BUNDLING AND VALUE BASED CARE:
HOW TO GET STARTED

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40 Minutes
The existing deficiencies in health care cannot be corrected simply by supplying more personnel, more facilities and more money. These problems can only be solved by organizing the personnel, facilities and financing into a conceptual framework and OPERATING SYSTEM that will provide optimally for the health needs of the population.

DR. ROBERT EBERT
FOUNDER, HARVARD COMMUNITY HEALTH PLAN, 1965
PATIENT CENTERED VALUE SYSTEM FOR DELIVERING VALUE BASED CARE ... THE “HOW TO” BUNDLE

Experiences

Outcomes

True Cost
THE BASICS: VALUE BASED CARE AND BUNDLING
MOVING FROM VOLUME TO VALUE

Value = Outcomes
(Important to Patients)

Cost
FEE FOR SERVICE (FFS) VS BUNDLING

FFS: Each provider delivers care and bills separately for their services.
FEE FOR SERVICE (FFS) VS BUNDLING

BUNDLING FOR EPISODIC CARE:

-A single entity (hospital, physician group or a 3rd party) coordinates all care (sometimes called the “convener”)

- Services provided within a defined episode of care and for a set time frame

- Assumes all financial risk for full episode and receives a single payment
EARLY PRIMITIVE BUNDLING: Diagnostic Related Groups (DRG’s)

- Hospital paid fixed amount for a DRG
- ”Bundles” initially only hospitalization then extended to 30 days post discharge for readmissions and complications
- However, excludes most professional services and all outpatient services
“MODERN” BUNDLING PROGRAMS

• All providers, services and costs included in the defined time frame for a given care episode
WHAT DOES A BUNDLED PAYMENT MEAN?

TRADITIONAL FEE-FOR-SERVICE

PAYMENT FOR EACH SERVICE REGARDLESS OF QUANTITY OR QUALITY

$ $ $ $ 

PRE ADMISSION SERVICES

PART A INPATIENT SERVICES HOSPITAL

PART B INPATIENT SERVICES MDS

POST ACUTE COST

PART A AND PART B

PART A INPATIENT SERVICES HOSPITAL

BUNDLED PAYMENTS

PAYMENT FOR COMPREHENSIVE, COORDINATED INTERVENTION

$ $ 

VS.
GOALS OF BUNDLING PROGRAMS

• Meant to incentivize providers to redesign care across the entire episode and time frame, i.e., “full cycle of care”
• Should include quality, outcomes, and experience metrics.
• Make costs “known” for payer
• Promotes care coordination between providers and organizations
• Creates alignment and reduces silos between patients, MDs, hospitals and organizations (inpatient and outpatient)
• Improves quality, reduces waste and variation (?)
• Lowers cost (?)
CONS

• Doesn’t tackle utilization of services
• Patient selection or “de-selection”?
• More risk than FFS
• Forcing change which can be tough for individuals and organizations
• Can seem to be very complex to get started and implement
BUNDLING CARE VS BUNDLING PAYMENTS
BUNDLING CARE VS BUNDLING PAYMENTS

• Must always bundle care first

• Engages clinicians and providers in the process early

• Once you define the care bundle, then you can assign costs/payment
THE OPPORTUNITY FOR PROVIDERS: BUNDLING CARE THEN BUNDLING PAYMENTS

- Couple clinical and financial performance
- Combine new care delivery models and payment systems
- Where and how to start?
PCVS: AMAZINGLY SIMPLE... AND SIMPLY AMAZING

Experiences

Outcomes

True Cost
YOUR “OPERATING SYSTEM” TO DELIVER VALUE

1. View all care as an experience through the eyes of patients and families

2. Co-Design

3. Implementation and Build Your Teams
PCVS IS THE WAY TO DEVELOP AND MANAGE YOUR BUNDLES AND DELIVER VALUE

- SINGULAR FOCUS AND CUSTOMIZED FOR HEALTH CARE
- BUILDS GREAT CARE TEAMS
- BREAKS DOWN SILOS
- GENERATES URGENCY
- DELIVERS VALUE, BUNDLING, POPULATION HEALTH
THE EXPERIENCE BASED DESIGN SCIENCES

- DESIGNING SERVICES, INTERACTIONS, PROCESSES AND ENVIRONMENTS FOR THE COMPLETE EXPERIENCE
- MAKING IT BETTER FOR THE END USER
ALIGNS OUR MISSION WITH THE CATALYST TO DRIVE CHANGE
BUNDLING
STEP BY STEP
HOW TO DEVELOP CARE BUNDLES: STEP BY STEP

1. Establish the care experience to bundle

2. Determine the time frame and the start/end of the care experience

3. Determine your “current state” by shadowing ie current (actual) care pathways, touchpoints and providers.
HOW TO DEVELOP CARE BUNDLES: STEP BY STEP

4. Establish your implementation team with representation from all the touchpoints determined from shadowing.

5. Compare your current state to the ideal goal and identify opportunities for improvement i.e. your gap analysis.

6. Close the gap with co-design.
HOW DO YOU DECIDE WHAT SERVICES TO BUNDLE?....EPISODIC CARE IS A GOOD PLACE TO START

- Market mandates bundle
  - Transplant services
- Physician expresses interest
  - Thyroid & parathyroid
- New opportunity for growth
  - Rare & complex cancer
- Payor/employer expresses interest
  - Joint replacement
- Self-pay services (often non-covered by payor)
  - Bariatric surgery
- CMS mandated bundled
  - CJR
EXAMPLE CARE EXPERIENCES

- TJR Care
- Spine Care
- Maternity/Delivery
- CHF patients
- CABG patients
- Heart valve patients
- Acute myocardial infarction patients
- Sepsis patients
- Primary Care
PATIENT CENTERED VALUE SYSTEM: THE “OPERATING SYSTEM” FOR BUNDLING

1. Build Teams Coupled With Patient Centered Process/System Improvement
2. Shadowing
3. Time Driven Activity Based Costing (TDABC)
1. PATIENT CENTERED PROCESS/SYSTEM IMPROVEMENT AND BUILDING TEAMS

1. DEFINE CARE EXPERIENCE

2. GUIDING COUNCIL

3. SHADOW, CURRENT STATE, URGENCY

4. WORKING GROUP THROUGH TOUCHPOINTS

5. SHARED VISION OF THE IDEAL

6. PCPI PROJECT TEAMS CLOSE THE GAP

IDEAL BUNDLE

CURRENT STATE
2. SHADOWING

- Shadowing is repeated real-time observations of patients and families as they move through each step of their healthcare journey.

- Shadowing the “system”
We watch what people do (and do not do) and listen to what they say (and do not say). The easiest thing about the search for insight – in contrast to the search for hard data – is that it’s everywhere and it’s free… …This enlightened perception reveals the experience, not just the process.

TIM BROWN
CHANGE BY DESIGN
SHADOWING

• DETERMINES YOUR CURRENT STATE

• IDENTIFIES TRUE CARE PATHWAYS

• IDENTIFIES IMPLEMENTATION TEAMS

• ENGAGES PATIENTS, FAMILIES AND PROVIDERS IN CO-DESIGN
goShadow: MERGING TECHNOLOGY WITH PROCESS IMPROVEMENT (goShadow.org)

APP COLLECTION TOOL

CLOUD BASED COLLABORATION PLATFORM
goShadow: AUTOMATICALLY GENERATED REPORTS

- CARE PROCESS MAPS/PATHWAYS
- TIME STUDIES
- OPPORTUNITY REPORTS
- TRANSITIONS OF CARE/SILOS
BUNDLING CARE? FOLLOW THE PATIENT!

1. Home
2. Physician Office
3. Hospital
4. Health Insurance
5. Pharmacy
6. Rehab or Skilled Nursing Facility
7. Home Health
8. Outpatient Therapy
WHERE TO START?
70+ CARE EXPERIENCE WORKING GROUPS

- Home Health Exp
- Mental Health
- Dental
- ER Registration
- Life After Wt Loss
- ENT Experience
- Imaging
- Urgent Care

- Communication in Ambulatory
- OP Surgery
- Urology
- Gyne-Onc
- Cancer Treatment
- Emergency Dept
- Ortho
COMMUNITY OF PRACTICE

United States: 27
International: 7
MOVING TO VALUE

Value = \frac{Outcomes}{Cost}

Outcomes (Important to Patients)
VALUE = WHAT MATTERS TO YOU?

• Learn What Patients and Families Care About

• This is Co-Design!
WHAT MATTERS TO YOU?

ACCESS TO PROVIDERS  
CARE COORDINATION  
COURTESY  
DIGNITY  
RESPECT  
SAFETY  
INFORMATION  
SHARED DECISIONS  
EMOTIONAL SUPPORT  
COMMUNICATION  
CONVENIENCE  
CLEAN  
QUALITY  
AFFORDABLE  
FAMILY INVOLVEMENT  
COMFORT
NUMERATOR = OUTCOMES

Value = \frac{Outcomes}{Cost}

Outcomes
(Important to Patients)
NUMERATOR = PATIENT REPORTED OUTCOMES (PRO’S)

Any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else. - National Quality Forum

Independent Assessment of Physical, Mental and Social Well-Being
DENOMINATOR = TRUE COST

Value = \frac{Outcomes}{\text{Cost}}

(Important to Patients)
Real Costs...Not Charges or Reimbursements

Hospital Charges $89,104

Patient $100

$26,696 Hospital Reimbursement
Time Driven Activity Based Costing (TDABC)

Shadow a full cycle of care:

- Personnel
- Space
- Equipment
- Consumables

All resources for any clinical condition

Robert S. Kaplan and Michael E. Porter
“How to Solve the Cost Crisis in Health Care,” HBR 2011
IMPLEMENT TDABC BY SHADOWING

1. Identify segment of care
2. Create process maps
3. Determine time/resource used
4. Determine $/min per resource
5. Calculate total cost
WELCOME TO THE MAGEE BONE AND JOINT CENTER

Delivering Value with Volume
THE BONE AND JOINT CENTER

• System Approach: “Hospital within a Hospital”
• 1,726 surgeries FY17 - 2 ORs/day
• 90+% of all patients d/c directly to home
• Lowest LOS
• Best Outcomes
• Best Operational Efficiencies
• Lowest (real) cost per case
• Best Performance in CMS Bundling
WHEN YOU DELIVER REAL VALUE PATIENTS AND FAMILIES BECOME “EVANGELISTS”

The Bone and Joint Center National HCAHPS Percentile Rankings

(![](chart.png)

- Rate Hospital (% choosing 9 or 10)
- Recommend Hospital (% choosing definitely yes)
ADDED BENEFITS OF CO-DESIGN: PATIENT AND FAMILY ACTIVATION

• Patient's knowledge, skills, ability and willingness to manage their own health and care

• Improves clinical outcomes
“REVERSIBLE CO-MORBIDITIES” IN BUNDLED CARE

- Weight No More (BMI)
- Blues No More (Depression)
- Smoking Cessation
- Pre-op Opioid Use
Determining the True Cost to Deliver Total Hip and Knee Arthroplasty Over the Full Cycle of Care: Preparing for Bundling and Reference Based Pricing.

DiGioia, et al., The Journal of Arthroplasty, 31(1)1-6, 2016
SHADOW THE CARE SEGMENTS (...SAME FOR ANY EPISODIC CARE EXP)
THIS IS YOUR BUNDLING TEAM

Personnel Categories

Pre-Hospital

23

Inpatient

27

Post-Hospital

14

Number of Organizations

3

5

4
TRUE COSTS FOR THE FULL BUNDLE

**THR**
- Personnel: 45%
- Space: 2%
- Equipment: 1%
- Consumables: 52%

**TKR**
- Personnel: 50%
- Space: 2%
- Equipment: 3%
- Consumables: 45%

**Implant Cost in a Bundle**
- THR: 40%
- TKR: 30%
IDENTIFY COST DRIVERS AND BEGIN PROCESS/SYSTEM IMPROVEMENT EFFORTS

TIGHTLY COUPLE CLINICAL AND FINANCIAL PERFORMANCE
FOCUSING RESOURCES

1. Pre-Op/Office
2. Pre-Op Testing & Consults
3. Day of Surgery/OR
4. PACU
5. Hospital Stay
6. Therapy
7. Follow-Up Visits

<table>
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<tr>
<th>Category</th>
<th>TKR %</th>
<th>THR %</th>
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<tbody>
<tr>
<td>Pre-Op/Office</td>
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<td>1%</td>
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<td>Pre-Op Testing &amp; Consults</td>
<td>7%</td>
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<tr>
<td>Day of Surgery/OR</td>
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<td>2%</td>
<td>2%</td>
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<tr>
<td>Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
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<tr>
<td>Follow-Up Visits</td>
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CONSUMABLE COSTS (THR) FOR THE FULL BUNDLE

53% of Cost related to Consumables

77% Implant

11% Medications

5% Custom Hip Pack

2% General Nursing

2% Saw Blades

1% Skin Antiseptic

1% Surgical Dressing

1% Suture Materials
TOTAL PERSONNEL COST

*All cost data has been disguised*
## Personnel Capacity Rate ($/Min)

**Total # of Personnel = 46 Categories**

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate ($/Min)</th>
<th>#1 - 10</th>
<th>Category</th>
<th>Rate ($/Min)</th>
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THREE DIFFERENT BUNDLES/HOSPITALS PLUS INPATIENT VS. OUTPATIENT THR

Facility #1 - $9,400
Facility #2 - $11,000
Outpatient THR - $7,400

- Pre-Op + Office
- Pre-Op Testing + Consults
- Day of Surgery + OR
- PACU
- Hospital Stay
- Therapy
- Follow Up Visits
ACHIEVING THE VALUE TRIFECTA

Blood Conservation Program

- Transfusion Rates <1%
- No AutoVac $75,951/yr
- No T/C $242,112/year
- No T/S $240,657/year
CMS – THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CJR) MODEL

• Started 4/1/16
• Episode: 90 days
• Hospital Centered
• Shared Benefits (and Risks)
CORPORATE QUALITY OF CARE FOR BUNDLING

Quality Performance

<table>
<thead>
<tr>
<th></th>
<th>CJR Year 1</th>
<th>THA/TKA complications measure quality improvement points</th>
<th>THA/TKA complications measure quality improvement points (if applicable)</th>
<th>HCAHPS measure quality performance points</th>
<th>HCAHPS measure quality performance points (if applicable)</th>
<th>THA/TKA patient reported outcomes (PRO) data</th>
<th>Composite Quality Score (Max=20)</th>
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BUNDLING AND POPULATION HEALTH NEEDS THE PATIENT CENTERED VALUE SYSTEM

• Identifying patients’ needs is crucial
• Different kinds of care teams
• Co-design with the community
BUNDLE AND DELIVER VALUE WHILE TRANSFORMING CARE DELIVERY

Experiences

Outcomes

True Cost
Patient Centered Value System

“I highly recommend this book to healthcare professionals of all types and at all levels, including Chief Executive Officers, Chief Financial Officers and those responsible for quality, safety and patient care. The Patient Centered Value System as the new operating system for healthcare delivery points the way to personal and professional satisfaction and the experience of joy in work while helping patients and families to become true partners in care through co-design.”

- Donald M. Berwick, MD
President Emeritus and Senior Fellow, Institute for Healthcare Improvement

www.crcpress.com
or
www.amazon.com