Bundled Payments and Drugs:
A New Role for Pharmacy

Cynthia Williams, BS Pharm, FASHP
VP/Chief Pharmacy Officer
Riverside Health System
FACULTY DISCLOSURE

The faculty reported the following financial relationships or relationships to products or devices they or their spouse/life partner have with commercial interests related to the content of this CE activity:

- Cynthia Williams: None
Learning Objectives

• Define episode-based care reimbursement and how pharmacy can play a role.
• Outline strategies for pharmacy to impact care in bundled payment initiatives.
• Demonstrate why outcomes become such an important metric in bundled payment
Practice Reflection Question

In which CMS alternate payment model is your organization participating?

A. Bundled Payment for Care Improvement (BPCI) Initiative
B. Comprehensive Care for Joint Replacement (CJR)
C. Oncology Care Bundle
D. None or not sure
Shift from Pay for Quantity to Pay for Quality

Traditional Medicare Fee for Service
- Payments made to providers for each service they perform for beneficiaries
  - Fragmented care
  - Minimal coordination across providers or settings
  - Rewards quantity vs quality

CMS Innovation Models of Payment
- Encourages hospitals, physicians and post-acute care providers to work together to improve coordination of care from initial hospital stay through recovery
CMS Innovation Models of Payment

• Accountable Care
• Episode-based Payment Initiative
  – Bundled Payment for Care Improvement (BPCI) Initiative
  – Comprehensive Care for Joint Replacement (CJR)
  – Oncology Care Model
  – Episode Payment Model for AMI and CABG
• Primary Care Transformation
• Programs focused on Medicaid/CHIP

Bundled Payments for Care Improvement (BPCI) Initiative

• 4 broadly defined models of care
• Links payments for the multiple services beneficiaries receive during an episode of care
• Organizations enter payment arrangements that include financial and performance accountability for episodes of care
• Aligns incentives for providers
• Models may lead to higher quality and more coordinated care at a lower cost to Medicare
• Voluntary

# Bundled Payments for Care Improvement (BPCI) Initiative

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>Selected DRGs; hospital plus post-acute period</td>
<td>Selected DRGs; post-acute period only</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
</tr>
<tr>
<td><strong>Number of Participants</strong></td>
<td>601</td>
<td>862</td>
</tr>
</tbody>
</table>

Types of Participants

• Awardee: Entity that assumes financial liability for episode spending

• Initiators: Healthcare providers that can trigger BPCI episodes of care. Participate in the model through agreement with BPCI awardee

• As of July 1, 2017, BPCI had 1224 participants
  – Acute Care Hospitals = 315
  – Skilled Nursing Facilities = 567
  – Physician Group Practice = 228
  – Home Health Agency = 79
  – Inpatient Rehab = 9

https://innovation.cms.gov/initiatives/bundled-payments accessed August 1, 2017
BCPI Participants

Source: Centers for Medicare & Medicaid Services

BPCI Initiative Clinical Episodes

• 48 clinical episodes include 180 Anchor MS-DRGs
• Represent approximately 70% of all possible episodes by Medicare volume and expenditures
• Episodes structured to promote high quality care for the whole patient throughout the episode, including
  – appropriate management of pre-existing chronic conditions,
  – coordination across settings, and
  – safety in individual care settings
<table>
<thead>
<tr>
<th>BPCI Initiative Clinical Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>AICD generator or lead</td>
</tr>
<tr>
<td>Amputation</td>
</tr>
<tr>
<td>Atherosclerosis</td>
</tr>
<tr>
<td>Back &amp; neck except spinal fusion</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
</tr>
<tr>
<td>Cardiac defibrillator</td>
</tr>
<tr>
<td>Cardiac valve</td>
</tr>
<tr>
<td>Cellulitis</td>
</tr>
<tr>
<td>Cervical spinal fusion</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Combined anterior posterior spinal fusion</td>
</tr>
<tr>
<td>Complex non-cervical spinal fusion</td>
</tr>
<tr>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Double joint replacement of the lower extremity</td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
</tr>
<tr>
<td>Fractures of the femur and hip or pelvis</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
</tr>
<tr>
<td>Gastrointestinal obstruction</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
</tr>
</tbody>
</table>
Comprehensive Care for Joint Replacement (CJR)

- Incentivizes increased coordination between hospitals, physicians and post-acute care
- Effective 4/1/16
- Hospitals paid under the Inpatient Prospective Payment System (IPPS)
- Located in 67 selected Metropolitan Statistical Areas (MSA)
- Not currently participating in Model 1 or Models 2 or 4 of the BPCI initiative for the lower extremity joint replacement clinical episode
- MS-DRG 469 and 470
Differences between BPCI and CJR

<table>
<thead>
<tr>
<th>Exhibit 1: Summary of BPCI and CJR Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
</tr>
<tr>
<td>Geography</td>
</tr>
<tr>
<td>Duration</td>
</tr>
<tr>
<td>Clinical episodes</td>
</tr>
<tr>
<td>Episode length</td>
</tr>
<tr>
<td>Responsible group</td>
</tr>
<tr>
<td>Target price</td>
</tr>
<tr>
<td>CMS discount</td>
</tr>
<tr>
<td>Reconciliation</td>
</tr>
<tr>
<td>Risk adjustment</td>
</tr>
<tr>
<td>Maximum gain</td>
</tr>
<tr>
<td>Maximum loss</td>
</tr>
<tr>
<td>Quality</td>
</tr>
</tbody>
</table>

*BPCI discount is 2% for 90-day bundles & 3% for others. CJR discount varies with quality score. NPRA = Net payment reconciliation amount.

http://www.aha.org/content/16/issbrief-bundledpmt.pdf accessed August 1, 2016
2017-2018 Episode Payment Models

- AMI, CABG and Surgical Hip/Femur Fracture Treatment (SHFFT)
  - Medicare A and B from hospital admit thru 90 days post discharge
- Released 7/25/16, published 8/2/16, 60-day comment period
- Effective January 1, 2018, 5 year duration
- Increased risk share over 5 years
- Target pricing a blend of hospital specific and region performance
  - Emphasis on region performance increases over time

Oncology Care Model (OCM)

• Medicare FFS beneficiaries receiving chemotherapy treatment and includes the spectrum of care provided to a patient during a six-month episode that begins with chemotherapy
• OCM participants are Medicare-enrolled physician groups (including hospital-based practices) that furnish chemotherapy treatment
• Provide enhanced services, including:
  – The core functions of patient navigation;
  – A care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”;^2
  – Patient access 24 hours a day, 7 days a week to an appropriate clinician who has real-time access to practice’s medical records; and
  – Treatment with therapies consistent with nationally recognized clinical guidelines.
• Use data to drive continuous quality improvement.
• Use certified electronic health record technology

Oncology Care Model (OCM)

• Application and selection process
• 200 physician groups, 17 payers
• Goals:
  – Utilize appropriately aligned financial incentives to enable:
    • Improved care coordination
    • Appropriateness of care
    • Access to care
• Two forms of payment
  – Per-beneficiary monthly enhanced oncology services (MEOS) payment for duration of episode ($160)
  – Performance based payment for episodes of chemotherapy care
• July 1, 2016 to June 30, 2021

Oncology Care Model Participants

Source: Centers for Medicare & Medicaid Services

Future of CMS mandated initiatives

• HHS Secretary Tom Price has opposed CMS mandatory initiatives
  – Among 179 members of congress who called on CMS to “cease all current and future planned mandatory initiatives under CMMI” including bundles
  – Letter to CMS stating that programs overstep the agency’s bounds

• BUT...
Future of CMS mandated initiatives

• Growing body of evidence, mostly in orthopedics, shows that such programs can improve outcomes, control costs or both.

• Medicare payments declined more for lower extremity joint replacements in BPCI participating hospitals than in comparison hospitals without a significant change in quality outcomes.

• 20.8% reduction in total spending per episode
  – Implants/supplies
  – Post acute care utilization
CMS will cancel major bundled payment initiatives

Written by Ayla Ellison (Twitter | Google+) | August 14, 2017 | Print | Email

CMS has proposed canceling the cardiac and expanded joint replacement bundled payment models.

The rule, which was sent to the Office of Management and Budget last week, would cancel the mandatory bundled payment programs for heart attacks and bypass surgeries as well as expansion of the existing Comprehensive Care for Joint Replacement model to include surgical treatments for hip and femur fractures. Those bundled payment initiatives have already been delayed twice. They’re currently slated to take effect Jan. 1, 2018.
Success with Bundled Payments

• Requires managing change in diverse group of stakeholders
  – Patients
  – Physicians
  – Executives
  – Care team
  – Post-acute care providers
Success with Bundled Payments

• Develop system to identify patients likely to qualify for bundled episodes
  – Access their risk for complications
  – Track their progress through the bundle episode

• Develop multidisciplinary teams
  – Physician led
  – Care redesign
    • Decision support tools
    • Reduce variations in care
    • Improve patient outcomes
    • Reduce costs
Success with Bundled Payments

• Develop a high-functioning discharge planning process
  – Ensure access to right care in right setting
  – Ensure effective communication across the care continuum
• Enhance data analytics and information sharing capabilities
• Post-acute performance networks
  – Ensure efficient, high quality care
    • Costs
    • Quality
    • Readmissions
    • Disease specialty programs
• Incentives
  – Gainsharing
Riverside Health System Overview
Integrated Health Delivery Network

- Located in Southeastern Virginia
- 10,000 team members
3 divisions

**Acute Care Services**
- 5 acute care hospitals
- 754 beds
- 1 specialty hospital
- 222 beds

**Riverside Medical Group**
- Medical home model
  - 110 practices
  - 565+ providers
  - 35 specialties

**Lifelong Health**
- 10 nursing homes
- 943 beds
- 43 PACE centers
- Helping 650 nursing-home eligible participants stay in their homes

**In-home health**
- Home Health
- Home-enabling technology
BPCI Initiative: Major Joint Replacement of the Lower Extremity

- Joined July 2015, exited June 2017
- Corporate oversight group
  - Service line (orthopedics, surgical services)
  - Providers (surgeons, family practice, long term care)
  - Post-acute care/Home Health/Therapy Services
  - Pharmacy
  - Nursing
  - Care Management
  - Business Intelligence
  - Project Management
  - Quality
- Monthly meetings
Project Plan

• Pharmacy involvement:
  – Pain management
  – VTE prophylaxis
  – Management of patient co-morbidities through PCMH
  – Development of educational materials (medication related)
  – Participation in Joint University
  – Transitions of care to post-acute
  – Other medication related opportunities as identified
Project Plan

• Ongoing data review
  – Due to claims processing, working 90 days or more retrospectively

• Overall opportunities
  – Education of all stakeholders
  – Documentation of co-morbidities
  – Patient selection and education
  – Facility selection
  – Post-acute care utilization
Where we had success

• Providers who embraced care redesign
  – Patient selection
  – Implementation of care bundle
    • Multimodal pain management, including liposomal bupivacaine
    • Aggressive physical therapy
      – Pre-surgical home visits
      – Inpatient: evening of surgery
      – Outpatient: day of discharge
    • Home health over SNF
  • Manage readmission risks
Oncology Care Model

• Joined July 2016
• Initial focus on care coordination
  – Development of billing model
  – Completion/documentation of required core components
    • Role of pharmacists
• Treatment with therapies consistent with nationally recognized clinical guidelines
Southwest General Hospital

- Southwest General Hospital (SWGH) is a 350 bed acute care community hospital partnered with University Hospitals of Cleveland, Ohio.
  - AHA Heart Failure Center of Excellence
  - Level 3 Trauma Center
  - “Blue” Distinction Center for Cardiac Care
  - Gold Plus Stroke Center
  - Top Performers on Key Quality Measures
Why Pick Heart Failure?

- Heart Failure #1 reason for readmissions nationally and at SWGH
- Readmission rate 20-25%
- High dollar / High volume
- Multiple healthcare interactions = High healthcare utilization
- Lack of good communication between providers
Why Pick Heart Failure at Southwest General?

• Initial groundwork already developed
  – Heart Failure LLC
    • “Company” partnering Southwest General with various cardiologist for shared risk / benefit
  – Multidisciplinary Heart Failure Committee already meeting regularly
  – Most of protocols in use at hospital
  – ECF group meets quarterly with SWGH to improve coordination of care
Pharmacist’s Role

- Patient Education
- Protocol Development
- Extended Care Facility (ECF) Cooperation and Care Sets
- Home Care
Pharmacists Lead Patient Education

• **Individualized education**
  – Prior to discharge, pharmacist speaks to patient and caregivers about **meds, salt and daily weights**. Also talk about Bundled Payment System
  – Check for medication affordability.
  – Ensure Core Measure Medication Adherence

• **Medication calendars**
  – Provide individual medication calendars at discharge

• **Daily Weights**
  – Write down daily weights in Heart Failure book and take to any MD / Hospital visit
  – Provide scale if patient does not have one
Integrating Pharmacy Technicians

• Patient Education
  – “Prescription” for TV Learning Channel, available in each patient room
    • What is Heart Failure?
    • Heart Failure: Leaving the Hospital
    • Heart Failure: Nutrition and Exercise
    • Heart Failure: Managing Day to Day
  – Provide Heart Failure booklets
    • Daily weights
    • Medication Guides
    • Calendar Cards
Protocol Development

• Heart Failure order set:
  – Standardized Care Plan including Core Measure medications:
    • Evidence-based Beta Blockers
    • ACEi / ARB
    • Spironolactone

• IV Iron protocol
  • Everyone receives iron studies on admission
  • Iron IV Push if indicated
Protocol Development

• Improve Information Exchange
  – Select ECF who demonstrate effective care for HF patients
    • Initially 3 preferred ECFs. Grew to ~15, Now 8 ECFs recommended for patients to choose from (Still free to choose)

• Daily weights and report if admitted to hospital

• Diuretic protocol
  – Avoid knee jerk reaction to “Just send patient to the ED”
  – ECFs have capability to give IV diuretic but there was reluctance from primary care to order
  – “We have an IV Diuretic Protocol, can we institute?”

• Robust handoff from hospital to ECF
Patient Label
Drug Allergies: Review patient allergies in power chart or in the electronic medical record (EMR) prior to prescribing / administering medications.

Order

Notify Physician/NP if patient has shortness of breath, worsening edema, SpO₂ <90%, and/or:
- Weight gain of 5 or more pounds in 3 days to activate Acute Heart Failure Exacerbation Workflow
- Weight gain of 2 or more pounds in 3 days to assess patient with LTC Heart Failure Assessment Tool
- Weight gain of less than 2 pounds after 3 consecutive measurements to signal patient has achieved a stable weight

☐ Pulse Oximetry
- Weight at the same time of day, same scale, in similar clothing
  - Daily, until weight gain of less than 2 pounds in 3 days after 3 consecutive measurements
- Blood Pressure, Pulse, Respiratory Rate
  - Daily and PRN

☐ Intake/Output
- Exercise Training/Ambulation (DVT prophylaxis)
- PT/OT
- Patient/Family Heart Failure education

☐ Fluid restriction
- 1.5 L/day
- 2 L/day
- Salt restriction 2 g/day (NO SALT SUBSTITUTES)
- Low cholesterol/low fat

☐ Diabetic - ADA cardiac diet

Acute Heart Failure Exacerbation Only:
- DIURETIC
  Choose only one:
  ☐ BOLUS (Torsemide or Furosemide) Max single bolus dose of Torsemide: 100-200 mg
  Initial dose: double patient’s daily dose (see below table)
    ☐ Torsemide
    ☐ Furosemide
  If net hourly diuresis:
  - > 1 ml/kg/hr and patient returning to baseline: hold diuretic for next 8 hours
  - > 1 ml/kg/hr and patient symptomatic: repeat previous dose in 6 hours
  - ≤ 1 ml/kg/hr: double previous dose and give within 2 hours

  ☐ CONTINUOUS INFUSION (Furosemide ONLY) Furosemide 250 mg in 250 ml D5W
  - Start drip at 0.1 mg/kg/hr dry weight
  - Increase hourly rate by 0.1 mg/kg to max rate of 0.75 mg/kg/hr or until net hourly diuresis is > 1 ml/kg/hr

<table>
<thead>
<tr>
<th>Loop Diuretic</th>
<th>Equivalent PO Doses</th>
<th>Equivalent IV Doses</th>
<th>IV Push, Rate</th>
<th>Continuous Infusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furosemide (Lasix)</td>
<td>80 mg</td>
<td>40 mg</td>
<td>10-200 mg, 40 mg/min</td>
<td>5-20 mg/hr</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(250 mg/250 ml D5W)</td>
</tr>
<tr>
<td>Torsemide (Demedex)</td>
<td>20 mg</td>
<td>20 mg</td>
<td>10-200 mg, 40 mg/min</td>
<td>2.5-20 mg/hr</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(250 mg/250 ml NS)</td>
</tr>
</tbody>
</table>

Refer to Medication Reconciliation - Ensure patient continues maintenance medications unless hypotensive (<90/60 mmHg)
- Beta blocker (Metoprolol succinate, Carvedilol, Bisoprolol)
- ACE-i/ARB
- Oxygen 2L PRN Shortness of breath

- BMP, Mg upon exacerbation
- PT/INR
Southwest General Transitions of Care
PGY2 Pharmacy Resident

- Southwest General PGY2 Transitions of Care Pharmacy Resident also rounds with hospitalist 1-2 times per week at ECF.
  - Previews patients, making recommendations
  - Monitors daily weights and labs
  - Rounds with hospitalist, initiating orders and follows up on any changes

- Reviews Admission Med Recs to ensure accuracy

- PGY1 Transitions of Care rotation

- APPE learning experience
Southwest General Transitions of Care
PGY2 Pharmacy Resident

• Prior to discharge from ECF, Transitions of Care Resident will:
  – Provide education on HF, daily weights, meds, calendar, etc.
  – Recommend home health, telehealth or other support services as needed
Home Health Education by Pharmacist

- Warning Signs of an Acute Heart Failure (HF) Exacerbation
- Appropriate Maintenance Therapy/ Normal Limits
- Acute Home Health HF Workflow to Reduce ED/hospital Admissions
- When Should My Home Health Patient go to the Emergency Room?
- Common Medications Seen in HF
- Loop Diuretic Equivalencies
- Heart Failure Rescue Kit
Home Health Education by Pharmacist

• Partner with Home Health Care Organization
  
  – Heart Failure Rescue Kit
    • Extensive patient and nurse education about kit
    • Free torsemide, metolazone, potassium and magnesium
    • If patient gains greater than 2 pounds in one day or 3 pounds in 2 days, initiate protocol after contacting physician
    • Administer torsemide, depending on current dose of diuretic, draw labs
    • If day two still increased fluid, give metolazone and electrolytes depending on lab values.
Heart Failure Rescue Kits

• Warning Labels on Kit
  – Do not open unless instructed by your Home Health Nurse or Physician
  – Do not use past _____
  – Not for daily use
  – Yellow Zone use only. Part of Green, Yellow Red Zones of HF
Coordinated Effort to Treat Heart Failure

• Early identification of heart failure patients
• Improved communication with all healthcare providers
• Avoid duplication
• Improved treatment protocols
  – Protocol development across the continuum
• Improved care!!
• Decreased costs!
Key Takeaways

• Episode based payment models are most likely here to stay
• Coordination across the care continuum is key to success
• Care redesign is required to drive desired outcome
• Pharmacy plays a key role in interdisciplinary team