

Keck Medicine of the University of Southern California: Examples in Practice

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This Q&A is with Tony Herrera, director of Payment Innovation and Transformation at Keck Medicine of USC. Keck Hospital of USC, a large urban academic medical center serving the Metropolitan Los Angeles area and southern California, and USC Verdugo Hills Hospital, a community hospital in suburban Los Angeles, have both assumed risk for major joint replacement of the lower extremity (MJRLE) episodes under the Comprehensive Care for Joint Replacement (CJR) model since April 2016. In this informative exchange from April 2018, Herrera discusses Keck Medicine's strategies for success in MJRLE episodes, including the surgical pre-optimization process, post-acute care strategy, and future opportunities for savings.

Originally, participation in CJR was required for hospitals in selected mandatory metropolitan statistical areas (MSAs), including Los Angeles. What were Keck Medicine of USC's upfront investments to participate in CJR?

Keck Medicine of USC developed a robust infrastructure to implement CJR. To prepare for the program, we assembled subcommittees for CJR focusing on clinical, quality, and financial aspects of the program. These subcommittees meet regularly to discuss performance in CJR and recommend care redesign opportunities. In addition, Keck Medicine hired more nurse navigators to assist with care management, since effective care management is crucial to program success.

What interventions have been most successful for your joint replacement population?

To date, Keck Medicine of USC has focused on three primary strategies to improve patient outcomes and reduce episode cost: 1) optimizing and educating patients before surgery, 2) modifying the referral process for home health visits, and 3) strengthening relationships with post-acute care providers.

To reduce the risk of complications resulting from surgery and improve the patient experience, we worked with our pre-optimization clinic, or the Pre-Op Clinic, which many MJRLE patients attend. The Pre-Op Clinic is responsible for coordinating pre-operative clinical services by working with patients and providers to coordinate pre-operative care activities and ensure that patients are prepared for surgical services. Patient risks are identified so that risk

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To encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs, the Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payments for Care Improvement (BPCI) initiative. Due to the success of this program, the Centers for Medicare and Medicaid Services (CMS) announced the Comprehensive Care for Joint Replacement (CJR) program in July 2015. This mandatory bundled payment program focuses on major joint replacement procedures. The AAMC has collaborative groups that support both programs.

The Examples in Practice Series highlights the challenges faced and strategies used by leaders at health systems participating in BPCI and CJR. These examples offer potential lessons for other institutions pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing these payment-reform programs.

For more information on bundled payments, go to aamc.org/bundling.

factors can be decreased before surgery. Additionally, nurse navigators educate patients about what to expect after they are discharged. Although referrals to the Pre-Op Clinic are determined by physician preference, all CJR patients receive education about their discharge disposition, either through a nurse navigator at the Pre-Op Clinic or during the patient's appointment with the surgeon before surgery. As a result, patients are more prepared for surgery and the remainder of the episode.

To provide more effective post-acute care for CJR patients, the CJR clinical subcommittee recommended that Keck Medicine change the default number of home health visits for DRG 470 non-fracture patients after surgery from 12 to 5. Physicians and nurse navigators communicate with patients to determine whether it is clinically appropriate for the physician to order additional home health visits. Although this has resulted in increased work for physicians, they have championed this change because it is the best thing to do for patients.

Keck Medicine has also been extensively engaged in developing a robust post-acute care (PAC) network. Because post-acute institutional care is often the largest driver of cost variation in MJRLE episodes, Keck Medicine identified PAC strategy as the greatest area of opportunity for generating savings. After analyzing patterns of Keck Medicine's referrals to skilled nursing facilities (SNFs) and home health agencies (HHAs),

we issued a request for information (RFI) to our PAC providers about their care management processes and quality protocols. Once Keck Medicine analyzed the RFI responses, we selected preferred providers on the basis of the quality of their responses related to information sharing, clinical protocols, and quality of care. Through the RFI process, Keck Medicine generated a preferred PAC provider network, which increasingly incorporates quality of care and physician preference, in contrast to a network based exclusively on volume.

To engage PAC providers in the development of a preferred network, Keck Medicine meets quarterly with SNF and HHA representatives. Keck Medicine will begin to encourage the SNFs and HHAs to lead the discussion in these meetings and share best practices with their peers in the marketplace in order to enhance quality and reduce cost. The process of developing a preferred PAC provider network has underscored the importance of educating and engaging PAC providers in their role in payment and delivery system reform. When hospitals communicate effectively with and engage HHAs and SNFs, many PAC providers are receptive to change, even if that means reduced length of stay (as clinically appropriate) and potentially reduced revenue. Keck Medicine has communicated that we also intend to strengthen our PAC network for commercial patients through a similar process. PAC providers recognize that adhering to our clinical protocols and partnering with us is crucial if they intend to care for additional patient populations (other than our CJR patients).

Because Keck Medicine, particularly Keck Hospital, draws patients from a broad geographic area, I would imagine that this complicates the process of establishing a preferred network. How has Keck Medicine managed the creation of a preferred post-acute care network for such a geographically diverse patient population?

Yes, the broad geographic reach of Keck Medicine poses a challenge in developing strong relationships with all our PAC providers. Because the catchment area of Keck Hospital is so large (many patients travel 25 to 150 miles to have their MJRLE procedure here), this limits our ability to develop strong partnerships with home health agencies and skilled nursing facilities that are far away from the hospital. It is not uncommon for patients to receive surgery when they are visiting Los Angeles or for patients to travel from Santa Barbara (up to 150 miles) for specialty care at our hospital and receive PAC care later near their home. When the patient is discharged to a SNF or an HHA in Santa Barbara and is later readmitted to the hospital, Keck Medicine will ultimately be at risk for the costs of the episode, despite our limited ability to monitor the Santa Barbara PAC provider. This is a challenge inherent to academic medical centers participating in bundled

payments. However, we do our best to recommend PAC providers to patients near their home that best meet our quality standards while still allowing patient choice.

Given that Keck Medicine has focused extensively on reducing post-acute care spending as clinically appropriate, has the PAC component of savings been exhausted? As target prices become increasingly based on regional performance and it's not enough to beat your historical performance to generate savings, how will Keck Medicine adapt?

Keck Medicine's work on enhancing and expanding our preferred list of providers has not been exhausted; there will always be opportunities to improve our post-acute care network. However, we are now targeting additional components of episode spending that are also cost drivers, such as surgical supply cost and durable medical equipment, in order to continually generate savings as target prices become increasingly regionally based.

So Keck Medicine is identifying opportunities for internal cost savings (ICS)?

Yes, we will continue to focus on reducing our implant costs. Surgery supply cost is also important, so we are working on how best to make our surgeons aware of these costs. Additionally, we remain committed to reducing our readmissions, especially readmissions that happen outside our system, by diligent outreach from our nurse navigators.

We also identified significant variability in practice patterns in the use of continuous-motion machines. Although the evidence of clinical effectiveness is mixed, some surgeons frequently prescribed continuous-motion machines, while others did not prescribe them at all. This drove significant variability in PAC cost while producing a negligible effect on outcomes. As a result, Keck Medicine is attempting to reduce the prescribing of continuous-motion machines when it is not clinically necessary.

Wow, it sounds as if Keck Medicine is focusing on the components of episode spending that are the most difficult to reduce!

Yes, the CJR program strongly incentivizes providers to collaborate across the continuum of care and target spending that does not contribute to increased quality. Here at Keck, we are really excited to demonstrate positive results with a very complicated process. Reaching those goals is additional incentive to push forward even more to do what's right for our patients.