



hfma[™] new jersey chapter
healthcare financial management association

Fall 2015 • vol 62 • num 1



Special Edition:

NJHFMA Annual Institute in Atlantic City

October 7-9, 2015



Using Gainsharing as a Foundation for Population Health Initiatives: The Inspira Experience

by April Venable



April Venable

The Inspira Health Network was formed in November 2012 by the merger of South Jersey Healthcare and Underwood-Memorial Hospital. Inspira's vision is to be the region's leading network of health care providers, delivering the full continuum of primary, acute, and advanced care services.

The non-profit network comprises three hospitals, four multi-specialty health centers and more than 60 locations in Cumberland, Gloucester and Salem counties. Nearly 50 specialties and subspecialties practice at Inspira Health Network, with more than 1,000 members of the Inspira Health Network medical staff. There are more than two dozen primary and specialty physician practices that are employed by Inspira.

While all three Inspira inpatient facilities participate in the gainsharing program, the Elmer and Vineland program is managed as a unit. The analysis and results presented use the Elmer and Vineland campuses to demonstrate how gainsharing forms the groundwork for Inspira's population health initiatives.

The Challenge: Physician Alignment

With the start of the new system, Inspira's leadership team recognized the need for systemic change. The team sought to enhance transparency and accountability on what matters most to patients and to payers: outcomes, cost, and value. Leadership recognized that essential for success is engaging physicians and aligning the hospital and physicians' financial incentives and quality goals.

Physician alignment is the collaboration between physicians and hospitals to share, understand, and work toward accomplishing the goal of providing quality care to patients. While the idea of aligning physicians with hospitals and health systems has been experimented with since the 1990s, the Affordable Care Act provided the catalyst to engagement. In particular, gainsharing is seen as a core strategy to aligning hospitals and physicians.

Since physicians are most responsible for managing costs within a hospital (Leff, et al., 2009), a gainsharing program enables hospitals to control costs through the direct payment

of incentives to physicians based on reducing inpatient hospital costs and improving quality performance. If hospitals can effectively reduce their costs, the gainsharing program enables the hospital to share a portion of that cost savings with physicians who manage the care of the patient effectively.

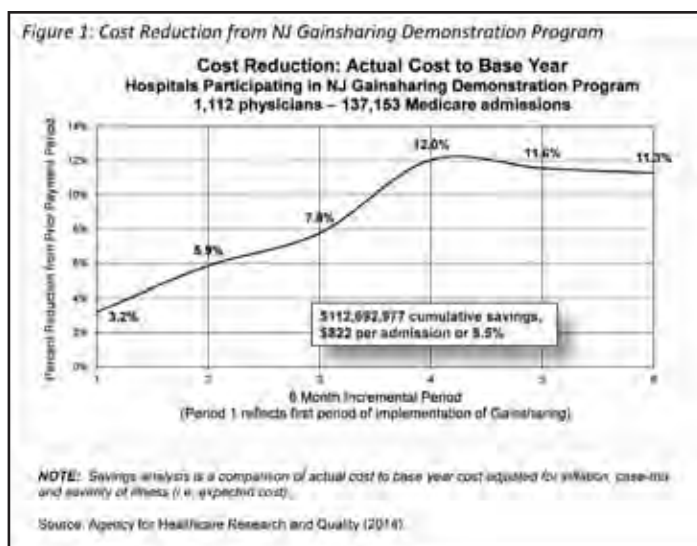
The NJHA Experience with Gainsharing

Clinical integration and population health requires Inspira to accelerate its hospital and physician alignment. Inspira looked to the New Jersey Hospital Association (NJHA) which implemented a Medicare Gainsharing Demonstration from 2009 – 2013 with 12 member hospitals.

NJHA partnered with Applied Medical Software, Inc. (AMS, Collingswood, NJ) in executing the gainsharing program. The AMS Performance Based Incentive System® (AMS PBIS®) provides an all-inclusive system of targeted, highly defined financial incentives covering all inpatient cases and all costs. From initial discussions in 1999 with Medicare, through over 10 years of Medicare gainsharing demonstration projects and commercial gainsharing programs, AMS is the acknowledged industry leader in gainsharing strategy. While alternative gainsharing approaches focusing on specific services and specific costs have been tried by some, Inspira determined that the AMS PBIS® provided a broad based, comprehensive gainsharing methodology, and involved most of its physicians, regardless of specialty or employment status. It also affected all hospital costs, and not just those limited to a specific area such as supplies.

As reported in an AHRQ profile (2014), the NJHA gainsharing demonstration program reduced costs per admission by roughly 8.5 percent, with these reductions generally increasing over time. Total savings for the 12 participating hospitals reached nearly \$113 million, of which roughly 17 percent (just under \$19 million) was paid out in incentives (reference Figure 1). Performance on various quality measures either remained the same or improved throughout the program.

The success of the NJHA demonstration led to its expansion and CMS offering it as part of the CMS Bundled Payments



for Care Initiative “Model 1” gainsharing program. Inspira participated in the NJHA Model 1 initiative which began April 1, 2013.

Program Framework

Aligning physicians through a gainsharing approach is appealing as physicians face economic and clinical challenges. Gainsharing addresses operational inconsistencies and complexities as costs and clinical standards are established and incentives encourage partners to work together to meet common goals.

The program starts with generating “best practice norms” (BPNs) based on state-wide discharge data (UB-04) for all inpatients. BPNs are established at the 25th percentile (lowest costs) for each specific APR DRG to account for case mix and severity. Costs are reported by cost center to enable utilization comparison of services such as lab and radiology. A baseline and BPN for each physician was established.

To incent physicians to improve their historical financial performance and to reach the BPN, incentives are based on two factors:

- 1) Performance - actual cost compared to the BPN.
- 2) Improvement - actual cost compared to each physician's historical costs.

Employed and private practice physicians are eligible to participate in the gainsharing program. Physician participation is voluntary. All patients admitted to Inspira receive notification on admission about the program.

A steering committee that consists of at least 50% physicians is critical to the success of the program. The committee insures the fair administration of program requirements, prioritizes institutional initiatives, and sets conditions for incentive payment regarding quality and performance issues specific to the institution. The committee establishes the appropriate thresholds to determine if incentives are to be paid, and if the program can include consultants, ancillary and other physicians. It also determines balance between Performance and Improvement incentives.

Currently the NJ program is limited to Medicare fee for service cases since it is a Medicare initiative and provides all the necessary waivers (e.g. antikickback, Stark and Civil Monetary Penalties). Discussions are ongoing to expand the program to include commercial cases. This will require an exception to NJ state laws (i.e., Codey law). Other states such as Pennsylvania and New York offer a program (Hopkins, Surpin, & Stanowski, 2015) using the AMS methodology only to Commercial patients (i.e., excludes Medicare and Medicaid Fee-for-Service) because those states do not have a state “Stark-like” law. The uniform methodology of the gainsharing program is held consistent across all programs to ensure patient protections and safeguards.

Gainsharing Complements Shared Savings Programs

“Shared savings” programs such as ACOs and Patient Center Medical Homes work by lowering overall health spending, typically by decreasing payments to providers by incenting use of low-cost high-value services to achieve desired outcomes. While this reduces the revenue that hospitals will realize, the insurer shares some of the savings from decreased payments to providers with those same providers.

Gainsharing acted as a “force amplifier” for Inspira to succeed in shared savings programs. While shared savings payments may distribute bonus payments anywhere from 18 months to 2 years after implementation, gainsharing provides physicians incentive payments within 9 months after start up, and then every 6 months thereafter. The gainsharing program is a quick and consistent reminder that Inspira has acted on physician engagement and alignment to reduce costs and improve quality.

By decreasing costs, hospitals can sustain reduced payments from shared savings programs. This is important as Medicare implements bundled payments in certain markets.

While there are some key differences between shared savings and gainsharing programs (reference Figure 2), the point is that at Inspira, shared savings initiatives and gainsharing are interdependent.

Communication Ensures Success

Communication is ongoing and is an essential element of success. Each participating physician meets in person with program representatives to receive incentive checks and review their performance. Physician consultation focuses on areas where performance exceeds BPNs, and opportunities for improvement with corresponding incentive payments.

At this meeting, the committee chair reviews care redesign, the executive sponsor reviews quality metrics, and the program coordinator reviews data results. Recognizing that not all changes can occur only with physician practice changes, feedback is solicited around opportunities for improvement for care redesign projects. The steering committee considers physician feedback in selecting care redesign projects.

continued on page 38

continued from page 37

Figure 2: Key Differences between Shared Savings and Gainsharing

	Shared Savings	Gainsharing
Examples	ACO, Bundled Payments (Model 2); Medical Homes	NJ Medicare Gainsharing Program/ Model 1 HAP, GNYHA, MHA, and FHA Programs.
Basis of incentive	Payor rewards providers that lower their growth in overall population health care costs.	Direct payment by hospitals to physicians, based on performance in decreasing case rate costs.
Basis of savings	Payments from insurers	Hospital patient costs
Impact on patient	Should decrease utilization of health services overall	Should decrease costs per unit of service
Impact on revenue stream of provider	Less revenue as patient volume is decreased	No change in revenue streams
Legal Structure	Complex; requires negotiating an algorithm for allocating payor savings among providers.	Not required. P4r unit savings are determined based on best practice and physician improvement.

Adapted from Surpin & Stanowski (2014).

Broadly, the entire medical staff is kept informed of the committee progress and the program success through vehicles such as quarterly newsletters and staff meetings.

Notably, physician participation increased from start-up, and by the last reporting period, accounts for more than 95% of eligible Medicare admissions at Vineland and 98% at Elmer.

Quality and Process Improvements

The gainsharing program lowers the cost and enhances the quality of patient care through care redesign protocols.

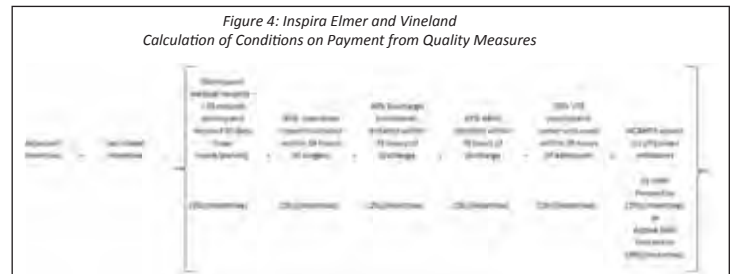
The Center for Medicare and Medicaid Innovation (CMMI) requires that organizations participating in the Model 1 program establish planned interventions and changes to the hospital's current health care model care. These care redesign protocols focus hospital and physician collaboration on initiatives consistent with hospital strategies. These protocols need to be standardized, use evidence-based guidelines, and be readily measurable. The interventions are required to improve quality of care, beneficiary outcomes, and the beneficiary experience of care that result in internal hospital cost savings. The protocols require that hospitals have the capacity to plan and track quality indicators and cost savings. Inspira also added care redesign projects that are in addition to those reported to CMS. Reference Figure 3 for Inspira's Care Redesign Protocols.

Figure 3: Care Redesign Protocols

	Coach Program	Sepsis Work Flow & Bundle	VTE Prophylaxis	Pneumonia Care	Palliative Care
Description	High risk patient transitions	Check list and bundle	Order sets and assessment protocols	Order sets for IV and PO work flow	Service Consults
Primary Improvement Goals					
Readmissions					
Mortality					
Complications					
Length of Stay					
Cost					
Guideline Adherence					
Core Measures					

Other quality standards need to be met and serve as conditions on the payment. These measures tend to be more physician specific measures. Quality initiatives are required because negative outcomes such as surgical site infections increase LOS and hospital costs. Other items such as preventable readmissions increase the overall cost of care.

Failure to meet the quality standards may reduce or even eliminate physician incentive payments. Figure 4 shows the calculation of Elmer and Vineland's conditions on payment. Overall, physicians saw an average reduction of 2% of the total incentive award. A majority of physicians had no reduction in incentive payments, while the rest saw payments reduced based on partially meeting quality standards by no more than 8%. (Effective July 1, 2015, the conditions of payments have been changed to impact 100% of the incentive if a physician does not achieve targeted quality levels.)

Figure 4: Inspira Elmer and Vineland
Calculation of Conditions on Payment from Quality Measures

The gainsharing program also directly advanced processes that required adjustment. For example, often physicians within a group round for practice patients without changing the physician name on the census (which reflects the name given by the patient). Within these group practice cases, Inspira put attribution in the hands of the physicians. The hospital responded by creating an order in the EMR to update the census to reflect the physician providing the majority of patient care. Physicians within a group can then understand variation among group members.

Other initiatives directly impacted care provided. The Inspira steering committee added patient experience to the quality metrics not only because it impacts the hospital via Value Based Purchasing, but also because patients are the focus of the mission. To foster physician success to improve outcomes, a program to train physicians on communication models like AIDET and iCARE was implemented. The steering committee drove the creation of a video created by residents to illustrate behaviors that support enhancing the patient experience, such as being listened to, treated with courtesy and respect, and having physicians explain things in an understandable manner. The hospital purchased a tool called Practicing Excellence which allows physicians to go through scenario applications of concepts supporting patient experience.

Physician advice was incorporated. During the review of gain-

sharing results, a physician suggested that the Care Coordinator assignment be changed from geographically based to physician group based. By creating a stronger alignment and relationships with physician practices, the effectiveness of daily huddles was enhanced. The care coordinator and physician shared common goals of more timely care facilitation, earlier discharge planning, and care transitions.

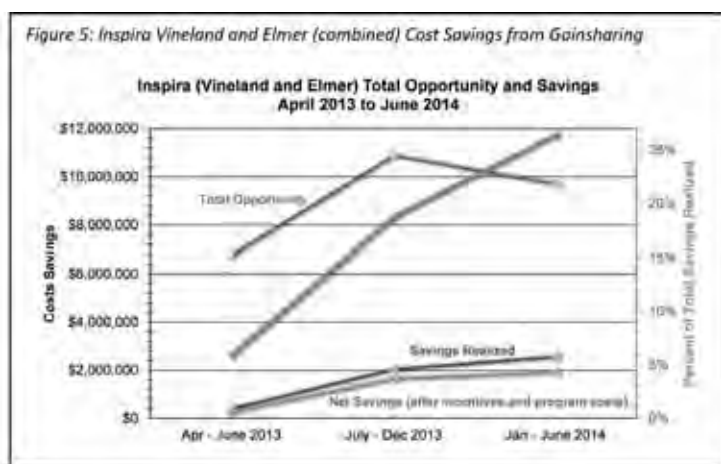
Results

Inspira found that the gainsharing program helped reduce inpatients costs (Reference Figure 5). Over the first 18 months of the program, the Vineland and Elmer campuses realized \$3.8 million in marginal cost savings after incentives and program costs. In the third time period (January – June 2014), they recognized nearly \$2 million in direct savings from the program, and identified 26% of savings opportunities. Additional opportunities for savings exist and are being pursued.

In terms of quality, Inspira's care redesign protocols have shown positive results. Three examples at Vineland and Elmer are:

- 1) The readmission rates for patients who participate in the COACH and palliative care programs is better than the 20% improvement goal.
- 2) Through use of the VTE assessment, hospital-acquired DVTs and pulmonary emboli are minimal.
- 3) The pneumonia core measure of administering the appropriate antibiotic reached 98%.

Most importantly, gainsharing aligned incentives with the medical staff and the health system. Inspira attributes much of the success of the Care Redesign protocols, patient centered healthcare, focus on metrics, and commitment to quality to the gainsharing program.



On To Population Health

Clinical integration and population health are core to Inspira's key strategic drivers. For this to happen, physician alignment is a key objective.

Gainsharing aligned provider incentives and fostered the trust necessary in the medical staff to participate in more complex alternative payment structures that while lowering revenue, served to decrease overall health costs. Gainsharing formed the foundation for Inspira to participate in Horizon's Patient Centered Medical Home program, an ACO for employees, enrollment in the Medicare Shared Savings Program, and other population health initiatives, all designed to achieve the triple aim: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

Conclusion

Inspira's success with the gainsharing program is anchored around an active, engaged steering committee, prioritizing projects that gained administrative support, and ensuring physicians are held accountable to meet with program representatives to receive earnings and provide feedback. While initial progress is encouraging, transformation is ongoing.

Overall, Inspira's process of gainsharing and population health continues the work done toward delivering the brand promise: to offer easy access to highly skilled physicians, advanced technology and the highest quality of care under one new, forward thinking, powerfully connected health network. The gainsharing program is a core tool to accelerate Inspira's success.

Note: The statements contained in this article are solely those of the author and do not necessarily reflect the views or policies of CMS.

About the author

April Venable is the Director of Population Health, Inspira Health Network, in Mullica Hill, NJ. April is involved in the development of gainsharing and shared savings programs that transition the healthcare payment model from volume to value. She can be reached at venablea@ihn.org.

References

- Agency for Healthcare Research and Quality. (2014, July 16). Hospital Gain-Sharing Program Offers Incentives to Physicians Based on Their Efficiency, Producing Significant Cost Savings Without Decline in Quality. *Innovations Exchange*. Rockville, MD, USA. Retrieved July 16, 2014, from <http://innovations.ahrq.gov/profiles/hospital-gain-sharing-program-offers-incentives-physicians-based-their-efficiency-producing>
- Hopkins, S., Surpin, J., & Stanowski, A. (2015, March). Lessons Learned from a Hospital - Physician Gainsharing Program. *HFM Magazine*, 69(3), pp. 78-83.
- Leff, B., Reider, L., Frick, K., Scharfstein, D., Boyd, C., Frey, K., . . . Boulton, C. (2009, August). Guided care and the cost of complex healthcare: a preliminary report. *Am J Manag Care*, 15(8), pp. 555-559.
- Surpin, J., & Stanowski, A. (2014, September 23). 6 essential differences between gainsharing and shared savings programs. (L. Dunn, Ed.) *Becker's Hospital CFO*. Retrieved from <http://www.beckershospitalreview.com/finance/6-essential-differences-between-gainsharing-and-shared-savings-programs.html>