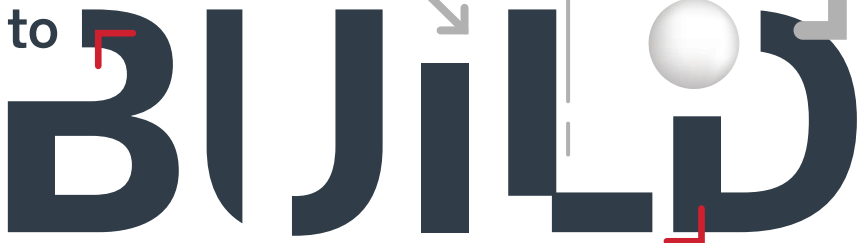


How
to



BUILD

Your No-Regrets CV Strategy

Insights on Foundational Priorities
for Program Leaders

When I ask CV leaders what's on their to-do lists for the next year, the answers can be overwhelming. Cardiovascular programs are still expected to be the growth engine of the hospital, yet they also find themselves consistently in the crosshairs for reform and regulatory efforts to curb costs and transform care delivery. CV leaders aren't just tasked with doing more with less, but doing better with less. With growing expectations from the C-suite, payers, physicians, and patient consumers, it can be difficult to prioritize, especially when the political landscape for health care is more uncertain than it has ever been.

That's why we're encouraging our members to focus on what we've termed your "no-regrets" priorities. Regulations come and go, and while chasing after each metric that comes down the line (from 30-day heart failure readmissions to 90-day CABG bundles) may succeed in the short term, this reactive strategy will not set you up for the long term. Instead, programs need to build a foundation now to prepare for increasing accountability for long-term care value.

In these articles, our research team provides insights into where CV leaders should be focusing their efforts to ensure they're pursuing the true no-regrets priorities. We hope these insights will spark new ideas and future conversations between you and our research team. So turn the page, access our supporting resources and tools, and email us at any time.

I look forward to hearing from you.



Megan Tooley

Practice Manager

Cardiovascular Roundtable

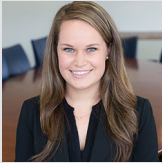
Featured Writers



Megan Tooley

Practice Manager

Megan provides strategic guidance to cardiovascular leaders across the country to advance their programs amid this ever-changing health care environment. Specific areas of focus include interpreting the impact of market and regulatory trends on CV program strategy, care management, and structural heart programs.



Julie Bass, MPH

Consultant

Julie's priorities include developing a smart CV growth strategy, optimizing network strategy, and enhancing physician alignment. She also leads our research on electrophysiology, supporting CV programs in optimizing care for patients with heart rhythm disorders.



Aaron Mauck, PhD

Senior Consultant

Aaron oversees our research on care variation, staffing, and vascular and heart failure program design, assisting members in streamlining operations, uncovering growth opportunities, and uncovering value.



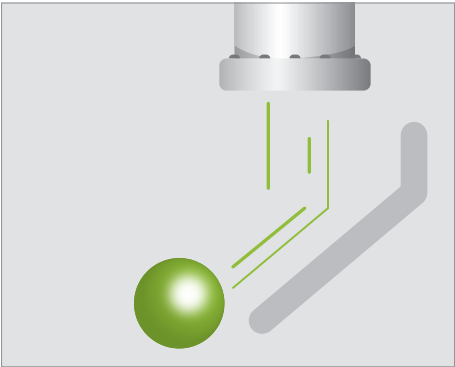
Marissa Schaffer

Senior Analyst

Marissa explores best practices to optimize care delivery and reduce care variation for CV patients. Her principal areas of expertise include improving value in structural heart care and optimizing same-day discharge for procedural patients.

To submit questions or comments to our team, please email cardiovascular@advisory.com.

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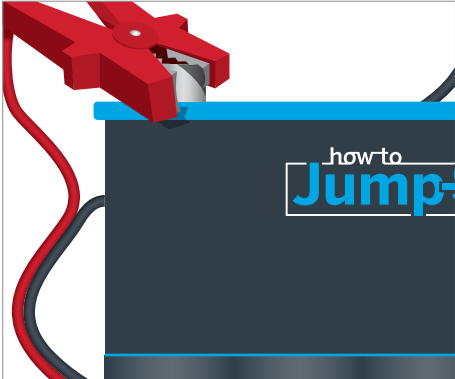
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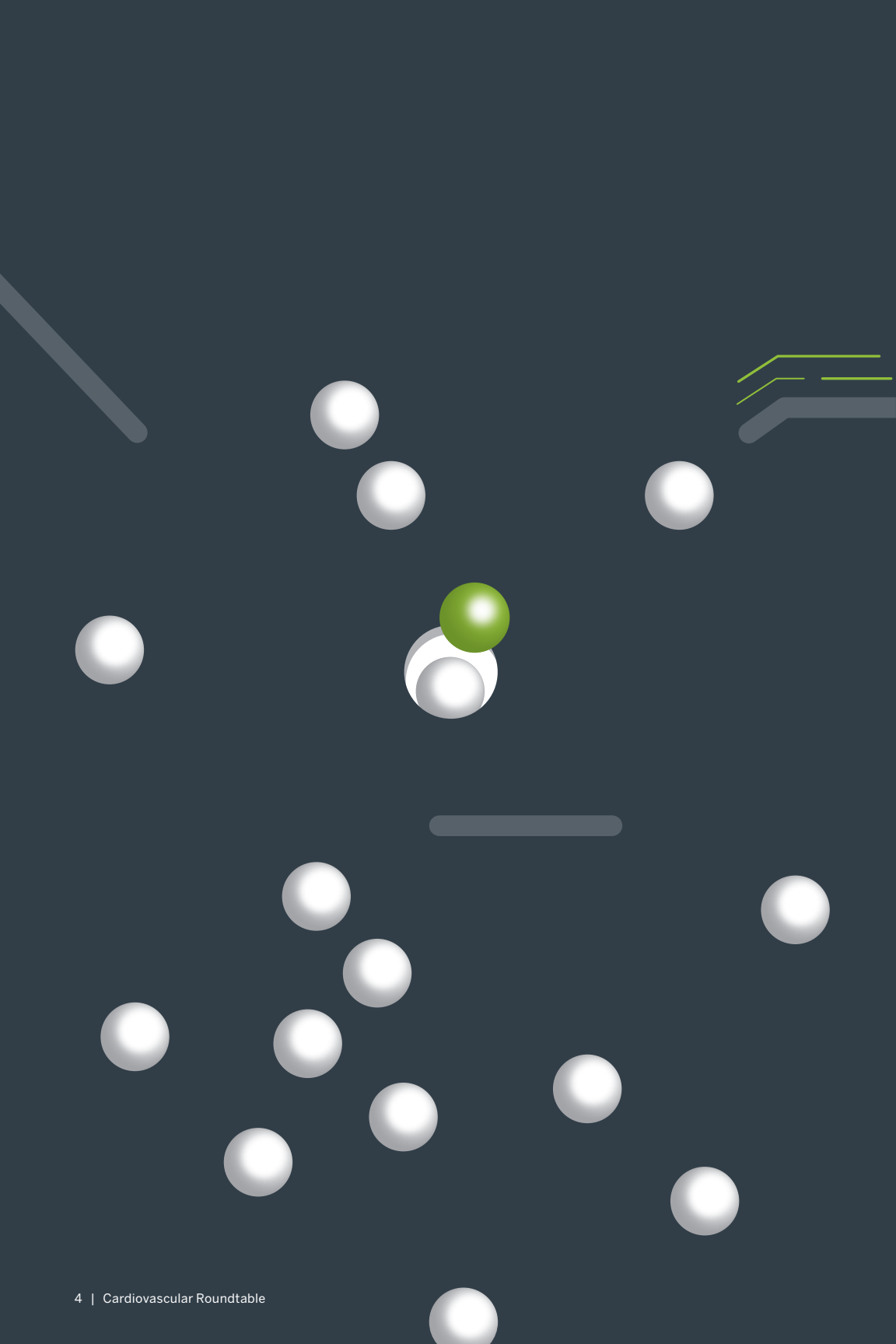
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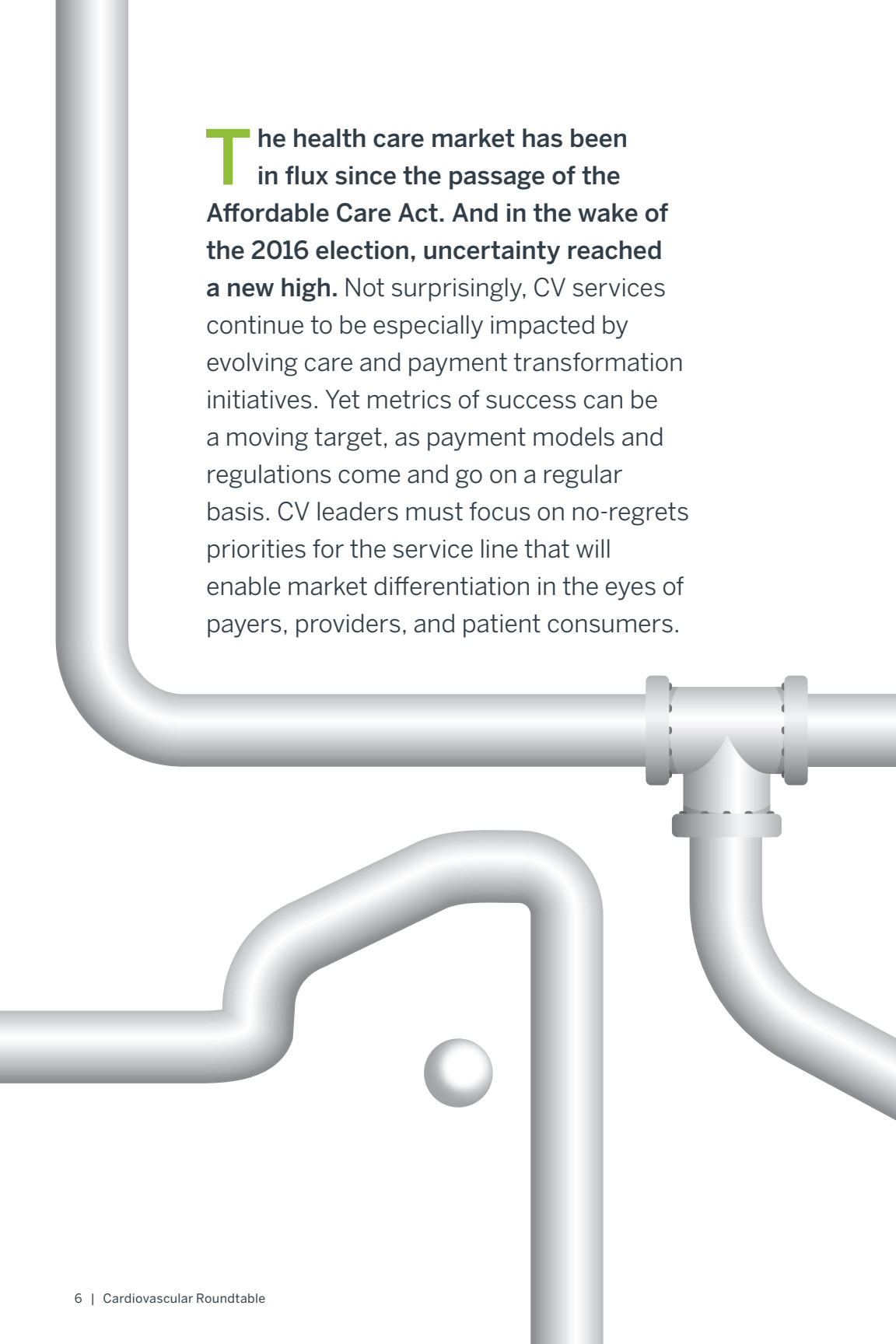




Making sense of uncertainty

The market realities impacting your CV strategy

Megan
TOOLEY

An abstract graphic featuring several thick, grey, 3D-rendered pipes. One pipe runs vertically down the left side. Another runs horizontally across the middle. A third pipe runs vertically down the right side. These pipes are connected by various fittings, including a T-junction and a cross-junction. A small, white, reflective sphere is positioned near the bottom center of the frame.

The health care market has been in flux since the passage of the Affordable Care Act. And in the wake of the 2016 election, uncertainty reached a new high. Not surprisingly, CV services continue to be especially impacted by evolving care and payment transformation initiatives. Yet metrics of success can be a moving target, as payment models and regulations come and go on a regular basis. CV leaders must focus on no-regrets priorities for the service line that will enable market differentiation in the eyes of payers, providers, and patient consumers.

To provide some clarity, we've identified five market realities that CV leaders need to account for when developing their strategy for the years to come.

Margin pressure is only going to intensify.

If there's one thing the government, payers, and health care industry as a whole agree on, it's that they do not want to spend more on health care. ACA-era "productivity" adjustments, declining reimbursement, and increasing regulatory scrutiny over utilization are bringing margin management front and center for hospitals. In fact, a recent CBO report estimated that under same course and speed, 60% of hospitals would have negative margins by 2025.¹



60%

of hospitals are expected to have negative margins by 2025

It's no surprise then that hospital executives are feeling the pressure to reduce costs. But while it's an institutional priority, has it necessarily been a service line one? In fact, while reducing costs is always a goal, CV leaders haven't quite felt the same pressure as hospital executives have. The CV service line is still often a profit engine at most hospitals and has been given some leeway accordingly—at least until now.

When you see health systems looking to remove hundreds of millions of dollars from their operating budget, it's likely that all service line leaders will soon be presented with major cost cutting goals, if they haven't already.



And it isn't just the C-suite that is requiring CV programs to be more efficient. As referring physicians and patients become more accountable for cost of care, they are likely to seek the lowest-cost CV provider.

While this is a tough reality, there is a path forward, and CV leaders can take this opportunity to support system strategy as well as sustainability of the service line. CV programs must look beyond the low-hanging fruit to implement long-standing strategies for managing cost, prioritizing top-of-license care delivery to mitigate the increase in staffing expenses, and building a foundation for reducing unwarranted—and costly—variations in care delivery.

CV is not just increasingly an outpatient business; it's an ambulatory business.

The CV business has been steadily creeping outpatient for the past several years and is poised to continue this trend. Historically, this outmigration has been a reactive strategy driven by regulatory scrutiny over unnecessary admissions (e.g., RAC audits, the Two-Midnight Rule), and typically resulted in a distinction between inpatient and hospital outpatient.



CV Five-Year Growth Projections All-Payer, 2016–2021

Inpatient

-11%

cardiac services

-9%

vascular services

Outpatient

10%

cardiac services

19%

vascular services

However, now programs are proactively moving services to outpatient sites—with lower cost and greater accessibility—to meet market demands to manage total cost, coordinate cross-continuum care, prevent readmissions, and attract price-sensitive consumers and payers.

The advent of site-neutral payment policy—which reduces the financial advantage of hospital outpatient sites over physician practices—has further driven programs to more carefully evaluate where they are placing their outpatient services. While site-neutral payment has negative financial implications for certain hospital outpatient services, programs now have the ability to place these services in lower-cost, accessible physician practices to attract consumers. In today's market, the question for CV leaders shouldn't be just "inpatient or outpatient," but "hospital outpatient or physician practice."

MACRA is rewriting the rules of hospital-physician alignment.


Ever since Congress passed MACRA² in 2015, this legislation has been top of mind for hospitals and physicians alike. MACRA has reinvented how physicians are paid, tying a significant portion of payment to cost and quality performance, and incentivizing adoption of alternative payment models.

But MACRA has a huge impact on hospital and service line leaders, too. Medicare risk strategy is no longer just about payment, it's now central to physician strategy. In fact, MACRA is converging payment strategy and physician strategy in a way we haven't seen before.

To be successful under this new payment paradigm, CV leaders need to be savvy on the mechanics of the program to maximize their performance under MIPS³ or qualify for the Advanced Alternative Payment Model track and its associated incentive. But more importantly, leaders will need to reevaluate their physician alignment strategy to set their service line and physician partners up for success.

Physician practices are keener on employment now due to increased reporting and financial burdens required by MACRA, and will likely be seeking hospital partners. Yet hospitals employing physicians will be accountable for their performance under MIPS, good or bad. CV leaders should carefully evaluate potential partners before employment to ensure they are able to support value-based performance metrics. Some programs are even adjusting physician compensation arrangements to reflect metrics important under MACRA to drive hospital-physician alignment and accountability. And regardless of track, CV leaders have to equip physicians with the tools and guidance to meet these new goals.

As referring PCPs become more accountable for population health, CV will need to play a bigger role.



In fact, MACRA is converging payment strategy and physician strategy in a way we haven't seen before.

Beyond payment transformation, CMS has continued to invest in models to change how care is delivered, such as Accountable Care Organizations (ACOs). Understandably, these models put primary care providers at the center of care delivery and coordination. However, CV programs often struggle to contribute to these efforts as these new models have not defined a role for specialists at all, despite the fact that specialists are critical for ensuring success.

But even though CV programs aren't at the center of ACOs, they'll still be affected. PCPs in ACOs, or even those at risk under MACRA, are more accountable for patient outcomes and costs than ever before. With more accountability, they're more likely to scrutinize the cost and quality of the care their patients receive. CV providers will need to not only meet the new quality, cost, and access requirements of accountable PCPs, they'll have to prove this value to secure referrals. CV programs that don't meet these requirements may find themselves locked out of a referral network or getting referrals too late in patients' disease progression.

Importantly, CV programs have a role to play in improving the health of their patient population, through supporting PCPs in identifying at-risk patients, increasing utilization of secondary prevention programs (e.g., cardiac rehab), and improving care management for highest-risk patients.

More payment will be tied to cross-continuum cost and quality in the future.

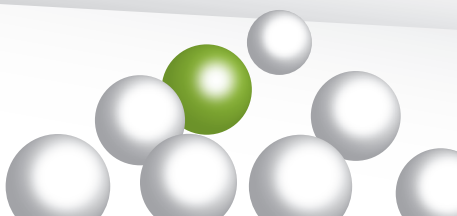
The creation of mandatory cardiac Episode Payment Models in July 2016 brought bundled payments front and center for CV leaders. Despite the subsequent cancellation of the rule in December 2017 due to political pushback on mandatory payment models, CV leaders heard loud and clear that payers and regulators will be increasing scrutiny over cost beyond the four walls of the hospital.

In fact, both public and private payers are increasingly tying payment to cost across an episode of care. For example, on the public side, MACRA and the Value-Based Purchasing Program both include episodic cost measures, and CMS's BPCI Advanced model is a voluntary opportunity to test bundling for several CV conditions.

Similarly, the private sector is not deviating from its path to value-based payment. In fact, the Health Care Transformation Task Force—a group of private payers and providers—committed to tying 75% of payment to risk-based models by 2020.

Given CV patient demographics, Medicare Advantage has in particular become a private model with a significant near-term impact on CV programs, and this is only going to grow. In fact, 40% of the total Medicare population is expected to be enrolled in a Medicare Advantage plan as opposed to Traditional Medicare by 2025. This means CV programs could expect more capitation, risk-based contracting, and payment tied to episodic quality and cost.

To prepare for this rising tide of episodic risk-based payment, programs must build a foundation for managing costs both internally and across the continuum, partnering with providers at each stage in the care pathway to improve long-term outcomes and reduce overall costs. ●



Action Items for CV Leaders

WATCH

CV Market Update

Hear our experts break down the key trends impacting CV strategy, with tactical guidance on how to prepare your service line for success.

► advisory.com/cr/2018SOU

USE

CV Market Estimator

See how market changes are playing out in service-specific volume forecasts for your region.

► advisory.com/cr/marketestimator

DOWNLOAD

CV Strategic Planning Template

Use our templates to revamp your strategic plan and set yourself up for success in today's health care environment.

► advisory.com/cr/stratplantemplate

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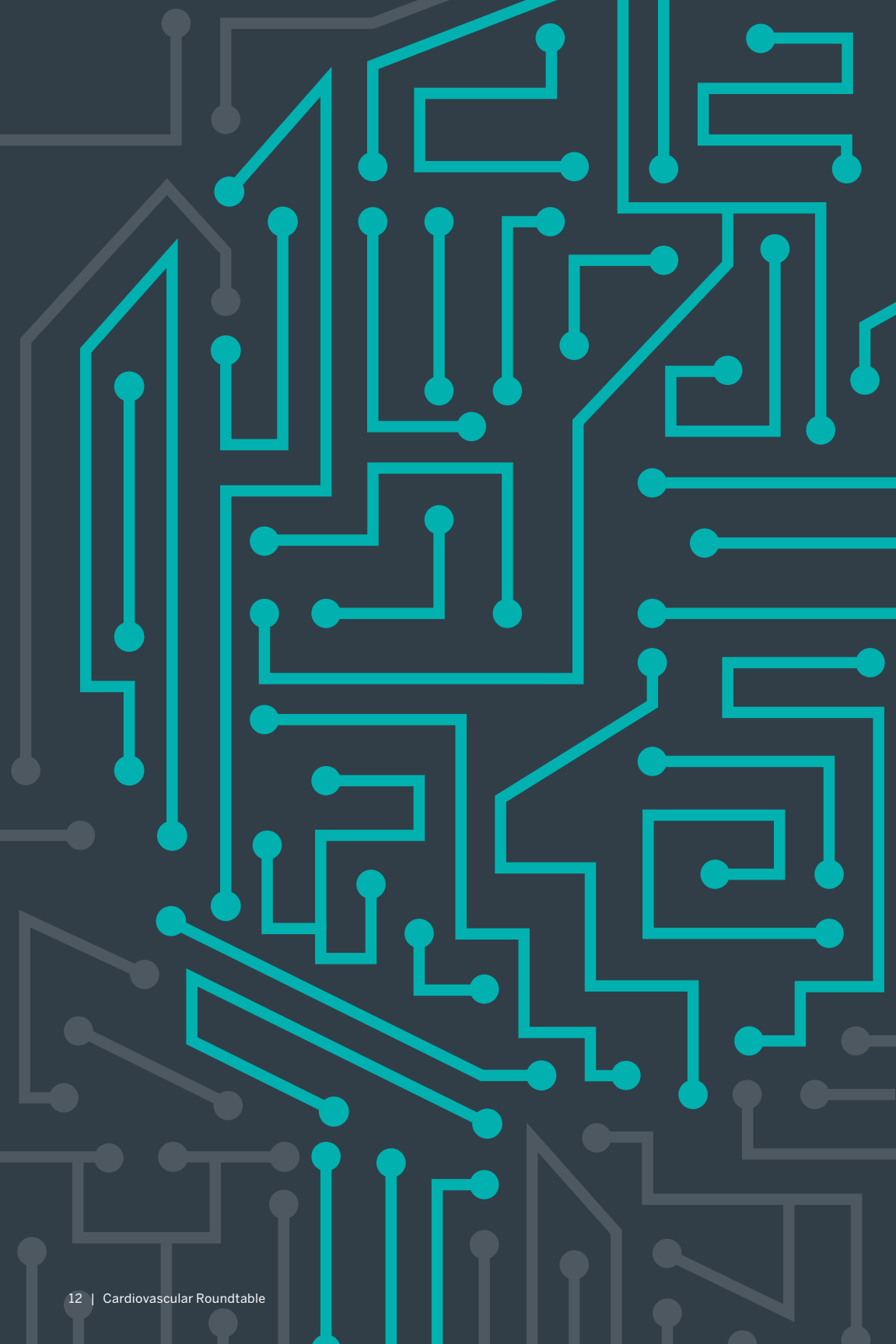
Cardiovascular Rounds Blog

Get the latest analyses and expert insights on major market trends delivered straight to your inbox.

► advisory.com/blogs



All resources accessible only to members of the Cardiovascular Roundtable.




A decorative background pattern of teal lines and dots, resembling a circuit board or a stylized map, framing the central text.


5 Ways to Think Smarter

About Your CV Growth Strategy

Julie
BASS



I spoke with hundreds of CV programs across the country as part of our research for the Cardiovascular Roundtable's 2017–2018 National Meeting. When it comes to program growth, I uncovered five common themes where programs are missing the mark.



Before we dive in, the “growth” we’re talking about isn’t traditional, acute volume growth. We’re talking about smart, sustainable growth that aligns with the goals of your program and meets the demands of your market. The market transition to value does not diminish CV growth expectations, but rather redefines what successful growth means for CV programs.

1 One-off tactics are not a comprehensive growth strategy.

When I asked CV leaders to share their growth strategy, many listed individual tactics or initiatives currently underway to increase program volumes. Individual tactics may be effective for driving growth in certain areas, but these tactics

do not represent a comprehensive strategy and frequently do not support the goals of a market transitioning from fee-for-service to value.

Many initiatives aimed to promote growth are developed in response to immediate market forces—rapid investment in technology to keep up with local competitors, acquiring physician practices to increase market presence and guarantee referral streams, and relying on brand value instead of developing new means to attract patients and physicians.

When crafting a sustainable growth strategy, CV programs should incorporate the following steps:

- Conduct a market assessment to determine the needs of the community
- Integrate physician and administrative perspectives
- Align with institutional priorities as well as capabilities of the CV service line
- Prioritize opportunities based on assessment and feasibility
- Hardwire a process and define accountability for strategy execution

2 Evaluate opportunities for program openings and closures.

For many organizations, today’s distribution of CV services across sites of care is less a product of strategy than history. In pursuit of new market share and profitable volumes, organizations

have acquired new programs, expanded existing site capabilities, and aligned with local physicians.

However, prioritizing growth over market demand has led to an imperfect distribution of CV services, with excess capacity in some markets and a lack of services in others. Poor service distribution can significantly undermine an organization's efficiency in the near term, cannibalize volumes, and increase costs. The proof? The recent increase in open-heart program closures.

Historically, CV programs have viewed program closure as a failure, but a strategic program closure can actually be an opportunity for growth. For institutions that are part of a system, service distribution across the network can make way for new market-capture opportunities (e.g., wellness, early patient identification). For institutions not part of a system, partnerships and affiliations to support program closures can be successful strategies to redirect resources to smarter growth opportunities based on the institution's goals and needs of the market.

3 Your access strategy should be more than just a phone line.

Enhancing access to CV services is no easy task, and current market dynamics make the process even more complicated. Patients and payers are now prioritizing lower-cost alternatives to the inpatient procedures that were once the backbone of the CV service line. Even with the right service portfolio, most CV programs are ill-prepared to

provide services how and when patients want them. Patients and referring physicians are making convenience and timeliness their main priorities at the point of care.


The first step toward enhancing patient access is realigning service distribution according to demand—but that's easier said than done. CV leaders are struggling to measure the impact of service rationalization, win over stakeholders, and balance service comprehensiveness with sustainability. Programs must balance physician outreach and partnership opportunities in new markets with demand for services in their communities.

Optimizing the CV market footprint is only part of the solution for profitably increasing access. CV programs must also focus on increasing the availability and convenience of upstream, outpatient CV services to accommodate increasing patient expectations of timely, convenient care.

4 Lunch-and-learns take your physician referral strategy only so far.

Our recent analysis of almost 13,000 patients discovered that 86% of CV referrals are physician-driven. The analysis also found that patients can be surprisingly loyal to physician referrals.

In fact, three-quarters of cardiac surgery patients said they would drive an hour to follow a physician referral to a specific surgeon, and almost one-quarter of patients said they would fly three hours.



... 86% of CV referrals are physician-driven.

While we know physician referrals are important—especially in CV—the amount of effort CV programs are using to hardwire referral streams isn't cutting it. Just about every program we spoke with mentioned “lunch-and-learns” as a cornerstone of their physician referral strategy. This may be considered a tried-and-true method, but since PCPs have relationships with 14 different CV specialists on average, it may not be enough. To enhance alignment between CV specialists and referring providers, some programs are developing new strategies to strengthen referral relationships, including:

- Hosting PCPs in multidisciplinary forums to discuss patient care plans
- Inviting community providers to participate in CV case review conferences
- Creating service agreements with local primary care groups

5 Marketing needs to target what self-referring patients really value.

The idea of “patient consumerism” has generated a lot of buzz in the health care industry over the past decade.

We've witnessed patients becoming increasingly selective in where they seek health care, making decisions based on quality, cost, convenience, and experience.

Although this is a growing phenomenon, it hasn't quite hit CV with the same force it's hit other service lines like primary care or radiology. CV is seeing some patients select outpatient diagnostics based on cost and accessibility. But high-end treatments, like surgery or PCI? Not yet. These procedures immediately blow through a deductible, so there's no incentive for patients to choose based on cost. Patients still largely rely on their physician's referral for these services.

However, since 14% of CV patients are self-referring, it's important to understand the needs and drivers of this group. These consumers likely aren't your typical CABG patients, but may be potential TAVR candidates seeking alternative treatment options to CABG, or EP patients searching for minimally invasive options with better quality outcomes. To better capture self-referring patients, CV programs must:

- Identify the populations in their market most likely to self-refer
- Target self-referring subgroups (e.g., age range, condition) in marketing efforts
- Collaborate with marketing team when developing more targeted strategies to attract self-referring patients (e.g., screening programs, community events). •

Action Items for CV Leaders

WATCH

CV Growth Webconference Series

Watch these presentations to hear our experts discuss successful tactics for developing a smart growth strategy.

► advisory.com/cr/growthpart1

► advisory.com/cr/growthpart2

READ

CV Specialist Partnerships

Access this publication to learn best practices for enhancing CV specialist partnerships and referral relationships with primary care providers (PCPs).

► advisory.com/cr/specialistpartnerships

USE

Regional Utilization Profiler

View market-specific Medicare utilization rates for inpatient and outpatient CV services and track utilization trends over time to better inform growth decisions.

► advisory.com/cr/utilizationprofiler

READ

Guide for Assembling the Accessible CV Network

Get strategies to optimize geographic reach and availability to grow market share.

► advisory.com/cr/CVaccess



All resources accessible only to members of the Cardiovascular Roundtable.



reduce

UNWARRANTED

CARE
VARIATION

to improve your bottom line



Aaron
MAUCK

Finding ways to reduce costs is a huge priority for today's CV leaders. Given the financial headwinds that many programs are experiencing, every dollar counts when it comes to operations and care delivery. However, programs have often focused on quick-fix solutions that rarely add up to a sustainable cost-reduction strategy.

Here at the Cardiovascular Roundtable, we're working to design solutions for margin management that can help you think beyond next quarter's results.

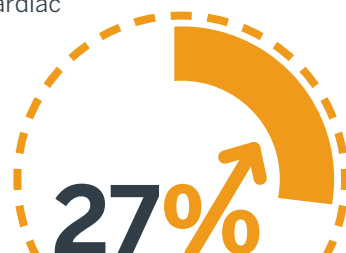
A more sustainable cost-reduction strategy involves reducing unwarranted variations in CV care through the installation of effective care standards. By "unwarranted variation" we mean deviation from a shared, deliberate approach to care delivery through overuse, underuse, or misuse. Not all variation falls into this category, but the care that does can have significant cost and quality consequences.

Recently, Advisory Board undertook an analysis of the potential cost savings programs could achieve by eliminating unwarranted care variation. The results for CV programs were eye-opening: for cardiac services as a whole, the cost-savings opportunity per case was \$2,319, or 27% of the average total cost per case for a cardiac procedure.⁴

Breaking down the cost savings for individual procedures illustrates an even more striking opportunity.

For instance, inpatient heart failure care presents an average cost-savings opportunity of \$1,634 per case, or roughly 30% of the average cost per case. Valve procedures involving cardiac catheterization present an even greater average cost-savings opportunity of \$20,589 per case, or 41% of the average cost per case. Even CABG procedures, which have been a common target of CV care variation efforts, continue to present a cost-savings opportunity: an average of \$4,641 per case, or 20% of the total cost per case, can be saved by eliminating unwarranted variation in CABG procedures without cardiac cath.

In light of the significant impact care variation can have on your financial bottom line, it's critical for CV programs to build an infrastructure to identify, prioritize, and eliminate sources of variation. In our work with members



Estimated potential cost savings from reducing care variation per CV case

across the country, we've developed a framework for sustainable care variation reduction, including the four key insights below.

Select the right targets for reducing variation.

CV programs can't drag their feet when it comes to reducing care variation. At the same time, it's impossible to tackle all sources of variation at once. When working with CV programs that have been successful, we've found it's important to incorporate a variety of stakeholders in selecting your first targets. For example, input from finance and IT can help you identify expensive sources of variation you may not have anticipated, and help proactively identify hurdles to the implementation of standards.

Cost and quality implications are key considerations when selecting targets, but they shouldn't be your only ones. Programs must also take into account the feasibility of any care standard. It is often best to start with a defined target you know you can tackle, using techniques that can be scaled to more challenging targets in the future. It is also important to take into account the impact any future market or policy changes may have on the importance of the area you have selected. If a procedure is likely to be in the crosshairs of future regulations, for instance, it may be worth targeting for care variation reduction even if the immediate potential cost savings are less than for other possible targets.

Ensure the care team is on board with your strategy.

Whether you're identifying targets for standardization or crafting the standards themselves, you must ensure that you have engaged all the relevant stakeholders in the process. Multidisciplinary representation from across the hospital will ease the process of implementation and ensure smooth operations between your program and other departments. The greater the engagement of such stakeholders, the more likely they are to embrace care variation reduction efforts and work to ensure their success. Most important, however, is buy-in from the care team who will need to use standards at the point of care. Physicians may push back on the validity of standards or the imposition on their autonomy if they are not actively engaged in creating and using them.

Programs can pursue a variety of strategies to ensure buy-in from physicians and other staff. For instance, we've encountered programs leveraging compensation to support their efforts. Placing a percentage of physician pay at-risk for developing and using care standards, and regularly revisiting the metrics associated with at-risk compensation, can help ensure that your care variation strategy is fully supported and continues to evolve to address new targets.

Be aware of the impact on workflow.

One of the biggest impediments to the implementation of care standards is the additional demand they may place on already overburdened care teams. Care standards should therefore be designed with workflow considerations in mind. If the standards you wish to introduce create additional paperwork, take time away from other important tasks, or provide unwarranted limits on clinical autonomy, they are less likely to be successful than standards that can be integrated into your existing workflow. To ensure successful implementation of standards, CV programs have adopted strategies such as:

- Setting clear “trigger points” to ensure care team knows when standards should be applied
- Minimizing documentation requirements for new care standards and incorporating existing data from patient records when possible
- Allowing the option to deviate from standards based on patient need in select cases

Ensure that your care standards can evolve.

When it comes to implementing care standards, we've learned from programs how important it is not to take a “set it and forget it” approach. With any effort to reduce care variation, it's essential to learn what works and what doesn't, and refine your

standards accordingly. Successful care standards generally change over time in response to physician feedback, new approaches to CV treatment, or changing market demand.

It's therefore essential that programs put in place a process for evaluating the success of care standards themselves. We've found that the most successful programs not only have mechanisms for assessing individual performance and utilization of care standards, but also have hardwired touchpoints for evaluating what works or doesn't work within a standard itself. In general, programs have scaled their evaluation of care standards, offering more frequent opportunities for stakeholders to evaluate standards that have been recently introduced.

As your care standards improve, you will find that providers are more engaged with initiatives to reduce care variation, as well as your greater efforts to save costs and improve quality. •



Action Items for CV Leaders

READ

Playbook for Reducing CV Care Variation

Learn our framework for developing a sustainable strategy and read case studies of best practices.

► advisory.com/cr/carevariation

ACCESS

Protocols, Pathways, and Guidelines

Access our library of protocols, pathways, and guidelines to help develop care standards fit for your program.

► advisory.com/cr/carevariation

READ

Compensation Model Design

Discover how programs design compensation models to encourage buy-in for care variation reduction efforts.

► advisory.com/cr/carevariation

USE

Hospital Benchmark Generator

See where your program has opportunity to improve operational, clinical, and financial performance.

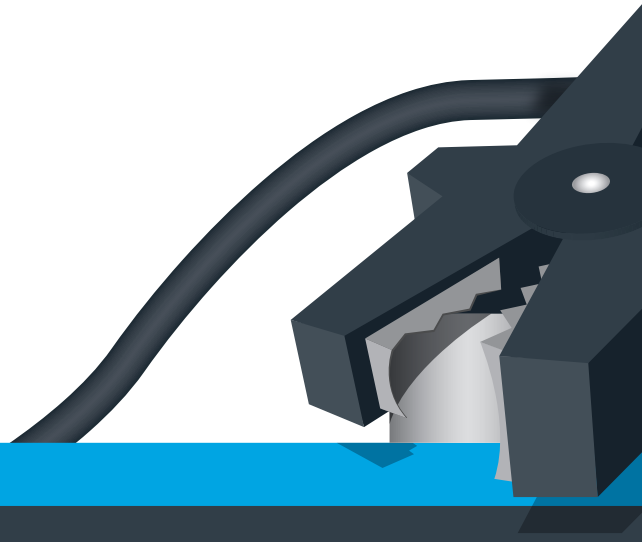
► advisory.com/benchmarkgenerator



All resources accessible only to members of the Cardiovascular Roundtable.



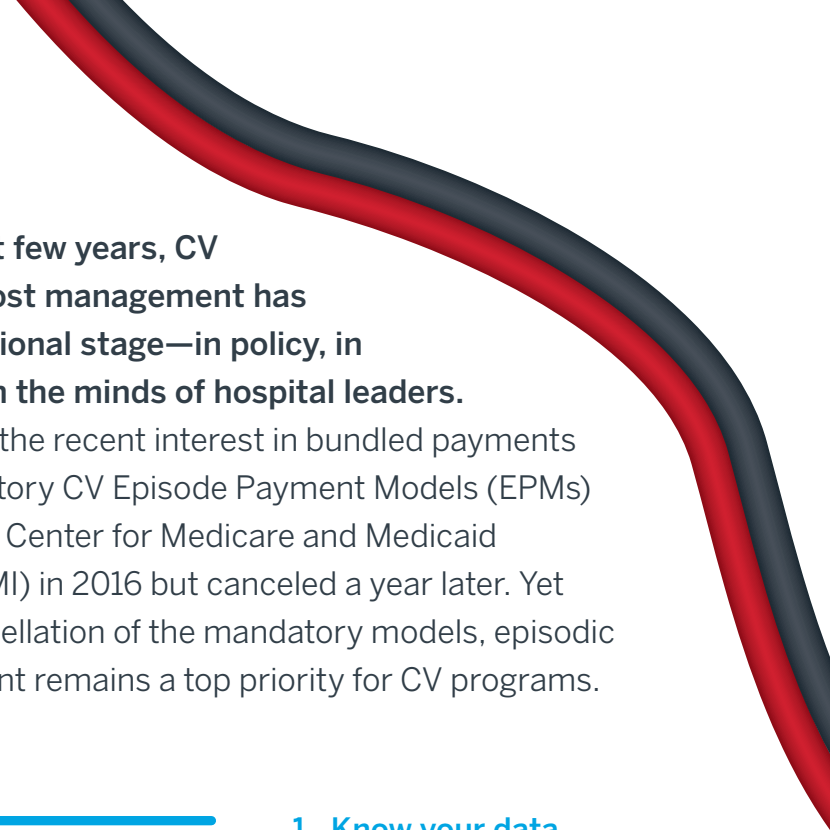




how to **Jump-Start**

Your CV
Episodic Cost
Management
Strategy

Marissa
SCHAFFER



Over the last few years, CV episodic cost management has been on the national stage—in policy, in the news, and in the minds of hospital leaders.

Driving much of the recent interest in bundled payments were the mandatory CV Episode Payment Models (EPMs) proposed by the Center for Medicare and Medicaid Innovation (CMMI) in 2016 but canceled a year later. Yet despite the cancellation of the mandatory models, episodic cost management remains a top priority for CV programs.

The voluntary BPCI Advanced model, beginning in 2018, includes several CV episodes and may qualify programs for the Advanced Alternative Payment Model track under MACRA. Furthermore, pay-for-performance programs (e.g., Merit-Based Incentive Program, Value-Based Purchasing) continue to scrutinize episodic cost more each year, private payers are increasingly entering into bundled arrangements, and health system executives are putting the pressure on service lines for cost control. To prepare for increasing episodic cost scrutiny, CV leaders need to reevaluate their current strategy and identify opportunities to better manage costs across the continuum.

Here are the steps to get you started.

1. Know your data.

To begin, CV leaders need to understand the sources of episodic costs, as well as the variation in total costs across multiple episodes. For example, sources of cost will differ substantially between CV medical episodes and surgical episodes, meaning programs will need tailored strategies dependent on the condition or procedure. While accessing and interpreting this data can be challenging, the Cardiovascular Roundtable's Care Coordination Episode Profiler allows programs to instantly access and compare their hospital-specific data to national and regional benchmarks. The tool breaks down payment by site of service and over time (e.g., 30, 90 days). With this data in hand, CV leaders can better understand the sources of cost and identify areas for improvement.

Individual Facilities  Compare

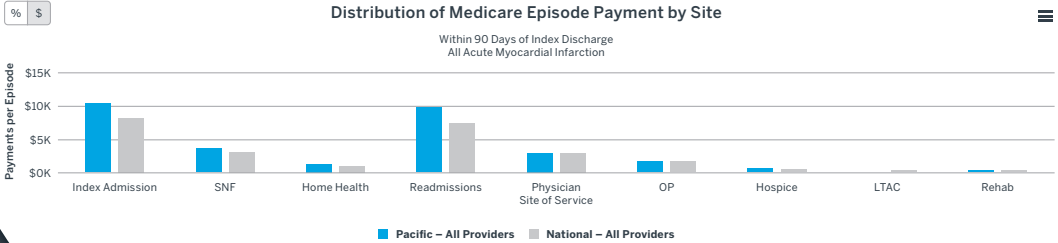
Program	BPCI Advanced Model	▼
Episode Type	Acute Myocardial Infarction	▼
Index DRG	All Acute Myocardial Infarction	▼
Time Range	Within 90 ▼ days of index discharge <u>between 2016 Q1 and 2017 Q1</u>	

Target Episode

Initiated Pacific – All Providers ▼ ⓘ

Comparison Episode

Initiated National – All Providers ▼ ⓘ



Tool spotlight:

Care Coordination Episode Profiler

The Care Coordination Episode Profiler allows Cardiovascular Roundtable members to examine their own episodic payment by site of service or time for services included in bundled payment programs (e.g., BPCI Advanced). The above example shows national episodic payment data for AMI across a 90-day episode.





2. Engage your physicians.

In the movement toward high-value care, engaging physicians and aligning them closely with institutional priorities is essential. Physicians have direct control over the cost of patient care—from treatment selection to post-discharge destination decisions, but often are not engaged or enfranchised in making the highest-value decisions for their patients. CV leaders must develop strategies to hardwire physician involvement in meaningful ways to drive improvements. In speaking with early adopters of bundled payments, we uncovered several effective strategies for this. Identifying physician champions for episodic cost management can help secure buy-in from throughout the physician staff. Enhancing data transparency on cost performance—such as through physician or group scorecards—will also often reveal to physicians the impact their decisions can have on the programs, and physician champions are often best positioned to lead these conversations. And of course, developing financial incentives that align with episodic cost goals will ensure these priorities are top-of-mind and that physicians are rewarded for their time and effort.

3. Collaborate with post-acute care providers managing your patients after discharge.

Traditionally, CV program purview has been largely contained within the four walls of the hospital, yet post-acute care (PAC) is a significant contributor to total episodic cost for many CV conditions. CV programs have faced challenges controlling those costs, reducing variation across sites, and improving PAC quality due to limited collaboration with PAC providers. To succeed under episodic payment models, CV leaders need to develop new collaborative relationships with PAC providers that establish care standards and help those providers in achieving cost and quality outcomes. Successful strategies include engaging patients and physicians in selecting the appropriate discharge destination, evaluating PAC providers and encouraging patients to use preferred facilities, and creating shared care standards for PAC providers. ●



To succeed under episodic payment models, CV leaders need to develop new collaborative relationships with post-acute care providers...



Best practice spotlight:

Baystate's CABG Post-Acute Care Road Maps Support Partner SNFs

At Baystate Medical Center in Massachusetts, CV leaders saw a number of post-acute care providers struggling to meet the performance expectations of hospitals when managing complex CV patients without some degree of structured support. To support their skilled nursing facility (SNF) partners in improving care for CABG patients, Baystate developed a comprehensive post-acute care pathway for CABG patients.

Baystate's road map outlines the expected care for each day the patient spends in the SNF and lists milestones for discharge. For example, during the first few days, treatment guidelines include incision assessment and dressing changes. Education goals include exercise plans and nutrition counseling. The road map also includes lists of common side effects as well as instructions for when further intervention may be needed.



Action Items for CV Leaders

USE

Care Coordination Episode Profiler

Assess your institution's episodic spending up to 90 days after index hospitalization for select CV services.

► advisory.com/cr/episodeprofiler

READ

Playbook for CV Episodic Cost Management

Learn strategies for CV leaders to manage cross-continuum costs in preparation for risk-based payment models.

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Endnotes

1. Hayford T, et al., "Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios," Working Paper Series Congressional Budget Office, September 2016.
2. Medicare Access and CHIP Reauthorization Act of 2015.
3. Merit-Based Incentive Payment System.
4. Cost savings per case for a single facility, based on Advisory Board's proprietary analysis of AP-DRG data from 468 hospitals.

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