Driving Success in Bundled Payments

Rapid-Fire Session Moderated by:
Molly Bogan, MA, Institute for Healthcare Improvement

December 12, 2017
1:30-2:45PM

#IHIFORUM
Welcome and Introductions

Molly Bogan, MA
Director
Institute for Healthcare Improvement

Stephanie Calcasola, RN, MSN, CPHQ
Vice President of Quality and Safety
Hartford HealthCare

Trisha Frick-Hoff, MS, RN
Director, Bundled Rate Contracting
Johns Hopkins HealthCare

Rocco Orlando, MD, FACS
Chief Medical Officer and Senior Vice President
Hartford HealthCare
Session Objectives

After participating in this session, participants will be able to:

- Name three ways clinical care innovation and redesign can support effective clinical care under bundled payments
- Demonstrate approaches to engage physician stakeholders in successful care bundles
- Identify key elements of successful operations management in a bundled payment environment
Rapid-Fire Topics

- Policy environment
- Clinical care innovation, including post-acute integration
- Physician and stakeholder engagement
- Operations and administrative models to support bundles

Ample time for Q&A and discussion with audience at close of presentations
HHS Sets the Stage

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

“Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people” – Former HHS Secretary Silvia Burwell
So where is CMS at today?

“In 2012, we had 0% of payments in alternative payment models, where the providers were accountable for quality and total cost of care, and by 2016, we were ahead of schedule with over 30% of payments in alternative payment models like accountable care organizations, bundled payments, comprehensive primary care.”

- Dr. Patrick Conway, former CMS Deputy Administrator for Innovation and Quality
And the overall market?

- 29% of total U.S. health care payments tied to alternative payment models (APMs) in 2016 vs. 23% in 2015
- Total APM spending to ~$354.5 billion dollars nationally

2016 Payments

- Fee for Service: 43%
- Pay for Performance: 28%
- Shared savings/risk, bundled or population-based payments: 29%

Source: “Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs” - Report released by the Healthcare Learning and Action Network October 30, 2017
Conducted from June to August, 2017, the report reflects survey data collected from over 80 participants, accounting for nearly 245.4 million Americans, or 84%, of the covered U.S. population.
The Opportunity

The simultaneous pursuit of

- Improving the **health** of populations
- Improving the patient experience of **care**
- Reducing the per capita **costs** of health care
Fee for Service | Pay for Performance | Shared Savings | Shared Risk | Global Payment
Focus on Individuals | Individuals and Populations | Individuals, Populations and Communities
Care | Care and Cost | The Triple Aim
Policy Uncertainty

Source; Muhlestein, Saunders, and McClellan; “Growth Of ACOs And Alternative Payment Models In 2017” Health Affairs Blog; June 28, 2017
However...

Shift Toward Value-Based Payments in the Industry and at Organizations Is Accelerating

As an industry, at what pace do you think health care providers and payers will shift toward value-based payments in the coming years?

- Very fast: 3%
- Fast: 16%
- Moderate: 40%
- Slow: 28%
- Very slow: 9%
- Don’t know: 4%

59%

At what pace will your organization shift toward value-based payments in the coming years?

- Very fast: 8%
- Fast: 19%
- Moderate: 36%
- Slow: 19%
- Very slow: 8%
- Don’t know: 9%

63%

Base = 712

The Good News

Hospitals warm up to CMS bundled payments as agency cools off on them

CMS Expresses Support for Value-Based Payment

Good news from the Trump Administration this month on value-based payment. In a recent op-ed in the Wall Street Journal (WSJ), Seema Verma, Administrator of the Centers for Medicare & Medicaid Services (CMS), expressed strong support for value-based payment, including the Center for Medicare & Medicaid Innovation (CMMI).

Bundled-payment joint replacement programs winning over surgeons
What’s next?
Thank you!

Molly Bogan, MA
Director
Institute for Healthcare Improvement
mbogan@ihi.org
Stephanie Calcasola, MSN, RN-BC, CPHQ
VP of Quality and Safety, Hartford Healthcare
Previously, Sr. Director of Quality, Baystate Health

Rocco Orlando III, MD
Senior Vice President & Chief Medical Officer
Hartford Healthcare
Objectives

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Baystate Health Is Committed to the Development of an Integrated Regional System of Care for All Residents of Western Massachusetts

Integrated Delivery System
- Baystate Medical Center – Tertiary Center
- Baystate Wing, Baystate Franklin, Baystate Noble Community Hospitals
- Baystate Mary Lane Outpatient Center
- Baystate VNA & Hospice
- Baystate Medical Practices (700 MDs and advanced practitioners)
- Baycare Health Partners (1,200 MDs in our PHO)

Integrated Health Plan
- Over 200,000 Members
- Only Provider Sponsored Health Plan offering Commercial, Medicare Advantage and Medicaid Managed Care Choices
- Medical Home for all lines of business, including MassHealth

Focused on Quality
- Nationally Recognized for Quality Care:
  - Leapfrog Top Hospital
  - Truven Top 100
  - Top 100 Integrated Systems
  - Magnet Designation
  - NCQA Level 3 PCMH
- Health New England:
  - Top 10 health plan in country
  - #1 customer service in the country

Focused on Quality
- Regional Campus of UMASS Medical School
- 320 Residents
- Educated 1/3 of PCPs in Region
- Pioneer Valley Life Science Institute
- Center or Quality of Care Research
- TechSpring – IT Innovation Center

Partner to the Community
- Volunteer Community Board
- $40M Hospital Community Benefit
- Partners for a Healthier Community Public / Private Partnership
- Baystate – Springfield Educational Partnership
- $2.68 Economic Impact

“To Improve the Health of the People in Our Communities Every Day, with Quality and Compassion”
Baystate Bundle Initiatives

Center for Medicaid & Medicare Innovation (CMMI)
- Total Hip & Knee Replacement (DRGs 469, 470)
- CABG (DRGs 231-236)
- Colorectal – Active July 2015 (DRGs 329, 330 & 331)
- Oncology Care Model – (withdrawn, June, 2017)

Commercial Health New England
- Obstetrics
- Bariatric Surgery – (2013 Completed)

Next Generation ACO Shadow Bundles
- Built within the ACO
- End stage renal disease
Bundle Model Transformation

<table>
<thead>
<tr>
<th>Care Model</th>
<th>Care Teams use standard processes for quality, cost and compassionate care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Model</td>
<td>Single Payment for episode of care including doctors, hospitals, post-acute care</td>
</tr>
<tr>
<td>Operating Model</td>
<td>Leadership, Clinicians, Quality Improvement, Financial Analysts, Care Management</td>
</tr>
</tbody>
</table>
Bundled Payment Approach

1. Convene the right team
2. Define the episode
3. Develop measures
4. Develop model of care
5. Price the bundle
6. Develop cost reduction opportunities
7. Plan the gain-sharing
8. Develop a continuous process improvement plan
Bundle Clinical Care Re-Design

Reduce practice variation:
- Evidence based guidelines
- Standard pathways
- Interdisciplinary care rounds

Post-acute care management:
- Narrow networks and partnership
- Transitions of care / Avoidable readmissions

Enhanced care navigation:
- Cross Continuum Care Coordination
Reduce Variation: Daily Rounds

Components of reliable rounds
• Clear aim for rounds
• Structure and timing
• Leadership
• Patient engagement
• Measurement and improvement
### CABG Clinical Pathway – Sub Acute

**CABG Coordinator:** Name of Coordinator & Phone Number Here

**Surgeon:** ___________________________ Cardiac Surgery Office Number: 413-794-5550  
**Surgical Date:** ________________________

**Potential Sub-Acute DC Date:**

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Sub Acute Admit Day 0</th>
<th>Sub Acute Admit Day 1</th>
<th>Sub Acute Admit Day 2</th>
<th>Sub-Acute Admit Day 3-6</th>
<th>Sub Acute Admit Day 7-10</th>
<th>Sub Acute Admit Day 10- ___ or DC Day</th>
</tr>
</thead>
</table>
| Admission Physical Assessment | Warning Signs Assessment:  
- Temperature >101  
- New or increasing Shortness of Breath  
- Abnormal pain  
- Increased redness, tenderness or swelling at incision sites  
- New or increasing drainage from incision sites  
- Sternal Drainage  
- Change in pulse (resting HR > 120 bpm or < 50 bpm)  
- G3 Sat <92%  
- Palpitations &/or irregular pulse; new onset Afib  
- Weight gain of more than 2-3 pounds in 1 day or 5 lbs in 1 week  
- Medication Side effects (Refer to last page of pathway) | V5 every shift for 72 hrs  
- Warning Sign Assessment  
- Incision/Wound Assessment  
- Assess for Sternal Drainage—Notify Cardiac Surgical office for evaluation  
- Dressing change as ordered  
- Pulmonary Assessment  
- CV & Edema assessment  
- Weight assessment  
- Daily Temperature  
- GI/GU Assessment  
- Neuro Assessment | Vital signs daily and PRN  
- Warning Sign Assessment  
- Incision/Wound Assessment  
- Assess for Sternal Drainage—Notify Cardiac Surgical office for evaluation  
- Dressing change as ordered  
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- Incision/Wound Assessment  
- Assess for Sternal Drainage—Notify Cardiac Surgical office for evaluation  
- Dressing change as ordered  
- Pulmonary Assessment  
- CV & Edema assessment  
- Weight assessment  
- Daily Temperature  
- GI/GU Assessment  
- Neuro Assessment | Goals:  
- Incisions clean & Dry  
- No Sternal Drainage  
- Lung sounds @ baseline (clear/diminished)  
- Trace Edema  
- Pulse @ baseline (50-100)  
- Weight within 3 # of Baseline |
<table>
<thead>
<tr>
<th>Activity</th>
<th>Sub Acute Admit Day 0</th>
<th>Sub Acute Admit Day 1</th>
<th>Sub Acute Admit Day 2</th>
<th>Sub-Acute Admit Day 3-6</th>
<th>Sub Acute Admit Day 7-10</th>
<th>Sub Acute Admit Day 10- ___ or DC Day</th>
</tr>
</thead>
</table>
| PT/OT Consult | Do not lift greater than 10 pounds for 12 weeks  
- OOB to chair for all meals  
- Ambulate at least 4 times per | | | | | |
| Assessing Mobility/ Balance | May take Shower with assistance as necessary  
- No tub baths  
- OOB to chair for all meals | | | | | |
| Set goal discharge date | | | | | | |

***If physician/provider is informed of patient change in condition, notify CABG coordinator within 1 business day.***
# Reduce Variation: Total Hip Pathway

## Baystate Medical Center Total Hip Replacement: Model of Clinical Care

### Pre OP

- **Medical evaluation by PCP or Pre op clinic - Approximately 2-4 weeks before surgery:**
  - If the evaluation demonstrates significant abnormalities, surgery should not proceed until they are resolved.
  - Dental visit if not done within 7 years.
- **Pre op teaching sessions:** This is a 2 hour class. A discharge planner will be at this meeting. The plan will be to go home. Teaching will impart physical therapy services patient will receive at home, blood draws and nursing services.
- **Anesthesia Consult:** review your medical history with you as well as different anesthetic and pain modality options that are best for you - Epidural and/or general anesthetic, Femoral nerve catheters, Pudenda block catheters and other blocks.
- **Review home safety checklist:**
- **DME needs:**
- **Pre op Ortho Vish EARP 1-3 weeks before surgery; pt Q&A:**
- **Pre op home visit - safety evaluation, equipment needs set up by family education:**
- **Good night guest TMA admit night before scheduled surgery:**

### Pre op status

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Intubated</th>
<th>D6A Bed</th>
<th>D6A Bed</th>
<th>D6A Bed</th>
<th>D6A Bed</th>
<th>D6A Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Discharge</td>
<td>Evening of POD 2</td>
<td>Before 11AM POD 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre op care</td>
<td>ITY at 06:00 pre op</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td>TPR, BP, O2 sat Q4H x 2 days &amp; then Q8 until discharged / neuro vascular checks q4h &amp; pm x 24 hrs &amp; then Q8H</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2</td>
<td>02 via N2 2 LPM x 24 hrs then DC</td>
<td>24 hrs then DC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopad (protocol orders)</td>
<td>DC on POD 1 if q4h then M/D 06hr</td>
<td>Monitor and re infuse per protocol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>Monitor dressing</td>
<td>Monitor dressing</td>
<td>Change dressing on POD 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total Joint Replacement Home Safety Checklist

**Purpose:** The following is a checklist to use as a guide as you review your home in preparation for your total joint replacement. Please make note of any questions you might have and bring this list to your pre-operative teaching class. During the class you will discuss this list with a therapist or total joint replacement nurse. You will have the chance to order any needed home equipment at the pre-operative teaching class. Our goal is to provide excellent care and get you home in a timely manner to a safe environment.

#### Stairways

- Sturdy and secure handrails on all exterior and interior stairways
- Exterior and interior stairways are clear of obstacles and well lit
- Any loose carpeting on stairs is repaired to prevent a tripping hazard

#### Bedoom

- Bed is a safe height: when you sit on the side of the bed, the height of your hip should be higher than your knee with your feet resting flat on the floor. If bed is too low you can purchase bed risers at a department store or bed/bath store to raise it; if too high (you cannot sit on the edge of the bed with your feet on the floor), consider using a different bed after surgery until your mobility improves
- Sturdy armchair available to use while dressing
- Most commonly used clothing placed in top drawers for easy access
- Phone on table next to bed
- Lamp and flashlight next to bed
Medicare Spend on Post-Acute

Acute and Post-Acute Payments for 30-Day Episodes

Medicare Acute and Post-Acute Care Payments for 30-Day Episodes that Begin with Hospitalization ($)

Managed care spending is not included in this chart.
Source: CMS, Office of the Actuary (Healthcare Spending and the Medicare Program MEDPAC, June, 2012)

Post-Acute Model Redesign

- **Strategic Post-Acute Care Governance**
  - Alignment and decision-making
  - Measurement and transparency
  - Strategic planning

- **Post-Acute Preferred Partnerships**

- **Transitions in Care/Cross Continuum Collaboration/Readmission Prevention**
Post-Acute Care Network Considerations

- Narrow network of partners
- Quality and citizenship ratings
- Embedded providers
- Seamless communication
- Post Acute performance improvement teams
Transitions in Care

- Risk screening on index admission
- Targeted intervention for high risk patients
- Standardized education tools/Models of Care
- Medication reconciliation
- Follow up phone calls
- Appointments made before discharge
- Active cross continuum teams
- Automated readmission notification EMR
- Post Acute Care performance improvement teams
- Real time patient notifications (Patient Ping)
Considerations and Success Factors

- Plan early
- Evaluate for “Bundle” / Innovation Readiness
- Engage and aligned physician partners at the outset
- Embrace transparency for performance of program, providers, post-acute facilities
- Establish an improvement system for testing change and sustainability (LEAN, MFI, Six Sigma)

*If you can't measure it, you can't improve it.*
- Peter Drucker
Thank you!

Stephanie Calcasola, MSN, RN-BC, CPHQ
VP of Quality and Safety
Hartford Healthcare
PHYSICIAN ENGAGEMENT: A CRITICAL SUCCESS FACTOR FOR BUNDLED PAYMENTS

Rocco Orlando III, MD
SVP and Chief Medical Officer
Objectives

- Name three ways clinical innovation and redesign can support effective clinical care under bundled payments
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- Identify key elements of successful operations management in a bundled payment environment
A high performing physician network advances its organization’s clinical and operational strategy by recruiting and developing the right clinical talent, defining and executing a differentiated strategy and delivering high quality, reliable care in the most appropriate setting.
Succeeding in Bundled Payments with Aligned Physicians

- Develop tools for partnerships with physicians
- Develop strong governance to ensure decision making
- Eliminate unnecessary clinical variation
- Data transparency with docs is critical
- Ensure complete and accurate coding and documentation
HHC has a pluralistic physician engagement model

HHC Medical Staff = 2,419

- 72% Non-employed
- 15% Employed by HHC Hospital
- 13% Employed by HHCMG

December 12, 2017
HHC Medical Group: A potent driver for change and engagement

- Will include nearly 500 providers by January 2017
- Serves as laboratory for physician engagement
- Will pilot new experience curriculum for providers this year
- Developing a cohesive culture fostered by physician engagement in the direction of the group
- Physicians are key leaders in the medical group
Tools to Engage Physicians: The Clinically Integrated Network

Integrated Care Partners: HHC has a clinically integrated network with 2000 providers
- 5 commercial contracts – 200,000 covered lives
- Medicare Shared Savings Program
- Responsible for managing CJR Bundle (Hips and Knees) with our orthopedic surgeons
Tools to Engage Physicians: Co-Management Agreements

- Co-management agreements are used with large orthopedic groups to oversee two orthopedic institutes: Bone and Joint Institute at Hartford Hospital and Connecticut Orthopedic Institute at MidState Medical Center.

- Orthopedic surgical leadership is charged with operating these facilities in partnership with the health system including bundles and ambulatory surgery centers.
Tools to Engage Physicians: Clinical Councils

Over 40 Councils at Hartford HealthCare drive clinical improvement: these groups can be used to be successful in bundled payments

- System focused
- Improve clinical outcomes
- Identify best practices and eliminate variation
- Aligns Physicians with health system efficiency outcomes
- Set clinical goals
Councils 1.0: The Beginning

- First effort to drive clinical performance across our system
- Began in clinical areas with good relations
- Began the work of the councils with the hospitals and expanded to include community and behavioral health organizations over time
- Council work in the first two years was **optional**: work was brought back to member institutions and **might or might not be adopted**

**2011**

**Founding Four**

- Emergency Medicine
  - System-wide ED Risk Assessment
- Hospital Medicine
  - Common Protocols and Procedures
- Pharmacy and Therapeutics
  - Standardization achieved significant cost reductions
- Infection Prevention
  - Universal Influenza immunization for HHC

**Early Lessons**

- Interdisciplinary teams were more effective
- We added structure and rigor to the process
- Physicians ahead of nurses in readiness to eliminate variation
- **We have always been able to reach consensus!!!**
Councils 2.0: Driving Change

Requires Attention to “Clinical Governance” Clinical leadership, Council oversight

Focus on clinical best practices/standardization

Hospital Medical Executive Committees Adopt Council Work & Becomes “Consent Agenda” Approval

Increased Efficiency & Decreased “Time to Market” for New Policies & Procedures

Enhanced “Systemness” with Central Policy Office

Embedded Supply Chain with enhanced focus on cost effectiveness
Councils 3.0: Integration

- Council structure incorporated into institutes (where appropriate)
- Councils Set Annual Goals
  - Quality & Safety
  - Efficiency ($)
- Work is tied to Balanced Scorecard Initiatives
- Councils have accountability for results
- Councils will now incorporate Lean Facilitation
- Continue to do EPIC work
Clinical Governance at HHC

Medical Executive Committee

VPMA Leadership Council

Hospital Clinical Leadership Council

Nursing Executive Council

Boards

Non Institute Councils

Emergency Medicine
Ob/Gyn
Hospitalist
Wound Care
Endocrine
Care Coordination
Critical Care
Antibiotic Stewardship
Palliative

Peri-Op Services

Peri-Op
Surgical Anesthesia
Robotics
*GI
Bariatric

Institute Councils

Cancer
Breast DMT
GU DMT
Lung DMT
GYN Onc DMT
GI DMT
Hematology
Thoracic
Radiation
Medical Oncology

Neurosciences
Stroke
Spine
Epilepsy
Movement Disorders

Cardiovascular
Cardiology
Endovascular
Acute Coronary Syndrome

Behavioral Health
Behavioral Health Quality
Suicide Prevention

Bone and Joint
Orthopedics

Nursing

Support Councils

Pharmacy & Therapeutics
Infection Prevention
Pathology
Patient Experience
Radiology
Clinical Informatics

System Collaborative

Penn-Op Nursing
Pressure Ulcers
Falls
Policy & Procedure
Med. Administration
Clinical Documentation
Nursing Clinical Practice
Culture: An essential element of success in bundled payments requires an investment in physicians

- Provider Leadership Development Institute
- 7 years ago, there was only a single physician executive at the system level
- Presently, there are 3 physicians in the system C-suite
- Physicians-in-Chief are senior leaders in the organization
- Medical Group Physician leadership is robust with a Physician-in-Chief, VPs for primary care and specialty and a divisional structure for MD leadership
- Many system executives have their roots in clinical care: RN, MD and RPh
Thank You!

Rocco Orlando III, MD
Chief Medical Officer
and Senior Vice President
Hartford HealthCare Corporation
Operations and Administrative Models to Support Bundles

Trisha Frick, RN, MS, Johns Hopkins HealthCare

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Johns Hopkins Health System

6 academic and community hospitals

3 affiliated delivery systems

39 primary health care outpatient centers

40,000+ employees
Maryland Medicare Waiver

- All-payor, hospital rate regulation since 1974
- In 2014, CMS approved a new waiver, a 5 year pilot program
  - Accountable for total hospital cost of care on a per capita basis to meet triple aim
  - Cost reductions built into rates
- Maryland hospitals not allowed to participate in CMS based bundled payment programs
- All bundled rate agreements are Prospective Models
Bundled Rate Experience FY17

- Total Revenue: $50.4M
- Number of Cases: 533

BMT $24.5M
SOT $18.4M
Joint Replacement $4.3M
Bariatric $1.7M
Cardiovascular $1.5M
Executive Health $11K

BMT 153 cases
SOT 83 cases
Joint Replacement 177 cases
Bariatric 74 cases
Cardiovascular 42 cases
Executive Health 4 cases
Bundled Operations Team

Contracting Director
Contracting, Pricing, Regulatory and Operations Oversight

Contracting Assistant Director
Contracting, Pricing, and Regulatory Reporting

Finance Assistant Director
Financial Reporting, Accounting and Billing Oversight

Nurse Coordinators
Bundled Patient Identification, Clinical and Financial Monitoring

Claims Administrators
Bundled Rate Billing and Claims Monitoring
Claims and Payment Process

1. Provider bills services
2. OMC receives claims (set up as payor in EPIC)
3. OMC reconciles claims and bills to payor
4. Payor renders payment to JHHC
5. JHHC posts payments to dept/facility
Software Requirements: Bundled Operations IT System

Must have an IT system to administer prospective bundles

- Operational Requirements
  - Patient registration
  - Clinical and financial monitoring by nurses
  - Produces one page summary bill
  - Accounts payable: divides up the bundled amount
  - Monthly accounting: Total Revenue, Volume, P & L by Payor, P & L by Procedure, Pay for Performance Payout
  - Calculate withhold, gain-share, shared savings

JHM Proprietary System

- Home grown at first
- McBee Associates assisted in development of our own database in 1998
  - Completed 3rd upgrade
Effective Feedback System

- Monthly Travel Operations Meeting
  - Contractual commitments: process improvement for meeting deadlines/obligations.

- Monthly Ortho Joint Practice Council
  - Present data: LOS, performance indicators
  - Process: where is the team not making the required time frames?
  - Where are there bottlenecks?
  - What can be done differently?
Contract Evaluation

- Bundled operations team assessment
  - Ask your team for any problem areas.
  - Are there any issues from the provider or payor perspective?
  - Is this anything that should be done differently?
  - Are there components that are missing?
  - Can billing process be more efficient?
  - Are there any terms/requirements influencing patient compliance?

- Finance and senior leadership
  - Financial performance reported monthly and annually
  - Shared savings calculations and reporting
  - Are the results worth the risk?
Thank you!

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Faculty Panel: Q&A