Implementing a Risk-Focused Strategy to Optimize Orthopedic Commercial Bundle Outcomes and Minimize Clinician Burnout

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THE RIGHT TIME FOR CHANGE

With a massive shift in healthcare from volume to value-based care, physician buy-in, well-engaged clinical teams, preferred provider networks, and strong support systems are a few of the key components necessary to yield positive clinical-quality and financial outcomes. However, a sustainable and scalable alternative payment model program must include a solid foundation of population health management strategies, focused on minimizing clinician burnout, for long-term success.

Since the Centers for Medicare and Medicaid Services [CMS] first implemented their Bundled Payment for Care Improvement [BPCI] initiative, many studies have been published that promote both the benefits and shortcomings of these voluntary programs, with opinions varying based on each author's experience. However, despite some warranted criticism, CMS announced in early 2018 that the next iteration of voluntary value-based bundles, an Advanced model, would commence in October. Existing participants were in position to evaluate their current care coordination workflow to identify best practices and determine if their programs would scale into the next three-year model.

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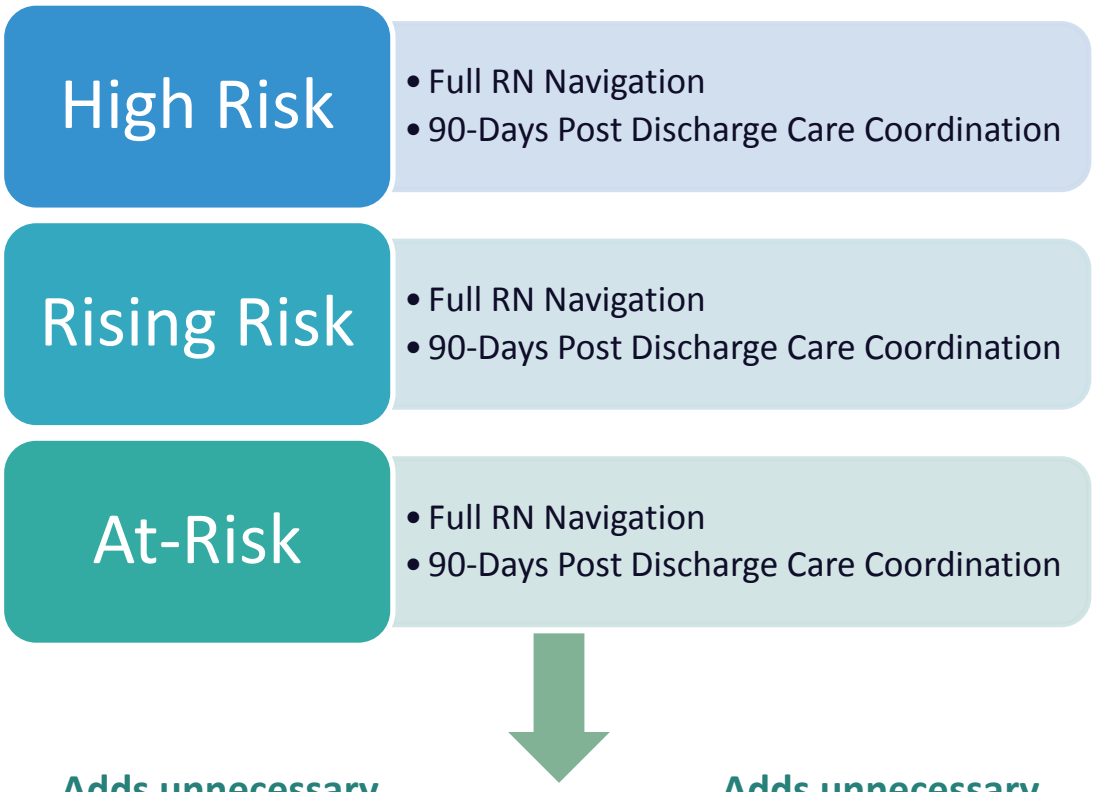
Shannon Clifton, President
Care Navigation Services

In December 2014, Panorama Orthopedics & Spine Center [Panorama], a trusted provider of orthopedic care in the Denver metro area, partnered with Care Navigation Services, a dynamic Texas-based population health management company, to implement a proactive and holistic patient-centered BPCI strategy focused on enhanced care coordination. At that time, neither organization was well versed in the tenants of population health and its many benefits in managing diverse patient groups.

However, a change in leadership at Care Navigation Services in 2016 brought an experienced team with proven success implementing Triple Aim, and subsequently Quadruple Aim, strategies.

Shannon Clifton, President of Care Navigation Services explains the challenge. "All of the orthopedic bundled patients followed the same care pathway and utilized the same resources despite their risk for readmission. While the collaborative resulted in decreased cost per Medicare beneficiary episode and attractive gainshares, the consistent volume increases resulted in our RN Navigators experiencing unnecessary burnout, ultimately creating an unsustainable model," added Ms. Clifton.

Currently All Bundle Patients Receive Same Interventions Regardless of Risk



Adds unnecessary workload to clinicians

Adds unnecessary program costs

Difficult to scale and sustain

Does not align with population health goals

INTERVENTIONS MUST ALIGN WITH RISK

In February 2018, Panorama was selected to manage a commercial bundle on behalf of a large health insurance company due to its BPCI success. When Panorama and Care Navigation Services operations leaders met to discuss how to incorporate the additional volume into the existing workflow, Care Navigation Services presented a value-based approach to optimize their clinical resources: rather than manage all bundle patients the same, stratify the patients based on their risk for readmission and assign the appropriate care pathway, interventions, and resources.

Ellen Ford-Barton, SVP Strategy & Operations for Care Navigation Services further explains the benefits. "Simply put, population health management promotes identifying appropriate patient engagement interventions based upon the risk of avoidable readmission. As their risk level increases, the number of patient touches should increase as well. This ensures both the patients' and clinicians' needs are met."

Segmenting our commercial bundle patients based on their readmission risk would afford us a scalable, cost-effective program that could potentially be applied to all of our patients.

Julie Meurer, VP Operations
Panorama Orthopedics & Spine Center

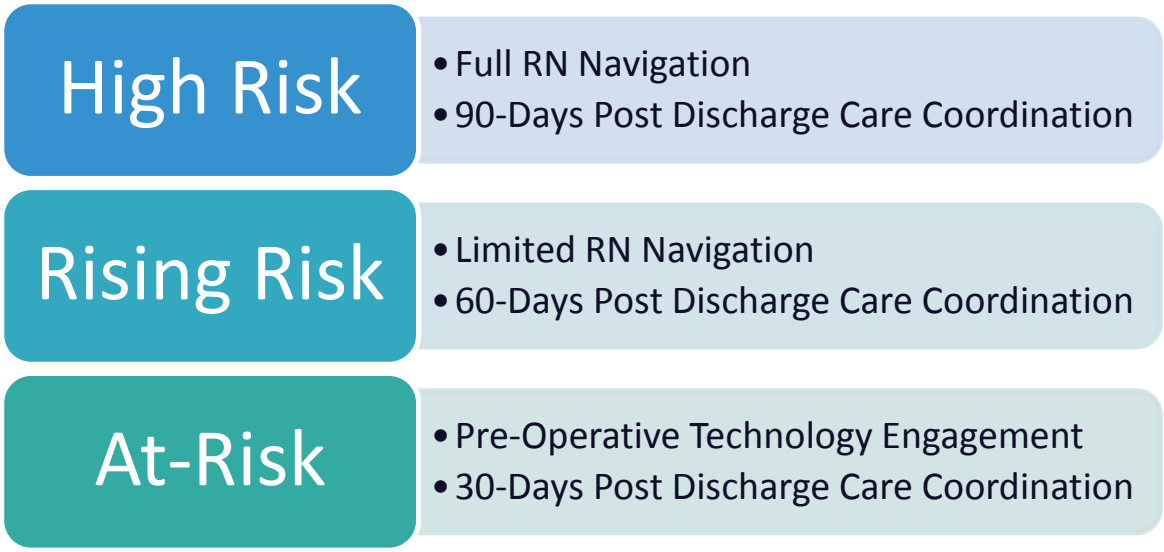
Panorama leadership quickly embraced the patient management change and expressed excitement about the long-term program potential.

"When Care Navigation Services presented this approach, I knew immediately it was a solution worth testing," states Julie Meurer, Vice President of Operations for Panorama. "Our program budget could not support adding resources to manage the increased volume. Segmenting our commercial bundle patients based on their readmission risk would afford us a scalable, cost-effective program that could potentially be applied to all of our patients. When I presented the change to our Total Joint Replacement Committee it was very positively received."

Care Navigation Services led the revised program management workflow process that centered on their recommendation to utilize each commercial patients' pre-operative physical therapy evaluation score [PT Score] as the basis for the risk stratification. The PT Score is calculated by assessing a patient's social functionality, cognitive readiness, home barriers that may impede recovery, physical assessment and Berg Balance Test results. Until this point, the score was used to dictate the post-acute pathway assigned to each patient, with lower scores requiring skilled nursing care and higher scoring patients discharging to home post-surgery, usually with outpatient physical therapy services.

Care Navigation Services collected and analyzed historical patient data in order to determine how to define the new risk categories. Clinicians participated in this process to provide valuable qualitative input. As a result, a patient-centric model was developed and approved for implementation by Panorama.

A Revised Patient-Centric Program Achieves Quadruple Aim Objectives



PROMOTING A CULTURE OF CHANGE

To promote a positive culture of change and forward movement the Care Navigation Services Operations Team facilitated bi-monthly meetings with Panorama

leadership and key strategic partners. The Team also met one-on-one with all stakeholders to afford a venue to address individual needs and develop solutions. Despite the steps taken to minimize issues, there was some resistance met from clinicians who had limited experience with population health objectives and instead advocated for adding resources.

"Moving to a value-based care environment requires organizational review and potential culture redesign, which is not easy when asking existing clinical teams to move from a model having previously demonstrated fee-for-service financial success," explains Ms. Clifton. "Healthcare continues to evolve at a rapid pace and providers are trying to be innovative without negatively affecting their bottom line. The issue is that often nurses feel the most direct impact and burden of program changes on a day-to-day basis."

As a result, the Care Navigation Services leadership prioritized educating their RN Navigators on the positive impact this revised strategy would have on their workload and ultimately, the patients.

"Since our enhanced model centers on changing the number patient touches based on risk group, the nurses expressed concern that less interaction would negatively impact outcomes," states Ms. Ford-Barton. They were reluctant to give up some of the pre-operative engagement steps that can be served by technology. Once we presented the benefits in allowing them to allocate more time with higher risk patients, they embraced the change."

RISK-BASED STRATEGY BENEFITS

- ✓ **Reduced clinician burnout**
- ✓ **Resource optimization**
- ✓ **Decreased costs**
- ✓ **Market differentiation**
- ✓ **Improved patient experience**
- ✓ **Operational excellence**
- ✓ **Scalable and sustainable**

PRIORITIZING CLINICIANS TO IMPROVE PATIENT OUTCOMES

Dedicating time towards clinician education throughout this process will afford a smooth transition to a new workflow model. With value-based measures of success focused primarily on cost reduction and improved quality, the impact on valued clinicians is often overlooked.

[The RN Navigators] were reluctant to give up some of the pre-operative engagement steps that can be served by technology, thus allowing them to spend needed time with higher risk patients.

Ellen Ford-Barton, SVP Strategy & Operations
Care Navigation Services

Since there is a direct correlation between clinician burnout and negative patient outcomes, every population health management program must prioritize clinicians. This, in turn, will create a positive experience for all key stakeholders and deliver a healthy return on investment. With a focus on a few simple steps, clinician burnout is easily preventable:

Regularly review workflow processes to identify creative, cost-effective opportunities for clinician efficiency

Utilize technology as appropriate to proactively engage patients and receive health status information

Collect and analyze data to validate program changes

Promote clinician work-life balance

ABOUT CARE NAVIGATION SERVICES

Care Navigation Services is a dynamic company affording innovative patient management solutions to favorably position health care providers and employers within a rapidly changing reimbursement environment. We uniquely combine patient and family empowerment with recovery and self-care, utilizing established clinical-quality solutions and workflow processes. Our proven person-centered approach engages patients to take a more active role in their recovery, resulting in improved self-health management and attractive Returns on Investment for a full continuum of health care providers.

For more information please visit www.carenavigationservices.com