

Patient Reported Outcomes in Value Based Payments

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Learning Objectives:

1. Explain what value in healthcare means and discuss the evolving role of Patient Reported Outcomes in the value equation.
2. Describe how Patient Reported Outcomes can be incorporated into a value-based payment model.
3. Identify barriers to, and facilitators of, successful implementation of Patient Reported Outcomes.



Objective #1: Explain what value in healthcare means *and* discuss the evolving role of Patient Reported Outcomes in the value equation.

Value in Healthcare


- Improving performance and accountability in healthcare delivery requires a shared goal between multiple stakeholders uniting what are often conflicting interests, such as:
 - Access to services, profitability, high quality, cost containment, safety, convenience, patient-centeredness, and satisfaction.
- Current consensus in healthcare seems to be that achieving high value is this shared goal. The idea is that as value improves, all stakeholders benefit.

value = health outcomes achieved per dollar spent

Value in Healthcare

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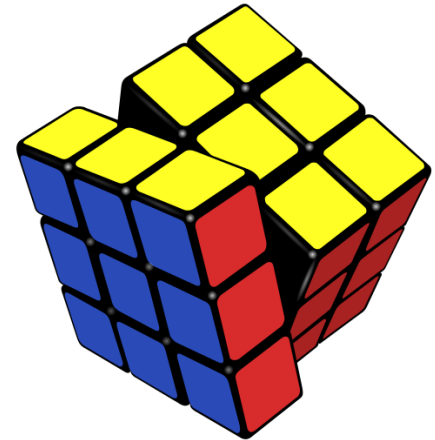
or

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


Improving value is optimizing the relationship between cost and outcomes. We want better outcomes, but at a lower cost.

Value in Healthcare: Outcomes & Cost

- To drive progress in improvement of value, we need rigorous and disciplined measurement and for value for *patients* to determine the rewards for all actors
 - Results measured by the **outcomes** achieved (not by the process of care used)
 - Outcomes (the numerator of the value equation) are condition-specific and multidimensional. No single outcome captures the results of care.
 - **Cost** (the value equation's denominator), refers to the total cost of the full episode of care for a patient's specific condition - not the cost of individual services.



Value in Healthcare: Connecting Cost & Outcomes

- Essentially, we have to create a mechanism where we:
 1. Bundle the costs for a clinical episode
 2. Measure patient value by outcomes achieved
 3. Tie the (bundled) payments to patient outcomes



Objective #2: Describe how Patient Reported Outcomes can be incorporated into a value-based payment model.

Bundled Payments Connect Cost & Outcomes

- In the emerging payment reform programs, the delivery system will shoulder a larger burden of financial risk and both hospitals and physicians will face increased accountability with payment tied to clinical outcomes.
- One of the most attractive payment reform programs is episodic bundled payments. In this model, a payer reimburses a contracted price for an aggregation of services within a defined episode of care.
- Under this payment, doctors, hospitals, and other providers share a single payment. **This challenges the delivery system to wring out inefficiency and push providers toward standardization intended to eliminate unnecessary services and improve quality.**

The CJR (CMS Bundled Payment)

- CMS implemented a new payment model starting in April 2016 called the Comprehensive Care for Joint Replacement (CJR) model in which acute care hospitals receive a retrospective bundled payment for hip and knee replacements.
- Includes hospitalization and 90 days post-discharge:
 - Physician's services, IP Hospitalization, IP readmission, SNF, Home health, Hospital outpatient services, Outpatient therapy, Labs, DME, Part B Drugs



CJR Bundle Risk Structure

- Retrospective, two-sided risk model with hospitals bearing financial responsibility:
 - Providers paid via Medicare FFS
 - After the performance year, actual episode spending will be compared to target prices
 - If aggregate target prices are greater than actual episode spending, hospitals may receive a reconciliation payment
 - If aggregate target prices are less than actual episode spending, hospitals will be responsible for making a payment to Medicare.



The CJR Pays for Quality

- A composite quality score reflects performance on the two quality measures (Complications and HCHAPS) in addition to reporting of THA/TKA patient reported outcomes.
- This composite quality score determines:
 - Hospital eligibility for reconciliation payments if savings are achieved beyond the target price
 - Amount of quality incentive payment that may be made to the hospital
 - *Note: Hospitals are allowed to create physician gain-sharing agreements subject to certain requirements of the CJR ruling*

Paying for Quality

- Hospitals must have a minimum quality score in order to have reconciliation IF there were savings achieved beyond the target price.
- Based on the quality score, hospitals may be eligible for a quality incentive payment which essentially translates to a discount percentage at reconciliation to 2% or 1.5%.



Example of Quality Composite Score (Pre Bundle)

- Below, you see where a sample of CJR contracted hospitals stood based on historical data before the launch of CJR.
- Note that only 3 hospitals had launched a PRO program of requisite scale, and 4 hospitals would have scored a 'Below Acceptable' quality score.

NAME	HCAHPS	Complications	PRO Points	Total Composite	Quality Category
	5.6	10	2	17.6	Excellent
	8	5.5	0	13.5	Good
	4.4	6.25	2	12.65	Good
	5.6	7	0	12.6	Good
	5.6	7	0	12.6	Good
	5.6	5.5	0	11.1	Good
	0	10	0	10	Good
	0	7.75	2	9.75	Good
	0	9.25	0	9.25	Good
	8	0	0	8	Good
	5.6	0	0	5.6	Acceptable
	0	5.5	0	5.5	Acceptable
	5	0	0	5	Below Acceptable
	5	0	0	5	Below Acceptable
	0	0	0	0	Below Acceptable
	0	0	0	0	Below Acceptable

Opportunity
↓

Alignment via Incentive Payments

- Hospitals may have certain financial arrangements with collaborators to **support their efforts to improve quality and reduce costs.**
- **CJR Collaborators** may include the following:
 - Skilled nursing facilities
 - Home health agencies
 - Long term care hospitals
 - Inpatient rehabilitation facilities
 - Physician Group Practices
 - Physicians, non physician practitioners
 - Providers and suppliers of outpatient therapy.



Alignment via Incentive Payments

- Hospitals may **share** with Collaborators:
 - Reconciliation payments in the form of a performance-based payment
 - Internal savings realized through care redesign activities
- Collaborators **are required** to engage with the hospital in its care redesign strategies in order to be eligible for such payments.



➤ Ideally, we have a hospital coming in under the target price more often than not and a good quality score – this is value according to the definition.

Value by the Numbers



	PY 1 (2016)					Projected Full-Year PY2			
	Volume	Initial Reconciliation Amount	Final Reconciliation Payment	Quality Score	Projected Quality*	Volume	Projected Final Reconciliation	Projected Gainsharing Amount	Adjusted Projected Final Reconciliation Amount
	72	(\$126,777)	\$0	Excellent	Good	132	\$156,038	\$0	\$156,038
	2	(\$26,909)	\$0	Acceptable	Good	2	\$4,660	\$0	\$4,660
	13	\$40,817	\$0	B. Acceptable	Acceptable	30	\$56,231	\$0	\$56,231
	88	\$247,897	\$131,345	Excellent	Excellent	212	\$286,299	\$0	\$286,299
	175	\$135,028	\$131,345			376	\$503,228	\$0	\$503,228
	98	\$249,618	\$119,676	Excellent	Excellent	254	\$314,350	\$157,175	\$157,175
	8	\$33,530	\$14,462	Good	Good	22	(\$9,783)	\$0	(\$9,783)
	37	\$15,553	\$15,553	Good	Good	86	\$106,666	\$53,333	\$53,333
	17	(\$36,654)	\$0	Good	Acceptable	62	\$86,655	\$43,328	\$43,328
	20	\$31,764	\$26,986	Good	Good	50	\$11,133	\$5,566	\$5,566
	180	\$293,811	\$176,676			474	\$509,020	\$259,402	\$249,618
	95	(\$93,277)	\$0	Good	Good	228	(\$366,219)	\$0	(\$366,219)
	56	(\$211,968)	\$0	Excellent	Good	86	(\$110,585)	\$0	(\$110,585)
	40	\$7,459	\$0	B. Acceptable	Acceptable	62	\$139,566	\$69,783	\$69,783
	516	\$324,661	\$324,661	Good	Good	1,048	\$653,217	\$326,608	\$326,608
	93	\$116,171	\$116,171	Acceptable	Acceptable	158	\$35,779	\$17,889	\$17,889
	21	\$93,784	\$42,699	Acceptable	Acceptable	32	\$54,276	\$27,138	\$27,138
	821	\$236,830	\$483,531			1,614	\$406,035	\$441,419	(\$35,384)
	1,176	\$665,669	\$791,552			2,464	\$1,418,283	\$700,821	\$717,463

Bumping up Quality Score

- There were many pieces of the care process that were re-designed or optimized to support achieving the target pricing (i.e SNF utilization, duplication of imaging, etc.)
- BUT no matter how well a hospital performed financially, if the quality was below acceptable, there would be NO net positive gain during reconciliation.
- Quality scores are very important in the model, and patient reported outcomes are a significant part of the outcome score.
 - AND, turns out, collecting and reporting PROs is.....difficult!

Objective #3: Identify barriers to, and facilitators of, successful implementation of Patient Reported Outcomes.

Summary of a PRO Solution

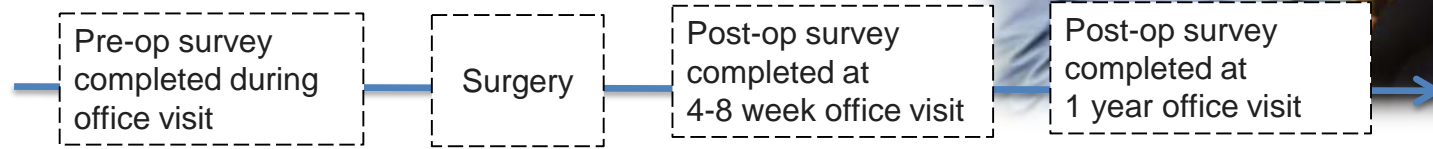
- PSJH spans diverse communities across 8 states 
- Well over 95% of our orthopedic surgeons are in private practice 
- Hospital system provides a venue to collaborate around care design and is supporting the PRO initiatives by:
 - Purchasing & configuring iPads
 - Device agreements w/ private practices
 - Contracting with PRO vendor (Tonic for Health)
 - Technical front end: survey requirements, design, testing and version control
 - Deployment, training, and support in the private practice setting
 - Technical back end: Data integration and enterprise data warehouse
 - Reporting and analytics (CJR, AJRR, ICHOM, internal value-based reporting, research)



Clinic Workflows



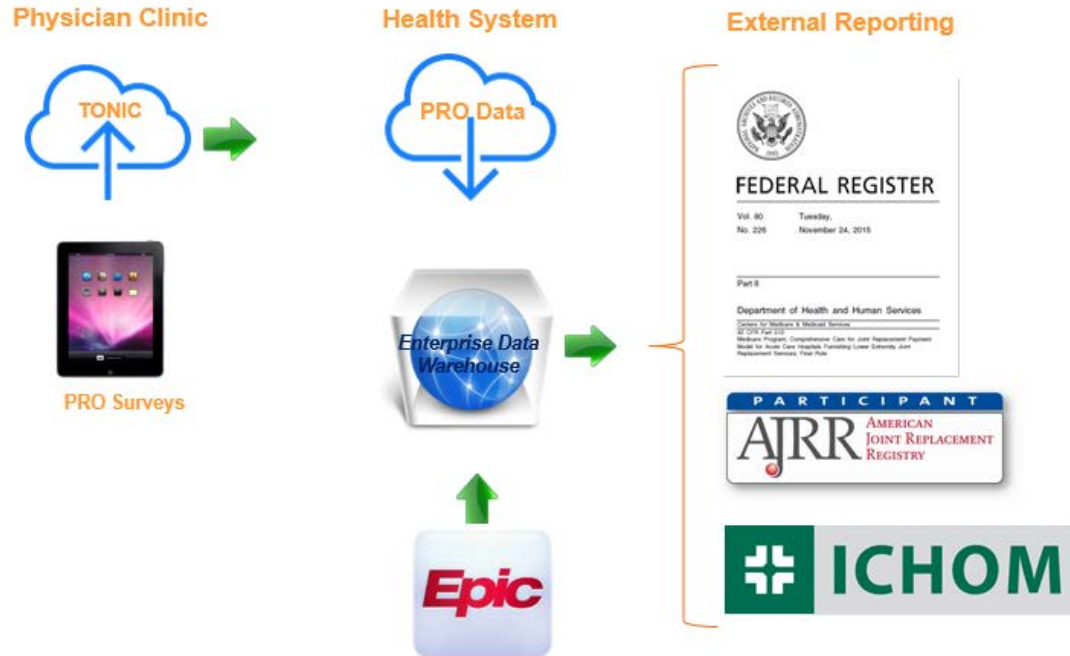
❖ Collection at Pre- and Post- Op during office visit



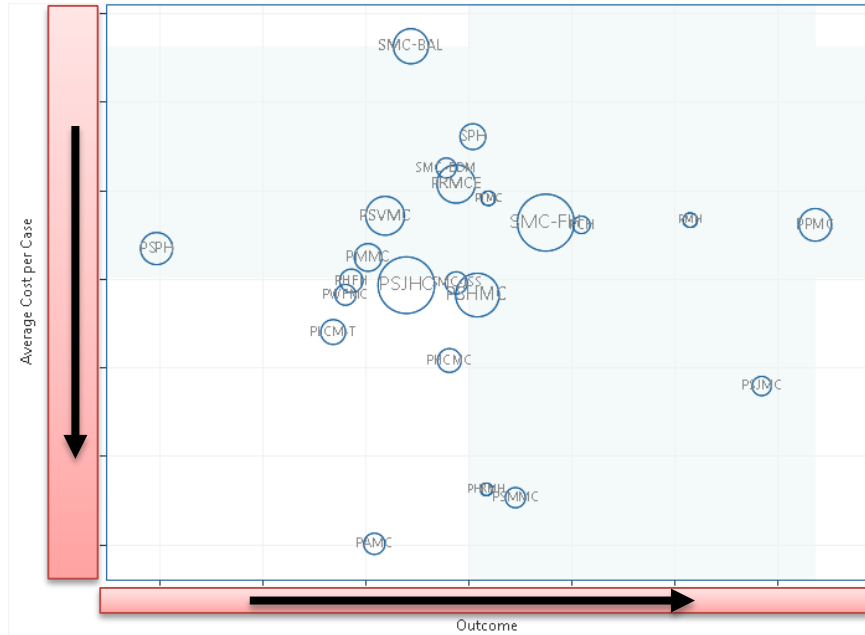
❖ Collection Pre- and Post-Op via email



Data Flow – VERY High Level



Internal Value Analytics

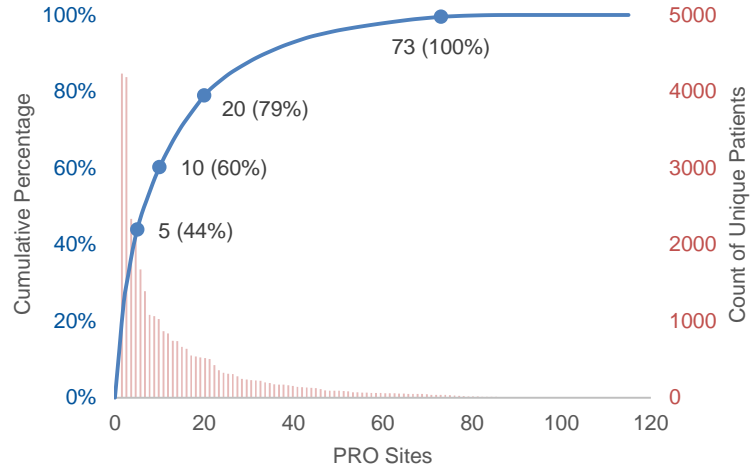


PRO matched EMR data

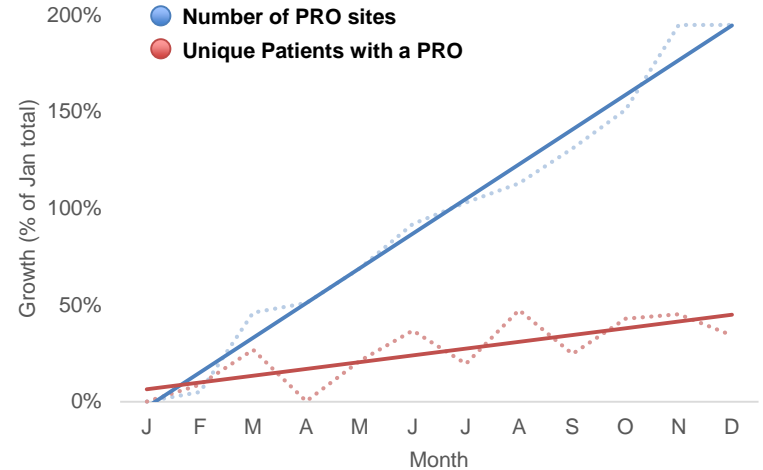
Matching the PRO data with our EMR allows for benchmarking and other quality and cost questions to be posed of the data.

Private Practice Adoption

In 2017, nearly half of patients who completed an assessment were seen at one of five clinics. Conversely, out of 115 sites, 43 (37%) collected virtually no PROs in 2017

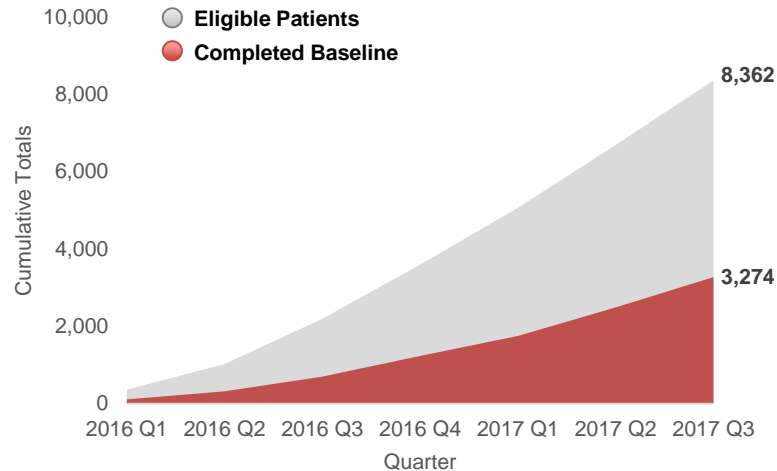


Despite 200 percent growth in the number of PRO sites, the number of unique patients who completed an assessment remained relatively flat, increasing by about 40 percent

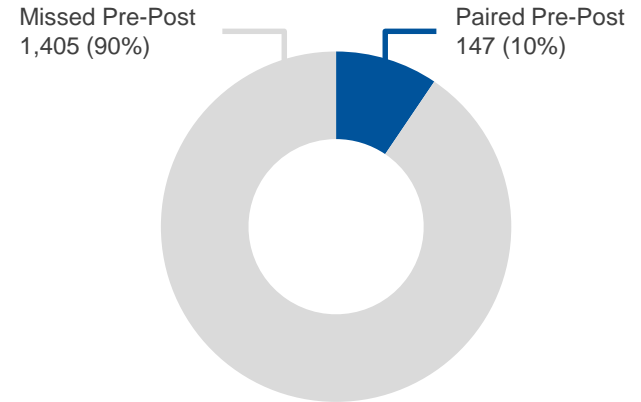


Proportion of PRO Capture

Looking within one Institute, where we have the most reliable data, we find that well under half (39 percent) of eligible patients completed a baseline assessment



After two years of data collection, we also have few paired assessment, which are necessary to assess the extent to which we are improving the lives of the patients we treat

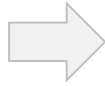
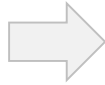
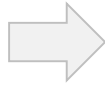
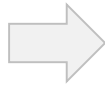


* Based on 1-year follow up

Evolving our PRO Solution

What have we learned?

1. PROs are not a “set it and forget it” activity. It requires optimization/continuous improvement
2. We need to move beyond thinking about PROs primarily in terms of data collection
3. Vendor ‘out of the box’ unlikely, need vendor willing to invest in the journey with PSJH
4. A small number of clinics account for the majority of data collection)



What are the Implications?

- Need to focus on quality over quantity, to ensure data are usable and to inform spread/scale of program
- Need to apply systems thinking to PROs, to deliver value to all stakeholders
- Need robust IT system with the functionality we need to be successful
- Shifting away from vendor to EHR may not be as disruptive as prior
- Ensuring we are getting good value from our enterprise licensing agreement



How do we proceed?

- Establish & track robust quality metrics
- Establish collaboratives to support local optimization efforts
- Collect/report data natively within Epic
- Develop new reporting objects to support operational excellence
- Move quickly to divest/replace vendor except where absolutely necessary
- Reprioritize Epic build to minimize reliance on vendor
- Renegotiate contract for 2019 to cover a specific number of clinics

Revisiting the 3 Learning Objectives

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Are there any questions or comments?

Thank you for having me today!

