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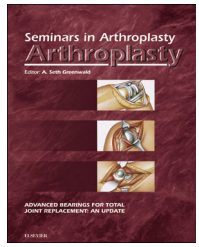

Alternate payment models for an episode of arthroplasty care: Are they good for patients?

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ABSTRACT

Alternative payment models are proliferating and are being viewed by many as a likely path for improvement in the cost structure of health care delivery. Despite the promise to reduce the increase in spending for government and other payers, of equal importance is the impact on patient outcomes and experience. As data accumulates to address this question, it is critical that developers of such payment models follow key principles that are designed to ensure that such a significant alteration in the payment structures turn out to be beneficial for the recipients of care. Payment reform that results in improvements in factors important to patients are likely to prove durable, whereas those that threaten patient access or experience are not likely to stand.

How one views the alternative payment models (APM) and the bundling of payments for an episode of care depends on one's vantage point. Perhaps one of the easiest ways to consider the implications and potential benefits of switching from a fee for service model of payment to a bundled payment model is to think about it from the perspective of a consumer of health care, rather than as a provider. When we do this, the concept of bundling the payments for all the services necessary to deliver a successful arthroplasty starts to become clear. Patients come to us with an end goal in mind, that is, the successful delivery of a solution to their painful arthritic joint, and the pain free restoration of function, all expected to occur within a specified time frame. The product that they are looking for is not a series of individually delivered services, but rather the composite of what those services look like when delivered as a whole—a bundle, if you will. They understand that this is a complex and multifaceted process with many individual steps and variables of significant importance, but, nonetheless, want to believe that we are delivering a total product in a coordinated way. The promise of the approach to arthroplasty as an episode of care is, at its core, an opportunity to live up to our patients' expectation that we will deliver a complete and high-value product to them.

There is broad consensus that total joint replacement (TJR) is a reliable treatment for end-stage arthritis, and, when effectively delivered to our patients, results in pain relief and return of function. The emerging work around bundling and episodes demands that we view this treatment as more than just a surgical procedure. In the new model, a TJR is a composite of all the care that goes into the surgical treatment of an arthritic joint that contributes to the final outcome and complete recovery. In fact, this complex system of delivery is, in essence, only as good as its weakest link. Or, stated plainly, even the best surgery or implant can fail to deliver the desired outcome if the result is compromised by a more mundane but potentially catastrophic deviation in the patient's care. Thus, it is the system as a whole, the complete package, that is

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deemed a success or failure in the patient's eyes, and our ability to unite the system around that perspective clearly increases our chances for success.

One of the biggest challenges to address when considering the concept of a bundled payment for care is that by our very description we have put the payment issues ahead of the care redesign issues. *The essence of this new approach does not rest in how we get paid for the product but rather in how we define the product for which we expect to get paid*. Providers who hope to get involved in developing an approach to bundling payments often get so hung up on the issues of gain sharing and governance (and these are important issues) that they never get around to rethinking the nature of a joint replacement as a composite, complex product from the perspective of the recipient. We would suggest that the most successful approach comes from first considering the elements that contribute to the value of an arthroplasty as seen through the eyes of the patient, and reserve discussions of sharing payment for later. For it is only after we can assess the value contributed by each element of the patient care value chain that discussions of who should reap the benefits of providing that value can occur. Further, the care coordination and care path development that surgeons and their teams bring to the process turn out to have substantial value to patients, and in the end, successful programs reward this buy in and care design and management efforts.

By understanding what condition is being treated and over what period of time, and coupling that with clearly defined metrics that define success for the patient, we can begin to define the value for the product. Our ability to attract patients, will depend on how effectively we deploy our resources and whether our product, our care, is on par or superior to others available in the market.

When constructing a total joint replacement bundle, the first consideration, as with any product, is determining who is the target audience. For a product, in this case joint replacement, to have value, it must meet a clear need, that is treat a definable problem, and there can be no dispute that there is a clear population of patients who have painful arthritic joint disease who will benefit from a joint replacement.

One common misconception regarding alternate payment models is that they fail to consider the uniqueness of individual patients and therefore promote standardized care that is not necessarily in the best interest of patients. But while this potential exists, the care redesign required of APMs provides ample opportunities to address this concern. Patients are not uniform, and neither is the severity of their problems. Specifically, not all patients who have traditionally been indicated for TJR will have the same likelihood of an optimal outcome and the resources required to meet their medical needs may vary substantially. Developing an appreciation for these differences and developing algorithms for managing different types of patients with different ranges of problems, when relevant, would be important keys to success. So, it is recommended that anyone venturing into bundled payments should do so with an interest in identifying meaningful differences between patients that can impact the care required. Thus, and this is a key point, the standardization in process that would be discussed later is meant to help identify when individualization of care through deviations from standard is needed. Think of the standardized processes as the gateways that help distribute patients into the correct path based on the clinical facets of their case that have the greatest impact.

Critics of alternative payment models have raised concern about access to care, patient selection and the subtle incentives to avoid high risk patients. It should be plainly stated that there may be patients who should be excluded from the bundle, either permanently or temporarily. Exclusion should occur when the rules and assumptions of the system of care at the heart of the bundle cannot be expected to effectively manage the risk associated with their unique set of conditions. If these conditions are defined as modifiable, then their exclusion may be temporary and efforts can be made to correct medical conditions prior to the beginning of the bundle. Patients with unremediable conditions that cannot be managed by the standard care pathways should be recognized as such and their care subject to exclusion from the bundle and subject to alternative payment methods that may reflect the degree of risk for which the provider is not equipped to manage. The method of selecting patients for inclusion into the bundle will have wide ranging impacts, and care must be taken to ensure that adverse selection of at risk patients does not result in care denial, if such care is medically necessary.

One of the greatest advances for patients has come from alterations in the way the preoperative process is managed for patients. With the recognition that patient engagement and medical optimization can have profound impacts on outcomes and cost of care has come a beneficial focus on rethinking this process. One of the best practices that has emerged is to separate two previously linked processes, indication and optimization.

The first phase is the indications phase where the decision is made regarding hard evidence that surgery is likely to be the right next treatment for the patient's medical condition. Documentation that accompanies this phase is very useful in avoiding utilization challenges and ultimately unfavorable audits or clawbacks of payments. We have developed structured documentation that requires clear delineation of (1) the degree and severity of symptoms, (2) the objective clinical and radiographic findings that define the disease process, and (3) the attempt and failure of prior treatments and/or the relative futility in attempting further alternatives. By bringing additional focus to this phase, including the use of patient reported outcome measures and in some cases shared decision making tools, patients now find that they may have better information about the expected merit of the planned procedure and its appropriateness for their condition. Once that is accomplished, the patient is a potential candidate for a joint replacement under an APM.

The second phase of the preoperative evaluation is to assess their medical, social and psychological fitness for surgery at this time. Another way of phrasing it is that while phase one has determined that arthroplasty is a reasonable and appropriate next step, though not yet compelled, phase two tells us if this is the appropriate time to proceed. The evaluation that occurs in phase two has often been called preoperative clearance, but that misnomer has prevented this