya know, I haven't, I guess a knee replacement example where um... there was very high pact percentage at one of the implementations we were working at. And almost every patient had um... post hemorrhagic post, post, procedure hemorrhage quoted on their claims. Ya know we went back and looked at it with the physicians and they said well the hospital is telling us to do this Ha-ha. So it's, you just don't know um... and, and so it's going back and it's always a working ya know progress to go back to them and say no, we don't want to be coding this or ya know you don't want to be coding that, but you do see based on the prevalence of codes if you're potentially over coding or undercoding certain things and I think you can look at it like that. But I think it really just boils down to keeping it simple from the standpoint as, as I've said and just as long as; you don't want to get too bogged down on that definition, you have to start with something, you have to start somewhere. As you said kind of from, um... you know even from a BPCI stand point ya know. We certainly have um... don't think it's a perfect model by any means but you put your, you know, you put your stake in the sand with something, you put your stake in the ground with something, you learn from it, and you move on from there. But as long as you're comparing apples to apples. Then you're getting a true comparative of ya know, how I am doing historically versus how am I doing today.

[Ed Bassin]

I am going to contradict myself a little bit here um... I think from a risk perspective it's really important because we're often dealing with fairly small end here. To watch the inclusion of big unrelated complications. I run simulations all the time where I show people what their risk profile looks like simulate what their results would be. Just set random if their patient mix were changed from quarter to quarter. And what I find is that when we have long bundles, we have ends of 200 cases which is not at all unusual to see in these reconciliations. The numbers fluctuate wildly, part of what I get to is I want to avoid some of that fluctuation. I watch people panic when things go bad, celebrate when things go well and I rather be lucky than good is one of my comments and a lot of it frankly has to do with luck. My solution to this problem is a little different, my solution is to borrow from what sometimes is used in some of the clinical trial, pharma world, its used in engineering. But a concept of failure rate analysis and the concept basically says that over time, the likelihood of a complication goes down and what we need to consider is when its most likely that the services that we see are related to the original thing that generated our episode. In this case we have a 12-month chronic episode which makes that harder, but

when most of the episodes we look at, most of the bundle definitions or for acute conditions whether they are acute medical, acute exacerbation of chronic or surgical. In those cases, my bias is to look at shorter definitions of the episodes. Because what happens in that period immediately after surgery or immediately after discharge from a hospital or immediately after the patient has an acute exacerbation of their CHF. Those things are probably related, as we go out further 30,60, 90 days' things get unrelated. And we see that, when we look at the readmissions are for most of these conditions. So my bias is, make it shorter and perhaps have a warranty period for a procedure. If you're doing a hip replacement, maybe you have even a year that you go out that you're responsible for hip revisions. But, the things that are most likely to be related to a, if you have a stroke on day 68, it probably wasn't because you had hip replacement two plus months ago.

[Jason Wasfy]

We'd love to take questions, please comment. There is a microphone in the back.

[Teresa Lee]

Hi thanks, this has been a really interesting panel. My name is Teresa Lee I'm with the Alliance for Home Health Quality and Innovation. Um... I am really interested in sort of the nesting approach that's being contemplated for the guidance document. And BPCI was mentioned in the context of this panel I'm just wondering. I mean was the nesting approach tested in BCPI has been tested by anybody yet? I'm just curious as to what the experience is because it seems like what the elective joint replacement guidance, that was really, I mean this is my understanding. I was informed by lot of experience through BPCI, I mean DRG 470 that's, that's your number one most popular MSTRG for bundled payments and you know there's a lot of low hanging fruit. But I think this is a very different area and I'm just concerned about putting a guidance out there if there hasn't been that much testing of the approach yet.

[Sarah Burstein]

Um...we have a couple of implementations that have started looking at it, we've done a lot of analysis and data though in terms of data sets and looking through it and um... certainly clinical expert you know expert clinical panels of cardiologists and surgeons who have all weighed in on the episode definitions and reviewed the data. Um... ya know, we're still its constantly being reevaluated and re-informed, you know as we go in through the fields um... but, we also have um.... our medical director who um... creates our, who oversees our episode definitions, actually happens to be a cardiothoracic surgeon by training. Um... so that helps us a little in the cardiac department certainly um... in terms of understanding those definitions but it, it's certainly is a work in progress, the nesting approach definitely, I don't think was really tested at all in terms of BPCI. But we've, you know we've been doing it for a few years now within our analytics um... and we do have you know implementations who are using the analytics and um... in play. And are, you know evaluating it and we continue to you know look at theirs and refine where necessary but you know.

[Ed Bassin]

I...I'm sorry.

[Sarah Burstein]

No go ahead

[Ed Bassin]

I wanted to make one comment from the work groups perspective, I think one of the things we did as a work group was try create sort of a little bit of a reach of the definition of some of these bundles. With an appreciation that a lot of people want to take small steps as they move towards that. Personally I like the idea of taking small steps um... but a ya know, this was one where we tried to create kind of a vision for where things might want to go. As opposed to necessarily taking the step of, this is what's been tried and true. Nothing could be more tried and true than hip replacements. Some days I get so bored of talking about hip replacements, I think I'm gonna just bang my head on a wall. But its uh... ya know at the same time we have experience and we are trying to figure out how do we take this model forward.

[Jason Wasfy]

I would just add very briefly that I think I, I appreciate the caution articulating it for sure. I mean, just as a clinician I guess the problem I have is that, ya know my hospital is uh... a tertiary and quaternary referral center. We have the capacity to do things like mechanical circulatory support and sort of very dire circumstances and as such a lot of our patients get referred from a distance to us. So if there is not a nested approach, clearly there something different to me about being that kind of hospital versus a hospital that may capture more of primary care based and sort of have more modest presentations of Coronary Disease.

[Unidentified Voice]

The only thing that I wonder though, is sorry I didn't mean to.

[Jason Wasfy]

No, no.

[Unidentified Voice]

The only thing I wonder about it whether it could make more sense instead of taking on cardiac care at large, rather just doing that small nest.

[Jason Wasfy]

Yea.

[Unidentified Voice]

Because that is a little closer to being like joint replacement.

[Jason Wasfy]

No I see what you're saying.

[Ed Bassin]

I think its good feedback, I mean it's something we've, sorry ha-ha. It's in my nature to just talk. Um... but its good feedback I mean it's something we've as a debate within the work group.

[Unidentified Voice]

I mean the other thing to think about I mean know this is a very domestic conversation we are only talking about united states. But I don't know its maybe 5 years ago there was a piece in health affairs about an experience in the Netherlands. About some chronic care bundles they created and this double

counting issue was huge, it was just a gigantic issue, with what they did. So anyway it's just something to think about ya know? We might not have all the experience here, but maybe we should think about what other countries have tried.

[Jason Wasfy]

Yea that's a good point thank you, here then we'll go here.

[Bill Bestermann]

I'm Bill Bestermann I'm medical director of the Cosac Practice Transformation Network, so part of the TCPI initiative. And um... you mentioned briefly optimal medical therapy in your slide and uh... So I think, I think that's really critical and it deserves some emphases so if you're looking at uh... yearlong primary care bundle. That's kind of actually what we focused on. We did practice transformation work with Blue Cross Blue Shield Louisiana. And we focused on uh... Hypertension, Diabetes, Coronary Artery Disease, and Chronic Kidney Disease. Paid doctors 25 dollars per member, per month if they were high performers in providing optimal medical therapy, we helped them understand what optimal medical therapy was. And um... there was really a very dramatic result. So, over a year and a half we saved 44 million dollars and hypertension control; now Louisiana's always 50th or 49th ok. But hypertension control improved from 47 percent to 64 percent and all those other sweets improved in a similar way. So if you're out there in the south, most patients and doctors still think, that if you got heart disease, it's all about a blockage. If you just get a stent or a bypass you're fixed and you don't have to worry about this. But I think this is something that your group needs to put a lot more emphasis on, because it can be scaled, industrialized, and produced almost like any other product. If that makes sense.

Yea, no as a clinician I totally agree with you and I think that's feedback, that's real helpful, so thank you.

[Ed Bassin]

Yea good

[Jason Wasfy]

Pass the microphone

[Lily Brostein]

Hi, I'm Lily Brostein from Horizon Blue Cross Blue Shield. Um... I love that change takes time and the sign, so one of my; we have a retrospective, very deliberately we have a retrospective program on episodes um... and we do have the largest commercial episode's program in the country. I always talk about this episode model, as all these value based models as evolutionary, right? And it really, we have to allow for the time for the changes to occur. Cause we're looking to change the paradigm. And you don't just go from fee for service in my opinion to prospective, risk based um... models. Because if everyone knew what to do, they would, they would just do it, but in fact not everyone knows what to do and one of the successes we've seen in our program is not just success in the triple aim of quality and uh... patient experience and cost. But also, the spirit of the relationships we have with our providers, is like nothing I have ever experience in managed care. I always say it's not your grandmas managed care program ya know it's like we put multiple providers in a room with us with um... Sarah was talking about. Um... she didn't mention her by name but uh... Doctor Stoegy who's the cardiothoracic surgeon, who's one of the architects of these very complicated nuanced um... episodes at Prometheus. We put multiple providers in a room on a call with her, with us, to discuss and understand are. That just alone in

of itself, we would never have done that years ago it was too scary to put more than one provider in a room. They would say all sorts of mean stuff to us, ya know? So that's the comment, but my question was I thought that nesting was used in two different ways and I wanna make sure I understand. I understand what Sarah, the complicated part. I didn't understand what you were talking about so much, um... Jason. When you were saying you're going to nest, it sounded like, I think here's what I think I understood. And you tell me, no you got it wrong or. I think I understood that you're doing um... something um... that sounded almost ACO like with the primary care, PCMH, PMPM basis, or some sort of thing. And then you're actually going to build a bundle within in that or an episode, that will address the specific care related to the Coronary Artery Disease and either do share savings or I didn't hear what the model was, I don't think you talked about that so much. Is that what you're talking about, when you say that episode will nest. And the second part of the question is, what happens, cause the chronic these chronic ones are messy right? We have some chronic ones too, they're different than hips and knees and colonoscopies; and they're messier. So are you intending for the patient who has ED and they go through their one-year episode, to just rollover the second year into another episode? Like has that been contemplated at all?

[Jason Wasfy]

Yea, I mean I guess, thank you for the very thoughtful questions, both of them. I guess, I would say first of all that. First of all, I'd reiterate that these aren't final recommendations, we're going to have the draft reported in May and people provide comments. There is an opportunity to sort of hash this out a little bit. I mean that is, what I had envisioned is uh... ya know separate payments for procedures and for the ongoing 12-month period um...I guess with respect to the second question about um... definitions of when patients are in uh... bundles or not. So I guess the, the, Coronary Disease again is very challenging because of the different ways the patients present. I, I think its partially my bias because of my clinicary, but I think it's also true, that it's more heterogeneous than other um... fields where we're doing bundling like maternity and um... an elective hip, ya know if we did Arthroplasty that was traumatic an elective, then it would be a little bit more complicated on their front but we don't. So I think that's the challenge. So there's a challenge on the other end too, which is when do you graduate? So, is there a point at which; and the truth cardiologists debate this clinically, so it's challenging. If you had a, I'll just invoke my; I just had dinner with my parents last night so, my dad had a heart attack in 1991. He still sees that nothing's happened since, thankfully. So he still sees the cardiologist once a year. For sort of, I mean his son's a cardiologist too some of the things that happen I could probably tell him too. But ya know, when is someone out of the chronic episode? Or are they ever? So clearly in Arthroplasty, there's a point at which their hips fix. But cardiologists honestly clinically debate, is Coronary Disease a chronic condition that exists for life even for people who are quiescent? Is there a period after which you say, we're going to stop these sequential 12-month episodes? And I think what we've come to conclude, again it's an ongoing discussion but, we think if there's readmissions or people with vascularization, or people with an Angina, then you're clearly still active. But how do we begin to find the end of that activity period? Is it not seeing a cardiologist anymore?

[Unidentified Voice]

If there is another trigger? Yea.

[Jason Wasfy]

Yea, I don't have a clear answer for that.

[Ed Bassin]

So this was the debate we had. We actually, the original version of this that got written up said that these were newly diagnosed patients with CAD. Problem is the data that we'll have are claims data. So, how do you know if this a newly diagnosed patient with CAD, or a new patient who's in the plan, or a patient who two years ago didn't have, hasn't been to their cardiologist in two or three years? And so we went through that, these are the kind of problems that you face and I don't have a great answer to this problem I think it is a real stumbling block as we try to, to implement this particular bundle. And particularly my concern would be, that if we created a system whereby there was ah... a payment that physicians got per year for treating a patient with CAD, are we creating an incentive to bring patients in who don't necessarily need to be there? I've heard the argument made so many times without data by the way, that like hip replacement bundles create a new incentive for, for um.. orthopedic surgeons to do hip replacements. By the way guys they only got paid in the past if they did hip and knee replacements. So that's a different story, in this case we're actually creating a new payment, often a potentially substantial payment; if for that patient is in there. And I think it's something that, we really appreciate your comments and your insight on. Because we haven't found an answer to it. And It's a real issue for us if we're going to implement this kind of bundle

[Jason Wasfy]

Yea, yea. I would just want to add I think I mean I think what's interesting about this and what's tough about this is that. It is clearly easier to construct a bundle around a specific discreet procedure right? But what actually is more interesting and some more valuable for the health care system because it points out the problems in American health care. Is to construct these chronic care episodes and I, it's tougher but I think tis more valuable in terms of improving value in American health care.

[Sarah Burstein]

And from our standpoint, just in terms of our episode definitions and the way that our trigger rules work and everything. Somebody who came in just once for ya know a yearly appointment would not trigger a Coronary Artery Disease bundle. You would need at least a second office visit basically within the year in order to do that or in some sort of acute event.

[Jason Wasfy]

One more question

[Allison Silvers]

Thank you Hi um... my name is Allison Silvers from the Center to Advance Palliative Care and I'm gonna go on the KISS principal maybe even a little Pollyannaish um... but um... on one your slides Jason you had the outcomes of an included symptom free days and um...and to me that's the holy grail of redesigning healthcare, is that you're actually contributing to more symptom free days for people who have chronic illnesses or certain episodes that happen. I'm just curious was that just ah.. throw away thing on the slide or are you really trying to quantify that, measure it, evaluate providers on a measure of symptom free days.

[Jason Wasfy]

No, we really mean it. I think um... I guess, first of all I would say; yea no, no for sure it's for real. I know this is actually something I really feel strongly about. First of all, I know your groups work and I admire it. I'm also on the New England Comparative Effectiveness Counsel, we just had a public hearing with one of your colleagues as the expert witness. There is no question that in Coronary Disease, Angina status is critically important to these patients lives. So its critically important to our metrics and the nice thing about this disease process is that unlike other disease conditions including terminal cancers and things like that. There are very clear problems that correspond with disease status. So they're well validated in Angina questionnaires, we would definitely anticipate that, that is and unlike the vulnerabilities that about billing codes that we've been talking about sort of almost continuously. There are the Seattle angina questionnaires, there are well validated instruments that have been developed to measure Angina. So, we think that is very important. Um... thank you, we'll stick around for a bit too yea.