ramping up for bundled payments
fostering hospital-physician alignment

Having begun as voluntary demonstration programs designed to coordinate care, lower costs, and improve outcomes, bundled payment initiatives are quickly becoming the new norm because of their potential to enhance care coordination. However, the absolute need for strong collaboration across the entire spectrum of care under bundled payment poses a challenge that continues to plague even forward-thinking health systems. Greater technology integration and a fully engaged physician community are essential to ensure positive outcomes and cost savings.

Bundled Payments Expand
More than 1,500 facilities nationwide are currently testing bundled payment innovation models, according to the Centers for Medicare & Medicaid Services (CMS). These numbers will continue to grow as the U.S. Department of Health & Human Services (HHS) forges ahead with its goal to tie 50 percent of all traditional or fee-for-service Medicare payments to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements, by 2018.

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a. See “Bundled Payment for Care Improvement (BPCI) Initiative,” CMS.gov.
For some organizations, bundled payments aren’t an option—they’re a requirement. Consider the Comprehensive Care for Joint Replacement (CJR) Model. This first-ever mandatory model, which went into effect April 1, 2016, is designed to test bundled payment and quality measurement for hip and knee replacements in approximately 800 hospitals across 67 metropolitan service areas. Hospitals required to participate in this bundle are accountable for the quality and cost of the entire episode of care, including 90 days post-discharge.

So far, the bundled payment model is working. More than 80 percent of participating hospitals report improved patient engagement, reduced administrative costs, and increased alignment with physicians. Impact on Physicians

The impact of bundled payments on physicians is significant. Some bundle models require physicians to negotiate payment arrangements directly with the hospital or hospitals included in the bundle. The hospitals—not the payers—then pay physicians accordingly.

When a practice is owned by or affiliated with a health system, the hospital can more easily negotiate a shared-savings arrangement and/or other nonfinancial benefits (e.g., office support staff) with physicians for participation in the bundle. Nonaffiliated providers pose a bigger challenge.

Some hospitals have used a comanagement approach in which any patient undergoing a surgery or admission automatically has a hospitalist consultation. A potential problem with this approach is that the hospitalist may duplicate testing that was performed prior to admission, driving up costs for the hospital while yielding minimal improvements in outcome.

Other hospitals are exploring ways to enable clinical documentation improvement (CDI) specialists to branch out into the outpatient setting and/or serve as liaisons with physician practices for bundled payment cases.

With bundled payments top of mind for physicians and hospitals, it behooves executives to proactively identify strategies for greater alignment, thereby creating a foundation for successful bundled payment arrangements and, ultimately, effective population health management.

CoxHealth: A Study in Bundling

CoxHealth, a five-hospital health system in Missouri, entered a voluntary bundled payment arrangement—a joint quality improvement project with Cox HealthPlans—in 2014 with a primary goal of reducing readmissions. CoxHealth’s first excursion into bundled payment was focused on two areas: pneumonia and respiratory infections. In 2015, CoxHealth voluntarily took on two additional bundles, congestive heart failure (CHF) and acute myocardial infarction (AMI). Its most recent bundle, the mandatory joint replacement bundle including hip and knee replacements, was implemented in April 2016. At the outset, the health system took four steps.

Established a working Medicare Severity DRG (MS-DRG). To implement bundled payment initiatives, the system had to determine which patients would fall into one of the bundles at discharge, once the chart was final-coded. CDI nurses worked with IT to design a daily report of all traditional Medicare patients who would potentially fall into the bundle (via the working MS-DRG entered by CDI staff), including patients whose reason for admission was a symptom indicating pneumonia or a respiratory infection (e.g., shortness of breath). Once each patient is reviewed by CDI, the working MS-DRG is entered into the medical record, allowing the care management team to follow the patient from admission to discharge and through the 90 days postdischarge.
**Revamped requirements for post-discharge appointments.** Best practice for bundled initiatives requires the patient be seen by a provider within seven days of discharge from an acute care inpatient stay. If a patient doesn’t have a primary care physician, CoxHealth helps make the connection and ensures that an initial appointment is scheduled with urgency—and within the seven-day time frame. Patients are more likely to adhere to their follow-up appointment when it is made for them prior to leaving the facility. CoxHealth data from year one showed a 93 percent adherence to follow-up appointments when scheduled by hospital staff prior to discharge and a 75 percent adherence if the patient or clinic made the appointment.

**Established a call center for after-hours scheduling.** This call center schedules follow-up clinic appointments after normal business hours as a convenient resource for patients.

Early success with pneumonia and respiratory infections resulted in both decreased readmission rates and reduced emergency department (ED) utilization. Baseline readmission rates for pneumonia and respiratory infections for CoxHealth averaged 25.9 percent prior to initiating bundled payment; within six months, that number had decreased to 23 percent. ED visits postdischarge also decreased, from 42.4 percent to 33.6 percent. After this early success with pneumonia, CoxHealth entered the voluntary bundled payment initiative for CHF and AMI in January 2015.

**CHF, AMI, and Major Joint Bundles Added**

The strategic goals for CoxHealth’s second wave of bundled payment initiatives was twofold: better manage CHF and AMI and keep patients with these chronic conditions out of the ED. To achieve these goals, the system used the previously described tactics, but also added social services and educational resources.

CoxHealth hired a social worker specifically for the ED. This individual identifies patients at high risk for hospital admission and works to coordinate services, such as durable medical equipment and oxygen, at home. Additional patient and family education regarding hospice care also was incorporated for CHF and AMI cases to improve service for end-stage patients, some of whom had as many as 16 ED visits annually.

With four bundles successfully implemented, CoxHealth turned to major joint replacements of the lower extremity. This area, in particular, required a focus on achieving stronger alignment with physicians—in this case, orthopedic surgeons.

**Three Ways to Align Physicians**

Collaboration with physicians is essential when entering a bundled payment program. By effectively engaging physicians during voluntary bundled payment initiatives, CoxHealth was able to establish a strong foundation for success as it expanded its bundled payment efforts. The health system believes three strategies for alignment and participation were instrumental in building this foundation.

**Reiterate the importance of coded data on publicly reported outcomes.** This is an effective way to pique surgeons’ interest in and curiosity about important coding areas such as severity of illness and risk of mortality, both of which play an important role in bundled payments.

**Perform peer-to-peer physician education for clinical documentation.** Orthopedic surgeons should be trained on how to document a thorough and complete history and physical to accurately reflect risk adjustment. At CoxHealth, the medical director of the CDI program underwent formal training as a physician adviser to be able to serve as an advocate and physician resource for orthopedic services.

**Revamp documentation processes.** Physician assistants and nurse practitioners should be engaged to assist the orthopedic surgeons with documentation to the extent possible.

**8 Proactive Steps**

Preparing for bundled payments is a smart move, even for hospitals not currently required to participate in the CJR model—bundled payments may eventually become a requirement for all. To get started, consider the following.
Invite the right players to the decision-making table. Participants should include CDI, case management, nurse management, and coding specialists; quality managers; and executive and physician leaders. At CoxHealth, a hospitalist oversees each bundle initiative, and an ED physician governs the entire program.

Meet regularly to discuss challenges, progress, and goals. Cases that fall into the bundle require close examination, because every case affects the target price. Particular attention should be given to cases that include mortality, readmission, high cost, or prolonged length of stay (LOS) to ensure patient complexity is accurately represented in clinical documentation and coding. The following are key questions to ask at this point:
> What’s the cost of these cases, and how do they impact the bundle?
> In cases with above-average LOS, are all comorbid conditions being captured?
> Does documentation accurately reflect disease severity and risk of mortality?
> Is case management performing effective discharge planning?

Enable data sharing via the electronic health record, when possible. To facilitate information sharing among providers, CoxHealth is converting all clinic EHRs to the same system used by the main hospital. This move also will allow the health system to focus more on preadmission/outpatient CDI.

Use data analytics. Doing so helps identify high-risk patients and enables real-time performance monitoring for specific bundle initiatives.

Define each bundle population correctly to ensure an accurate target price. Complete and accurate documentation and coding are required to capture all comorbid conditions that will appropriately define the severity of the population under treatment. If documentation doesn’t reflect patients’ conditions accurately, it won’t justify resource intensity.

It is also important to define the chronic disease burden of the respective population. The CMS-Hierarchical Condition Category (HCC) model, in particular, affects outcomes. To avoid being penalized, hospitals must ensure total costs do not exceed their hospital-specific target prices (based on historical fee-for-service payments).

Develop evidence-based care protocols for each MS-DRG in a particular bundle. Let physicians know that failure to follow these protocols designed to minimize clinical variation means a higher risk of falling outside the quality metrics for national outcome reporting.

Focus on physician buy-in. To fully accept participation in a bundled payment arrangement, physicians need to have a reasonable expectation that they will see an ROI. However, in addition to understanding the potential financial benefit of gainsharing, physicians should maintain their primary focus on clinical care. The goal of bundled payments is to foster collaboration and improve care through evidence-based medicine, cost-effective procedures, and patient engagement.

In addition, every attempt should be made to use peer-to-peer physician champions alongside hospital leadership to inform and engage the medical staff about bundled payment initiatives—voluntary or required.

Create a department devoted to population health management. This department typically is led by a vice president of quality or a quality coordinator who:
> Identifies target MS-DRGs
> Establishes chronic disease burden at the beneficiary level
> Coordinates CDI and coding efforts beyond the walls of the hospital
> Examines outcomes and strives for continual process improvement
> Establishes discharge clinics
> Assembles a high-performing post-acute care provider network of physician practices
> Coordinates care across all settings, including home health, skilled nursing, rehabilitation, and lab

Filling the Order
Bundles already have led to the expansion of ACOs and to the formation of clinically integrated networks
that go beyond employed physicians to include payers and health plans. During a time of increased transparency and a shift toward quality-based reimbursement, many providers realize that banding together makes more clinical and financial sense than working in silos. As with any major initiative, physician buy-in is critical.

Equally critical are the data that hospitals report and rely on for process improvement. The onus is on hospitals to establish the chronic burden of illness preadmission and coordinate all care postdischarge. It’s a tall order, but taking the appropriate steps when pursuing a bundled payment initiative creates an essential foundation for effective population management and value-based payment.

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