Where Heart Programs Are Leaving Money On The Table – And How To Get It

Larry Sobal
Executive Vice President and Senior Consultant
August 25, 2017
A powerful CV community:
The nation’s largest network of cardiovascular leaders focused on sharing insights and solutions

- 370+ cardiovascular organizations
- 6,800+ physicians
- 3,500+ C-suite leaders
- 700+ cardiovascular coders
- 460+ coding managers

46 states
1,800+ locations
Background: Larry Sobal

Provider Experience

- Leadership of independent and employed single specialty and multi-specialty physician groups


Hospital Experience

- Hospital Executive
- Insurance CEO
- Heart Institute CEO
- Service Line VP
- VP Care Transformation
- Small, regional and national health system roles
- Trained LEAN and Value Stream facilitator
Audience Poll - Show of Hands Please

• How many of you are organizations that have a formal cardiovascular service line?
Audience Poll - Show of Hands Please

• How many of you are in an organization that have an alignment with cardiologists either through co-management, PSA or employment?
Audience Poll - Show of Hands Please

• How many of you need to leave the meeting today with some practical and real life strategies to improve both financial performance in your heart program?
Why is cardiovascular special?

- Nationally accounts for 20% of all healthcare spending and 33% of Medicare spending
- Nationally accounts for 20 – 60% of hospital total contribution margins
- Ahead of all other specialties in driving quality (ACC, STS) and Appropriate Use Criteria
- Physicians control or influence a high % of CV cost
- Still ahead of cancer as America’s leading cause of death
What We’ll Cover Today – 5 Opportunities in CV programs where we routinely create over $1 million in annual benefit (each one)

$ Cath lab
$ Revenue Cycle
$ Cardiology Practice
$ APP utilization
$ CHF
Cath Lab
Cath vs PCI Relatively Flat

Per 1,000 Patients in the Cardiology Practice Panel

<table>
<thead>
<tr>
<th>Year</th>
<th>Catheterizations</th>
<th>Total PCIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>69</td>
<td>29</td>
</tr>
<tr>
<td>2013</td>
<td>74</td>
<td>29</td>
</tr>
<tr>
<td>2014</td>
<td>79</td>
<td>30</td>
</tr>
<tr>
<td>2015</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>2016</td>
<td>71</td>
<td>30</td>
</tr>
</tbody>
</table>
Fewer Caths Without Intervention

Percent of PCIs to Cath

- 2012: 36.1%
- 2013: 38.4%
- 2014: 39.0%
- 2015: 41.2%
- 2016: 41.9%
Which Quadrant Are You In?

Department Functionality

- Stagnant
- Progressive

Procedural Platform

- Cardiac Cath Lab
- Ablative/Interventional Program

Very Good

??
Four Priorities to Improve CV Lab Financial Success

<table>
<thead>
<tr>
<th></th>
<th>Priority</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Optimizing Daily CV Lab and Provider Schedules</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Improving Number of Patients w/ Safe-Same Day Discharge</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Accurate Professional and Technical Procedure Coding</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Interventional and EP Product Standardization</td>
<td></td>
</tr>
</tbody>
</table>
Optimizing Cath Lab and Provider Schedules

1. Poor Patient Handoffs – Office Scheduling to Cath Lab
2. Excessive Patient Prep – Delayed Cath Lab Start Times
3. Lack of Contemporary Same Day Discharge Protocol
4. Outpatients Staying Overnight in Inpatient Beds
Cath Lab Optimization

Maximizing cost reductions, improving quality and patient, physician and staff experience
Achieve the QUADRUPLE AIM

SDD
Admit and Discharge within working day

Pre Hospital-Drs office
Admission
Pre Procedure Workup
Procedure
Recovery
Post Procedure/Pre Discharge
Discharge
24 hour F/U
Revenue Opportunities

- Add new lab capacity through use of efficient flow and efficient cath lab scheduling template
- Optimize your revenue cycle through effective documentation and coding to get fully paid for the work you are doing
- Optimize your rebates through effective supply chain contracts
Cost Opportunities

- Avoid unnecessary costs of care that occur when patients are admitted to a unit overnight when they could have been safely discharged same day.
- Avoid unnecessary staff overtime and call pay that come from an inefficient lab that results in elective cases being done after hours.
- Avoid unnecessary LOS by being able to schedule inpatient procedures to facilitate faster discharge.
### 3 Interventional - DRGs 246-251,280-287

<table>
<thead>
<tr>
<th>Metric</th>
<th>Percentile Rank</th>
<th>25th %</th>
<th>50th %</th>
<th>75th %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Charges</td>
<td>Rank</td>
<td>$37,478</td>
<td>$32,770</td>
<td>$57,782</td>
</tr>
<tr>
<td>Mean Cost</td>
<td>Rank</td>
<td>$13,802</td>
<td>$13,179</td>
<td>$16,921</td>
</tr>
<tr>
<td>Mean Payment</td>
<td>Rank</td>
<td>$9,842</td>
<td>$9,838</td>
<td>$12,127</td>
</tr>
<tr>
<td>Margin</td>
<td>Rank</td>
<td>-29%</td>
<td>-31%</td>
<td>-20%</td>
</tr>
<tr>
<td>GMLOS</td>
<td>Rank</td>
<td>3.90</td>
<td>2.90</td>
<td>3.40</td>
</tr>
<tr>
<td>CMI</td>
<td>Rank</td>
<td>1.66</td>
<td>1.22</td>
<td>1.77</td>
</tr>
</tbody>
</table>

#### Hospital's Cost Per Case

![Bar chart comparing hospital costs to national average](chart.png)
279,987 PCI records from NCDR, all eligible for SDD, were linked to Medicare Claims Data.

2014 Hospital costs were estimated using cost to charge ratios.

TRI w/SDD was associated with fewer complications and lower in-hospital costs.

TRI with SDD was found to have lower cost point of $3689 per patient vs transfemoral overnight OPs.
Real Client Results

1. 350 PCI, 220 Beds, $750K
2. 600 PCI, 560 Beds, $2.4M
3. 600 PCI, 945 Beds, $1.6M
4. 1590 PCI, 665 Beds, $1.3M
5. 300 PCI, 380 Beds, $1.0M
6. 776 PCI, 750 Beds, $2.8M
7. 1136 PCI, 488 Beds, $1.7M
Revenue Cycle
Defining Your Revenue Cycle

• More than just billing and collecting
  – Concept Zero to Zero
  – Departments & Functions
  – Processes
  – Key Definition & Metrics

• Includes all processes and procedures that have potential to impact revenue
Maintain compliance, charge capture, coding and billing for all CV services provided

- Documentation completion standards – timeline/accuracy
- External audits and education
- Reconciliation of charges
- Develop a standard for charge lag days for clinic and hospital services.
- Measure missed charges
- Utilize certified CV coders – especially for high charge activity
Develop key indicators with downstream feedback

- Denial Measures to track performance.
- Productivity and Quality staff metrics.
- AR – Insurance and Patient
- Coding - Benchmarking by Provider
Are You Tracking CV Rev Cycle Performance?

2016 - Days in A/R for All Practices

51 Practices / 1184 Providers in Cardiology

StdDev: 14 Avg: 36

75% = 45
50% = 32
25% = 26
E&M “Risk-O-Meter”

Net Financial Risk is $631,788
Key CV Opportunities

• Charge Master Review and a process to maintain current
• Optimize facility coding and charge capture and professional service capture - largest $$ in Cath, Peripheral and EP
• Clinical documentation improvement process
  – Capturing of MCCs and CCs
  – Documentation timeliness/compliance
• Intake process pre procedure for ICD and Pacemaker implants
  – National Coverage Determinations
• Pre-Authorization process and downstream communication
Practice Optimization
Optimizing Practice Schedule

- Prioritize New Patient Intake
- Manage Established Stable Patient Care Intervals
- Actively Work Recall and No-Show Appointments
Prioritize New Patient Intake
(Partner Consensus)

✓ New pts= Growth (25% minimum – MedAxiom Goal 30%)
✓ Financial “Lifeblood”
✓ Improve access for referring doc satisfaction
✓ SPECIAL TIP: Consider established pt. for first pt. of the morning!
# Sample Physician Schedule w/New Patient Focus

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Time</th>
<th>Physician</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Patient</td>
<td>8:00</td>
<td>New Patient</td>
<td>1:00</td>
</tr>
<tr>
<td>New Patient</td>
<td>8:20</td>
<td>Established Patient</td>
<td>1:40</td>
</tr>
<tr>
<td>Established Patient</td>
<td>9:00</td>
<td>New Patient</td>
<td>2:00</td>
</tr>
<tr>
<td>New Patient</td>
<td>9:20</td>
<td>Established Patient</td>
<td>2:40</td>
</tr>
<tr>
<td>Established Patient</td>
<td>10:00</td>
<td>New Patient</td>
<td>3:00</td>
</tr>
<tr>
<td>New Patient</td>
<td>10:20</td>
<td>Established Patient</td>
<td>3:40</td>
</tr>
<tr>
<td>Established Patient</td>
<td>11:00</td>
<td>Established Patient</td>
<td>4:00</td>
</tr>
<tr>
<td>Established Patient</td>
<td>11:20</td>
<td>Established Patient</td>
<td>4:20</td>
</tr>
<tr>
<td>Established Patient</td>
<td>11:40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Manage Stable Well Patient Intervals

(Partner Consensus)

✓ Huge Barrier to Practice Growth
✓ Practice Cardiology not Primary Care
✓ Refer Patients Back to PCP for routine Care
✓ Consider 12 Month f/u Intervals, Alternate with APP
✓ Consider Use of Specialty Clinics for Chronic or Patients Not Meeting Goals
## RVU Comparison – Bust the Myth!

<table>
<thead>
<tr>
<th>17 Patient Office Schedule</th>
<th>6 Patient Cath Lab Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 11 - Established</td>
<td>• 2 - Right Heart Cath</td>
</tr>
<tr>
<td>• 6 - New Patients</td>
<td>• 1 - Right and Left Heart Cath</td>
</tr>
<tr>
<td>• <strong>39.94 RVU’s</strong></td>
<td>• 2 - Angio w/ Right &amp; Left</td>
</tr>
<tr>
<td></td>
<td>• <strong>22.72 RVUs</strong></td>
</tr>
</tbody>
</table>
APP Utilization
Appropriately Utilize APP Staff

- Create APP Work Standards
- Optimize APPs use in the clinic
- Improve Access and Care with APP Run Chronic-Disease or Function Clinics
APP WRVU Variation
Create APP Work Standards

(Physician Consensus)

✓ Understand society and state regulations governing roles/responsibilities
✓ Leverage skills in both hospital and office
✓ Move beyond scribing/shared visits
✓ Create standard on what types of patients they will see and intervals for follow-up care
Optimize APP Clinic Schedule
(Physician Consensus)

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Time</th>
<th></th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Visit (EST)</td>
<td>8:00</td>
<td>Established Visit (EST)</td>
<td>1:00</td>
</tr>
<tr>
<td>Established Visit (EST)</td>
<td>8:20</td>
<td>Established Visit (EST)</td>
<td>1:20</td>
</tr>
<tr>
<td>Established Visit (EST)</td>
<td>8:40</td>
<td>Established Visit (EST)</td>
<td>1:40</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>9:00</td>
<td>Urgent Clinic</td>
<td>2:00</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>9:30</td>
<td>Urgent Clinic</td>
<td>2:30</td>
</tr>
<tr>
<td>Post Hospital Follow-up/CHF</td>
<td>10:00</td>
<td>Post Hospital Follow-up/CHF</td>
<td>3:00</td>
</tr>
<tr>
<td>Post Hospital Follow-up/CHF</td>
<td>10:30</td>
<td>Post Hospital Follow-up/CHF</td>
<td>3:30</td>
</tr>
<tr>
<td>Post Hospital Follow-up/CHF</td>
<td>11:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Hospital Follow-up/CHF</td>
<td>11:30</td>
<td>Patient Follow-up, telephone, tasking &amp; Lunch</td>
<td></td>
</tr>
<tr>
<td>Patient follow up, telephone, tasking &amp; Lunch</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Improve Access and Care with APP Run
Chronic Disease or Functional Clinics

- CHF
- AFIB (ER or PCP Referrals)
- Lipids (Difficult Patients)
- Outreach Clinics
- Rapid Access Clinics
Productivity is dependent on the schedule not the APP

Optimally scheduled APP generated 3,220 RVU in 2016

MedAxiom “ideal” 3,600 RVU

Financially advantageous to health system

Challenges center on determining proper size of APP workforce and overcoming scheduling issues
**CHF Commonly a Negative VBP Impact**

### PROJECTED FINANCIAL IMPACT

<table>
<thead>
<tr>
<th>Estimated Hospital Base Payment</th>
<th>$103,201,626</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBP Incentive/Penalty</td>
<td>$(455,743)</td>
</tr>
<tr>
<td>RRP Penalty</td>
<td>$(2,634,466)</td>
</tr>
<tr>
<td>HAC Penalty</td>
<td>$-</td>
</tr>
<tr>
<td>Total Estimated Impact</td>
<td>$(3,090,209)</td>
</tr>
</tbody>
</table>

**Combined VBP, RRP & HAC Payment Adjustment**

- **2017 Payment**
  - Average Hospital: -0.56%
  - Your Hospital: -2.99%

Reference: CMS Hospital Compare CY2015
Solving the CHF puzzle
BPCI Version 2.0
Coming in 2018?
Bundling Heart Failure

And Why CHF Might be Appealing
## Bundled Volume & Cost Data

### Cardiology Bundles Volume and Cost: Based on BPCI Episode Definitions, 90 days

**State:** MA  
**Bundle:** All  
**Date Range:** 2015 Q1, Q2, Q3  
**Minimum # of episodes:** 18 to 7,035

#### Measure Names
- HHA  
- IRF  
- LTCH  
- Outpatient  
- Readmit  
- SNF  
- Avg. Anchor Ip Pay  
- Episode Volume

<table>
<thead>
<tr>
<th>State</th>
<th>Service Line</th>
<th>Bundles</th>
<th>Family</th>
<th>Number of Episodes</th>
<th>Avg Cost Per Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>Cardiology</td>
<td>Congestive heart failure</td>
<td>3,925</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiac arrhythmia</td>
<td>2,165</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute myocardial infarcti</td>
<td>1,915</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percutaneous coronary in..</td>
<td>1,563</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Syncope &amp; collapse</td>
<td>1,141</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other vascular surgery</td>
<td>1,062</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiac valve</td>
<td>968</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacemaker</td>
<td>903</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical peripheral vascul..</td>
<td>769</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest pain</td>
<td>718</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coronary artery bypass gr..</td>
<td>706</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Major cardiovascular proc.</td>
<td>368</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atherosclerosis</td>
<td>212</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiac defibrillator</td>
<td>93</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacemaker device replace..</td>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bundled Volume & Cost Data

This screams careful management!!
Look at Bundle Volume & Cost Data In your region
Example CHF Care Pathway Project

Memorial Hospital Heart Failure Quality Initiative

Education
- Medication
- Transition of Care
- Follow-up
  - 7 days
  - 30 days
- Home Health

Diagnosis Documentation

Coding Quality Metrics

Concurrent Coding
Chart Review/Adjudication

Billing*
Registry Entry*

Improved Patient Care

↓ LoS
↓ 30 d Readmission
100% Quality Metrics

Heart Failure Center of Excellence

*All quality metrics must be documented prior to final (30 day) submission.

Allen E. Atchley, MD FACC
Inpatient CHF Focus – Cardiologists and Hospitalists

<table>
<thead>
<tr>
<th>HF Order Sets</th>
<th>Discharge Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More aggressive, early diuresis (UNLOAD Trial)</td>
<td>• Geographic Rounding</td>
</tr>
<tr>
<td>• HF RN, CM, PT involvement</td>
<td>• Morning “Huddle”</td>
</tr>
<tr>
<td></td>
<td>• Prioritize discharge</td>
</tr>
</tbody>
</table>
Understand Your CHF Readmission Population

- 55% Non-Cardiac Related
- 34% HF Readmit
- 11% Other Cardiac Related
Managing Post Acute is Critical With CHF

• Standardized post-acute pathways & order sets
  – Evidence based approach for continuity of heart failure care and transitions per AHA/HFSA Scientific Statement (http://circheartfailure.ahajournals.org/content/8/3/655)
  – Expectation of LOS ≤ 14 days based MCG Health guidelines including Commercial and Medicare Populations

• Transitions of Care
  – Communication guidelines
  – Important contact information
  – Coordination of follow-up calls and appointments
  – Coordination of information
  – Managed hand-offs

• Provider and Staff Education
### POST-ACUTE FACILITY COMMUNICATION FORM--Attachment A

**Patient Name**: Heart Failure Bundled Payment Patient  
**Patient DOB:**

<table>
<thead>
<tr>
<th>Date of admission to facility:</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>Day 8</th>
<th>Day 9</th>
<th>Day 10</th>
<th>Day 11</th>
<th>Day 12</th>
<th>Day 13</th>
<th>Day 14</th>
</tr>
</thead>
</table>

**Anticipated DC Date:**

**DC Disposition:**

**Vital Signs:**
- **BP** (notify MD systolic <90 or >200)
- **HR** (notify MD apical >100 or <50)
- **O2 Sat** (notify MD <90%)
- **Respirations** (Notify MD >28/min or <10/min)

**Daily Weight (lbs)** (Notify MD-3LB/3 days or 5LB/7 days)

**2 Gm Low Sodium Diet- Y/N**

**Fluid Restriction (mL/day)**

**Intake/Output**

**Ace inhibitor (ACEI) name-if not on, reason why**

**Angiotensin receptor blocker (ARB) name-if not on, reason why**

**Beta Blocker name-if not on, reason why**

**7-10 day follow up appointment with PCP scheduled- YES/NO**

**30 day follow up appointment with Cardiologist scheduled-YES/NO**

**Identified Barriers to Care (ex: cost of meds, self pay, literacy)**

**Clinical Update:**

*Source of 14 day LOS based on MCG Health targets 20%ile-30%ile for commercial and Medicare payors LOS*
Get your customized EPM data set including:

- Your hospital's historical cost per case for AMI and CABG bundles
- Your hospital's cost by type – Hospital, SNF, HHA, rehab, hospital outpatient service, etc.
- Your hospital's regional cost per case, overall and by type of cost
- Your hospital's target hospital costs compared to 5 regional competitors (blinded)

GO TO medaxiom.com/EPMCustomReport
Audience Poll – Fist To Five

Raise your hand and indicate how many of these 5 opportunities you think your organization has which will produce significant financial benefit.

From zero (fist) to five fingers
Thank You

To read one of my weekly blogs that specifically addressed this topic, put the following in your search engine and it will take you to the blog link:

Larry Sobal blog heart program is leaving big money on table