Unique payer-provider structure, new models of patient-centered care.

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Dr. Dwight Burney welcomes back orthopedic surgeon and outcomes expert Dr. MaCalus Hogan, M.D., M.B.A. to the podcast. Dr. Hogan is the Vice Chair of Education, and Residency Program Director, in the Department of Orthopaedic Surgery at the University of Pittsburgh Medical Center, a health system serving 3 million patients. This discussion explores value-based payment models in the contexts of population health management and the social determinants of health, and from the perspective of a unique payer-provider system aiming to provide truly patient-centered care. All views expressed are the participants own.

Dr. Burney: Welcome to this episode of the Health Disparities Podcast, a production of the Movement is Live Caucus. You can learn more about Movement is Life and our initiatives at movementislifecaucus.com. I'm Dr. Dwight Burney. I'm an orthopedic surgeon in Albuquerque, New Mexico, and a member of the Movement is Life Steering Committee. It's my honor to welcome Dr. MaCalus Hogan MD MBA, the Vice-Chair of Education and the Residency Program Director in the Department of Orthopedic Surgery at the University of Pittsburgh Medical Center. Prior to joining UPMC, he completed his orthopedic residency at the University of Virginia, and then a Foot and Ankle Fellowship at the hospital for special surgery. He currently serves as the medical director for outcomes and registries for the UPMC Donald F Wolff Jr. Center for Quality Safety and Innovation.

Welcome back to the podcast, Dr. Hogan, we really appreciate your participation and insights on the important subjects we're covering. And I know you've supported both the podcast and our annual conference in the past.

Dr. Hogan: Absolutely. Hey, it’s great being here, and I really enjoyed working with and supporting and collaborating with Movement is Life over the years, and looking forward to many more opportunities to engage a partner together going forward.

Dr. Burney: Well, we're really grateful to have you. Tell us about your work at UPMC. You wear a lot of hats there.

Dr. Hogan: Yes. Here at UPMC, in addition to being a, you know, a busy clinical foot and ankle specialist, I work closely with healthcare leaders, both from our quality side, as well as with our UPMC health plan. And it also gives a unique opportunity to partner with orthopedic surgeons, both from the academic, as well as community, and private practice realms across our multi-hospital integrated network and system. It has been a fortunate ride thus far, and we continue to work to provide the best care for patients in the community, and really learn together in that process.

Dr. Burney: Well, you're really dealing with all the stakeholders in this value question that healthcare in our country has always been pretty much divided, defined by how it's paid for. All of the stakeholders, i.e., the patients, the providers, both individual and institutional, and the payers agree that the current healthcare costs are unsustainable. What has UPMC done to try and deal with this cost issue?

Dr. Hogan: We have taken a number of approaches. I believe the first, well the most important aspects is to truly acknowledge that costs have an impact on how we can provide the best care for our patients, how we may continue to innovate, and specifically for UPMC as a payer-provider and an integrated network, the cost has a number of definitions of perspectives, and a number of stakeholders, even within our institution. So, as a provider and as a payer, and managing 3.5 million lives through our health plan, we have to have an appreciation of costs. And so, a number of things that we've tried to do from the orthopedic perspective are we have a very strong orthopedic service line with physicians, partnering with our administrative counterparts and colleagues to really, how do we manage the cost question. How do we manage that while also being able to innovate and really our approach starts with really communicating and partnering together? We have set up a number of what we call value analysis committees, looking at implant costs, also a number of pathway committees, specifically in joint replacement, also spine, low back pain

disease, and a number of other realms across the orthopedic and muscle-skeletal subspecialties, really looking at our cost of care and cost of care delivery. And then we get the other side of that coin and that we will, where appropriate, part of where our health plan and really look at what are the downstream cost elements, not just on the hospital side, and physician or surgeon side, but on the claims paid and really population management side. And so, I do believe we have not identified or created our own utopia as of yet, but I do believe we have a great platform and all of the pieces to really help drive how we deliver care going forward.

Dr. Burney: Well, you mentioned all of the different varying viewpoints on cost, and I think it's very interesting that a lot of these are in conflict. I'm thinking of the Institute for Healthcare Improvement and what started out as the triple aim, which is now the quadruple aim, which is to improve access to care, improve quality and lower costs and use all providers to the best of their ability what's called at the top of their license. Sometimes these goals seem contradictory. Tell me about your efforts at UP to harmonize these goals.

Dr. Hogan: The quadruple aim, it is a great point. I mean, how do you find harmony when everyone's singing at a different note, and their perspective of what that may be, and while we've been through a lot this year with the pandemic, I mean, some would describe essentially what has played out

as a reflection of that, though things have come together and we're going in a positive direction. Healthcare, first the access piece, if you do not have access, and I believe this is important for hospital systems. If they can't provide access, they cannot thrive. And for insurance providers who are taking care of their members, if they do not have access to quality care and access, we know that they actually leak into the system or enter through doors and revolving doors that are actually the least ideal, in regard to emergency rooms, are constantly identifying care in only the urgent care setting, while those settings can be a great value when necessary for the right things.

And so, if you're not identifying access first, you can't improve. You cannot improve quality. How can you actually determine the appropriate quality for your membership, for your patients, or for your environment, if you do not even have access to the patients who need it, or for the patients who need it? And then the cost piece, there's no magic pill here. I think we would have already identified it. I believe you have to be willing to discuss it, and determine, okay, what, how can we optimize, how can we have this dollar go as far as possible, and it really just drives to the efficiency of how you use that and measuring outcomes and say, you know what, this works, there is no one magic bullet. I believe there are a number of different ways to skin a cat and having an appreciation for those is important.

And then the top of the licenses piece, how we disperse resources within healthcare has always been somewhat variable, and broad variation. And what that often is driven by is individual silos functioning the way that works best for them, or the way that had been created for them and they say, hey, this must be the only way. And when you think it's the only way you have a problem. And so, what we tried to do is have discussions. I'll give you a couple of examples. I mean, our orthopedic joint replacement program and our centers of excellence, we've essentially approached things with what are the core access points, you know, how should patients come in? Should they be coming in through a primary care referral? Should they be coming in through self-referral? But when they do come in, we want to know that when they are referred to a Center of Excellence Program within UPMC or UPMC health plan, these are the basic essentials you're going to receive. We're going to have an orthopedic care navigator, whether you choose to have that individual be a certified nurse, or whether it be a nurse practitioner, or whether it be a very highly educated, experienced former surgical tech who really understands joint replacement and that experience - you know what that actually is part of what we want. We want someone to be in that entry point and liaison and concierge to that experience. And then from there, essentially following metrics for the surgeons that are providing that care so that we know at baseline, we know the quality of care that you're going

to receive on majority of scenarios and really supporting that. And then also using surgeons, working with surgeons and practices that they want to engage on, how we can continue to be better. And even if it comes down to just, how do we maintain that high level of performance? It's not to say one's always better than the other, but the key is how do you maintain that bar? And those are the approaches we take. And we have a number of meetings and discussions, and the best part for me is that the surgeons are constantly talking, constantly providing feedback with one another, and that constant exchange with our healthcare system, administrative leadership, and also the feedback loop of patient outcomes. So, that's how we're trying to address that quadruple aim.

Dr. Burney: That seems to be a very comprehensive approach. I wonder if you'd comment on your experience in population health. You had mentioned that, and particularly when we talk about disadvantaged populations, people who have adverse social determinants of health and may also have access issues. What's the orthopedic surgeon's role?

Dr. Hogan: You have different opinions on this. My perspective and the perspective we've tried to build collectively here at UPMC. So, when you get into the social determinants of health, a majority of surgeons, at least the physicians I know in our environment. When our patients come in, we really want to have the opportunity and tools to take care of them. And I

think we do have to appreciate that everyone comes from a different position, a different place. Again, I use the pandemic example, right? What is socially distancing at home, in someone who has a three-story home with a basement and six bedrooms versus someone who has a two-bedroom apartment? They may cost the same depending on where you are, and the experience and the ability for them to socially distance or optimize their wellbeing in a bad situation or a good situation are vastly different, and our willingness to appreciate that as the first step. Okay. Now, what we try to do from there is recognizing that we look at our care across our different payer mix, whether that be Medicaid, Medicare, whether it be commercial patients, and really have tried to essentially set up our program to whoever comes in the door is going to get that optimal baseline care. And that's what we developed our optimization programs. So, when you have certain disparities, particularly black, Latino, there is a higher rate of comorbidities. We have to appreciate that. And so we have really worked to build in optimization pathways. We say, hey, look, these are the things we need to work with you to optimize for surgery. Not that you would never ever have a chance to get surgery, but how can we optimize your health so that you can have the best chance at a great outcome, and we can all feel good about this. And so, I do believe we have to be willing to address that, and optimization means different things for different populations and there has to be an appreciation of that on the side of the surgical providers.

Dr. Burney: Yes, I think it's very important that you emphasize optimizing health rather than just teeing somebody up for surgery because I think that we as surgeons, tend to be very focused on getting to the operating room. That's, where we're most comfortable. Have you had any experience at UP with alternate payment models?

Dr. Hogan: Yes. In our experience here, we were one of the mandatory programs for CJR for the mandatory joint replacement bundle. Respectfully to that when it launched in 2015, two or three years prior, again, one of the benefits of being a payer-provider is that our UPMC health plan had piloted a joint replacement bundle, as well as a spine bundle, real examples, and also a musculoskeletal home model in different pilots throughout the system. And they gave us an opportunity to really kind of learn and they kind of noodle at things. We essentially call it here at UPMC, we developed our own BPCI type programs and piloted within, and really use our living lab models to try to gain an understanding. That definitely propelled us forward. That gave us a foundation to build on when we were thrust into the mandatory program for joint replacement. And then simultaneously at that time, our health plan again, the incentives aligned. Our health plan aligned our commercial program product for all joint replacement under a bundled program, a retrospective bundle with quality targets, as well as financial targets to match that of the mandatory Medicare program. We

have experienced in that realm and we're still learning and still pushing those forward as well.

Dr. Burney: Are you involved in any capitated contracts?

Dr. Hogan: We do not have capitated contracts right now but the interesting thing about healthcare again, right, is that, as one of the things we're talking about here, a lot of it comes down to, how do you peel that onion? And so, in one environment, you call it capitation. Another environment says, well, it's a prospective bundle with a downstream target and others will call it a retrospective. But essentially it is, hey, here's the bar in line and how much can you get in under that line when it comes to finances but oh yes, by the way, we want the best, right. We want the best performance and what is the minimum best that you can provide us? And then when you do it, we want all of our patients to feel as though that it was great, you know, it's essentially saying, we want everyone to feel as though they've had a five-star dinner regardless of what the ingredients were. But we do have a number of capitated discussions that are ongoing and population management-type capitated discussions that are forthcoming right now. And that's being driven by industry, that's being driven by companies, Corporate America, and also, quite frankly the governmental space as well of, “Hey, well, where may this go?”

Dr. Burney: Well, that's interesting. I wonder how you've managed to get some sort of alignment in financial incentives with the alternate payment models that you've dealt with.

Dr. Hogan: So, a couple of things. One, we're a large system, 41 hospitals. We span across the State and into New York and Maryland now and even internationally. So one of the things we've talked about here in Western PA is the gain sharing models that are different, right, risk-sharing, and gain sharing. And we've definitely moved further down the line of a sharing model of what type of in-kind services can we support, what type of wraparound resources can we support for the center of excellence programs or quality programs that are performing well? In what direction does that go in regards to direct [14:46 inaudible] for surgeons, direct in-kind services for their programs. We have that discussion, and we have several things in place, in different settings. The other thing that we were talking about a lot is when you get into aligning those incentives, what I've found is that you definitely have to have those discussions up front. They can't be a barrier to getting off the ground. It can't be the only thing that will launch the rocket but you have to acknowledge it up front and then start talking through that together. And if you are willing to do that, I believe you can actually have a lot done. Mandates don't hurt. I mean, let's be honest here, the joint mandate that occurred five years ago, changed and rapidly amplified this discussion in orthopedics in ways that it

likely would not have occurred if it had just continued with BPCI and the voluntary approach. And so, I think it's upon us as surgeons and healthcare leaders, uh, to help lead that discussion. Otherwise, it will be thrust upon us in some way, the mandate showed it.

Dr. Burney: You had mentioned wraparound services. Tell me a little more about that.

Dr. Hogan: A lot of the things that we talk about are things that we've done over the years as orthopedic surgeons and really just hospitals. What is the patient experience, right? So, if the biggest limitation to a patient experience to drive higher an experience score is essentially just someone saying hello to them when they walk in the morning. That may be a low-cost alternative. And you say, you know what, how about someone else just say hello to them and stop by to see them, lend a positive comment. In other scenarios, if the efficiency to really be able to take care of patients and have them have a great experience so they're not finishing their surgery at 7 or 8 o'clock at night and not getting to a hospital floor until 10 or 11:00 pm. And so, they definitely didn't get up the day of surgery, right? If the limiting factor to that is really a resource of an additional, you know, surgical tech or a physician extender to help facilitate OR efficiency, then those are the discussions you need to have. And often, we were never able to get down to that level because we were caught into a kind of cookie-cutter approach of, well, if it doesn't fit on this baking sheet, then

we don't know how to actually apply it. And so, I think that's really what we try to look at. And we received feedback from our - we have five centers of excellence in Western PA and several others throughout the system. And we looked at search and feedback. Feedback from our nurse navigators who were on the floor. Some environments did not have a nurse navigator, so we had to decide as a system, is this something we want to invest in? And the decision was yes. And because we felt that represented a basic essential that was critical to the experience and the outcome of the program and those types of resources that you look into and then obviously extending into the outpatient space, and constantly surveilling and constantly collecting feedback on how you're performing, I think is critically important.

Dr. Burney: Okay. I was going to ask you if you had seen any specific instances of these alternative payment models actually inhibiting or worsening healthcare disparities.

Dr. Hogan: Yes, it's definitely there. It's definitely there. I'll give an example. We looked up a couple of years ago and said, you know, we surveillance. And we said, let's just look, you know, Medicaid was not in the mandatory bundle but there are some state programs that are state employees, and it's not that much difference, for example. And we said you know what, let's just take a look and see what has happened with our Medicaid

population over time that has actually undergone joint replacement or undergone elective surgery. And it dropped two or three percentage points and everyone was kind of looking around like, okay, it's this a real drop. Is this a significant drop? Is that a representation of those individuals being turned away? And what we looked at as a payer-provider, we looked back at, okay, what are we identifying in regard to their access to care, are the same number of those individuals coming in requesting surgery, or going into surgery providers with claims and fewer are getting surgery? And we actually didn't see that, but that said, we had to have a willingness to look just to ensure - okay, are we seeing significant differences, or is that something that's going to normalize in the future?

The other thing that I would say, I'm a proud pronouncer of this when we actually built our joints bundle program and, not just for joints, but across our value-based programming, we built out pathways surgical or preoperative optimization was a part of that regardless. And what we found was patients with lower BMI actually had a higher complication rate than those with higher BMI, malnutrition, failure to thrive. And so, essentially what our surgeons identified and that always kind of spooks people like, oh, really. What we found was we surveyed all the surgeons and it was 26 surgeons, and we said, if you knew you would not lose the patients, right, you would not be penalized for canceling someone the day of surgery, and all of a sudden, they want to pull your OR, you know,

block. All the things you're smiling about because you know, this is what they do to us. You know, how we feel the machine is against us. Would you say, you know what, I will pause to optimize my patient to have the best outcome for elective surgery? 100% consensus said, yes. If you praise it that way and said, you know what, if I know they're not going to leave and say the guy across the street, or my neighbor was willing to do it because I want to do the right thing by them. Yes, and you give me some wraparound resources, smoking cessation counseling, nutrition counseling. If I can have access to those types of programs, which by and large, we have to acknowledge, right, a lot of those programs have been wrapped into healthcare as practices have been acquired, as hospital systems have spawned, and as health plans have taken over this wellness perspective. You said that a hundred percent of the doctors agreed. We've never had a hundred percent consensus on anything else ever, and likely won't, but I think it's quite powerful that it was in the realm of optimizing their patients for great outcomes.

Dr. Burney: Well, talk to us a little bit about risk adjustment. These payment models - one of the criticisms of them in the past has been that they lack risk adjustment. And so, they disadvantage people with multiple medical problems, multiple comorbidities. How have you dealt with that at UPMC?

Dr. Hogan: So our approach is, one, you have to acknowledge that it exists. And that's a big market debate. They definitely, exist. There are different perspectives. And even some that I'm sure I'm not aware of on how you address it. There are some who say, you know what, there's just a natural rate of attrition of comorbidities and if we're going into a capitated model, you should feel okay with no risk adjustment because it's naturally in your population. Right? And, that one doesn't really make you feel, at least me as a surgeon, warm and fuzzy at night and I say, okay, a lot of hocus pocus, but essentially what we try to say is, okay, we have comorbidities, we need to do risk adjustment. Do we really want to focus on a procedure? So, in our case, we took just clean joints, for example, no joints with high complication rates, no 469 joints. As the coding has changed, you say, okay, where's our risk adjustment opportunity? Are there certain comorbidities that are higher risk than others? And so, one approach we've taken is we have a "bundle busting" criteria, where we really talk about, okay, you know what, we want to present a program of quality and optimized orthopedic care for elective procedures. And we want to contract this with companies and give them to patients and offer them. But we want to educate and say, you know what, if you actually have uncontrolled comorbidities in this realm, we will work to optimize you for this, but you may not be eligible initially for surgery, and more importantly, you may not be eligible for a fixed price bundled program, or you may have a different tiered price, or more importantly, the way you get

around some of that though so people are not shut out from care, in my opinion is, those individuals should be rewarded for engaging with that environment, because if you actually shove people away or you say, you know what, no-go here, they're going to go find someone somewhere if they need help. They're going to seek it out in as many places as possible. And unfortunately, there's not always a lending hand of positivity and great outcome around every corner. And so our goal is how can we build something where we're partners in improving their health and getting them access to care. But you have to talk about it. If you're unwilling to talk about it or assume that it's just going to flow with the ocean wave, you're fooling yourself. And I've had that complex conversation with not just surgeons, but particularly healthcare administrators and I'm willing to learn but we have to acknowledge that this is real, and to not acknowledge it, we're not doing the best for society.

Dr. Burney: Well, you had mentioned patient experience scores, and I'm particularly interested in that part of it because of my background in trying to train surgeons how to communicate effectively with their patients. I was very interested by the University of Utah Value Project and its definition of value. As you know, Movement is Life has sponsored community programs in different locations. And as part of those community programs, they have also done focus groups with the patients in those programs and also with some of the healthcare navigators or community health workers.

And so, one of the things that come out of that is that patients may have a very different opinion of what constitutes value as opposed to what providers or payers might have. The Utah Value Project has made a very simple equation. It was quality plus service divided by cost equals value. The project change groups that the Movement is Life sponsored, identified good communication and respectful, unbiased care as the things that they valued the most. My question for you is, in your opinion, where does the clinician-patient communication and respect figure into the value equation? Is it part of quality or is it part of service?

Dr. Hogan: So, I think they go hand-in-hand and the reason I feel this way is, let's say you have a star rating system. You've never actually seen someone receive a five star on how good their food tastes and actually get a one-star for their bathrooms being clean, dirty like no one is speaking to them, it just doesn't happen. I mean, when you really look at things, there's always an average. So, if you want to be great on all spectrums, often you have to have to be great across all those different realms, right? So, with that, you know, the quality piece, what are the quality of your experience? And that starts with how you're engaging with people in the office. If we're truly just in this robotic realm, then this will be a non-discussion, a non-starter. So, I do believe it sits in quality. And then, from there, to what degree are you really serving the patient and vice versa? So, I think they actually do go hand in hand. And so it doesn't answer your question

perfectly in regards to where do they sit? Here's my position. There should actually be no table of discussion without both of them on it is how I approach it. And often you'll have the scenario where a dog and pony, some places will have a Taj Mahal for a presentation, and they can fool some people and patients are usually, like, I thought it was going to be great because it looks so wonderful. But when it came down to actually the communication of the doctors, as you mentioned, and the staff, it was not great. And so, I think they both have to be at the table at equal weight.

Dr. Burney: Well, that certainly matches with my bias because I think it is both a component of quality, as well as a component of service and quality from the point of view of accurate diagnosis and being able to more readily understand the patient's context and the barriers they may be dealing with. I have just a couple more questions for you. You have a very unique perspective because you work with payers, you are an individual provider and you're also work in a provider system, and I assume, like me, that you must be a patient from time to time. And so, how do you personally define value in healthcare? What does that mean to you?

Dr. Hogan: So for me, is it something that actually made me better than how I was when I entered it? Did I come out on the other end in a better position and some people say, oh, what does better mean? Some of that is my perspective. I think it's a joint perspective of the surgeon or whatever

healthcare provider you may be seeing, whether it be a surgeon or your primary care physician. But am I better off when I come out of the vortex of that care experience than I was when I went in, and sometimes better off is simply peace of mind? It didn't mean something had to be done to me, right. It's like when you go to your primary care physician, what they really do to you other than hopefully reassure you that, you know, what everything checks out good today, and you say, you know what, I think that's important. In my mind, make it better than how you found it. And sometimes even if that just includes, you know, what, again, how I started, sometimes you just need someone to say hello, right? The experience changes. And so, I think that's important that we have to recognize that.

Dr. Burney: Well, thank you. I really appreciate that. What can individual orthopedic surgeons do to mitigate the unintended consequences of alternative payment models or just the barriers that they encounter in seeking care?

Dr. Hogan: This is a question I receive often. I think a number of orthopedic surgeons do who are very active in this space. I'm a strong advocate that we have to be willing to take the time to advocate for our patients with the same vigor that we advocate for our practices, for our wellbeing, for our ability to practice what we're passionate about. And so, we have to be willing to be at the table and taking the time to help drive those discussions, but also being a co-pilot in those discussions as well. If we have to really take the

appropriate steps to listen, to understand what is taking place in healthcare versus just listening to respond to what's happening in healthcare because I think if we take a little time to understand what's going on, the responses that we were able to give, we actually help steer us to a better place because we understand our craft quite frankly, better than anyone should. And often, as our patient relationships and communication builds, we understand our patients and our patients' needs better than anyone else can as well. And so I think that's critically important. So, we have to be willing to be at the table and we have to be willing to have difficult discussions, even those that we do not always know the answers to, and I think that's critically important.

Dr. Burney: I really do appreciate your assessment and sharing your knowledge and your expertise with us regarding the current situation. We've discussed the value equation of the social determinants of health and how remedies such as risk adjustment can give us a more patient-centric approach and help to narrow healthcare disparities in vulnerable populations. Thank you, Dr. Hogan. Thank you very much.

Dr. Hogan: Absolutely. This was fun.

Dr. Burney: We'll be returning to the subject frequently. So, please check back and visit our website movementislifecaucus.com for transcripts and other

resources. You'll also be able to sign up for the email list to receive alerts and updates. Thanks for listening. Be safe and be well.

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