Bundled Payments for Care Improvement (BPCI) Advanced

A Panel Discussion with BPCI Advanced Participants Live Event

Webinar Transcript

May 11th, 2023

2:00 PM EST

Mira Friedlander: So yes, perfect. Yes, so as you know, this meeting is being recorded, this event, so thank you again for joining the panel discussion with BPCI Advanced Participants. We're really excited to have this discussion today, so if you want to go to the next slide. Today we have a few different Zoom logistics to just make sure you're comfortable with the platform, so if you're hearing me now, you're connected to audio, so that is perfect. Feel free to use the chat box to introduce yourself. I know we've been testing it out with some of the icebreakers and putting in some questions or comments there. If you want to ask any questions throughout the session, there is the little Q&A box down at the bottom as well. Please use that if there's any questions for the panelists, we'll be making sure that we can use those during the open panel discussion.

Mira Friedlander: And if there's any questions that are for the CMS model team or regarded to the application process, we'll make sure that CMS is responding to that as well. We did receive a lot of questions during the registration process as well, so we'll make sure that we're integrating those either into the discussion or reporting out via the Q&A throughout the time. If you need to use the live transcript for closed captioning, there is that button down at the bottom, and then add a reminder if you're using the chat box to make sure it says to everyone versus panelists and hosts. That way everyone on the line can see all your great comments. If you do have any technical difficulties during the event, feel free to chat to the panelists and host and we can help you out.

Mira Friedlander: We can go to the next slide. Okay, so again, thank you. My name is Mira Friedlander, I work with the Deloitte team on the BPCI Advanced learning system side. So we will be, in the chat as well there will be these slides for today. They will be coming through as a link from the connect site, so it is an accessible public link. If you're looking for materials, after the event we'll be following up in about a week and a half with any of the materials that will be available on the model webpage, and all of you will be notified. So again, we encourage you to put any information or questions into the Q&A and then chat anything in, but I'll pass it off to my co-facilitator today, Jessica, to do the opening remarks and introduce yourself.

Jessica Dawson: Thank you, Mira. Hi everyone, my name is Jessica Dawson and I'm a social science research analyst here at CMS, but I'm also the present learning system lead for the BPCI Advanced Model team. We're pleased that you all took the time out of your busy days to join us for this discussion. As this call progresses, and particularly during our live Q&A portion of the call, we welcome you to share any questions that you might have. With just 20 days left before the portal closes we want to make sure

that this is an engaging call and is very helpful to make sure you guys have making an informed decision about deciding whether or not to apply to our model.

Jessica Dawson: As a gentle reminder, signing an application does not commit you to participate in the model, but will give you the time to potentially receive any additional data and information in order to make that informed decision. Additionally, we would love to invite you to our office hours open forum that we're having both next week and the week prior to the closing of the application portal. These will take place at 2:00 p.m. on May 18th and May 25th and will be an opportunity to ask the model team any last minute questions that you might have about submitting an application. The link for both of these will be available in the chat.

Jessica Dawson: And with that I will transition to review the goals for today's session. The purpose of today's session is to meet people where they are in their decision-making processes. Since we're currently in the application window, we know people are trying to learn what BPCI Advanced is all about and if they would like to consider applying. Today we'll be hearing from our peer leaders from Illinois Bone & Joint Institute, Signature Medical Group and Bozeman Health, who will all share their experiences from participating in the model. Each presenter will speak with the audience about why they think BPCI Advanced and bundle payments are great opportunities. They will then discuss any strategies for success in bundle payments, as well as share how they have navigated any challenges faced during their participation, and other factors to consider before applying to our model. We will then open it up to the audience for a live Q&A. And with this, I'll turn it over to Mira to get us started with a few polling questions.

Mira Friedlander: Yes, thank you, Jessica. Before we introduce our panelists and have them do a brief introduction of themselves, we want to make sure we're understanding who is on the line with us today. I know we did a little icebreaker on where you're calling in from, but a little bit more about what your experience and knowledge and involvement with BPCI Advanced is. If you can respond to the poll, as we are going through the application process as well, we want to make sure that we're providing you all the resources and information you need. We do have another question down there as well of what topics you might need additional information on, so we just want to make sure that we're applying all of that in ensuring that we're meeting you guys where you're at. We'll give you guys a few more minutes to respond to the poll and then we'll see who we have on the line today.

Mira Friedlander: Okay, I think we can push the poll results. Okay, so we have a wide spread of people today. We have about 28% current participants, 26% past participants or episode initiators, a few who are currently applying or a few that are currently interested, and a few others. Again, thank you for that. It's nice to know who we have with us today. And with that I will pass it to Jennifer to introduce yourself from Illinois Bone & Joint. You can go to the next slide.

Jennifer Brenczewski: Hi there. My name is Jennifer Brenczewski. I am a physical therapist and I've been with Illinois Bone & Joint since 2005 and I have been with BPCIA since 2020 and now I'm the director of the program. Our company has 160 surgeons, 140 of those are orthopedic surgeons. We have 2,200 employees overall at over 57 offices. Our surgeons also have privileges at over 45 different hospitals. I

was started as a physical therapist in the outpatient realm and I've now turned into a director of the program, so that's my transition through our company.

Matt Civili: Hi, Matt Civili, Signature Medical Group. Signature has been in the model since the original BPCI program. I've had various roles throughout our participation in the two different iterations of the program. Currently, oversee the value-based portion of Signature's participation in the model, as well as our convening segment as well. And we actually started on the CMMI demonstration projects prior to BPCI Advanced, working on a program called Strong Start, which was actually designed to reduce preterm birth rates in the Medicaid population. We got our exposure there and then decided to continue into both the BPCI models.

James Loeffelholz: And hello James Loeffelholz with Bozeman Health. Bozeman Health is a small integrated system in South Central Montana. We have 120-bed hospital main hospital and a much smaller critical access hospital as well. We have a medical staff of around 250 or thereabout, and we've been participating in, we were not a participant in the original BPCI but have been in on BPCI A since the beginning, of course. As system director for clinical value, while I'm an internist by training, my job and my purpose in that role is to facilitate our journey away from fee-for-service reimbursement. So I oversee not just BPCI A, but our participation in other advanced payment models like previously CPC Plus, Primary Care First and they'll potentially the enhancing oncology model as well.

Mira Friedlander: Awesome. Thank you to our panelists. We will go to the next slide. It has a brief breakdown of all of the information they just shared, and I will pass it over to Jessica and Jennifer to kick us off on the first panel questions.

Jessica Dawson: Thank you, Mira. Let's get things started with Jennifer. My first question for you is, as a PGP organization located in Chicago, Illinois and as part of the Spine and Ortho Service line group, what do you believe has attributed to your success in the BPCI Advanced model?

Jennifer Brenczewski: Yes, thanks, Jessica. I do believe that education is key, and that's education between the surgeons, their surgical teams, their clinical staff, physical therapists, whoever's going to be a part of it is just explaining the program and what it means and why we're in it. Because that really helps facilitate the staff to buy into it, and not just buying in from a way that they don't ... That, "Okay, we're going to do this now." Is really just making them understand the model and how it's going to be in line with patient values and everything else that we're trying to achieve out of it. I think education has to come first, and consistent education too. It's not just a one time and done. We have a very large physician organization and so we're always meeting and reeducating and talking about differences that come about in the years, so I think it's just constant communication.

Jennifer Brenczewski: And then just alignment of the surgeons to understand that you have to work cohesively as a group for the better outcome. And you can't just pick and choose different things that you're going to do to work with the program is just putting everybody on the same page and making a whole system that is easy for them to align with. And then I think that also comes through is that we

have a better understanding now amongst all of our care providers about appropriate length of stays when patients are at certain places in their care plans or in their 90 days, what's appropriate, making sure patients are where they need to be at appropriate times and the impact that can have on their overall care. I would say those things have attributed to our success overall.

Jessica Dawson: That's really helpful. Thank you for sharing that, Jennifer. My next question for you is, your organization has spent some time educating providers and what it means to be a part of the model and centering care delivery processes around the patient. What has been the outcomes from implementing these tactics?

Jennifer Brenczewski: I think the outcomes overall have been just better patient outcomes first and foremost. I mean, patient understanding of what it means to go to the care that they need, and the staff is able to communicate that to the patients from the start when they're talking about their surgical procedure. And then it goes to the physical therapist because we do a pre-operative program for them, a PT pre-op eval, and then they're reiterating it. Really it means that the patient has heard it a number of times from multiple areas because the staff does understand it well and they're able to educate patients on the program and how it can better the outcome of the patient overall. We really do look at social determinants of health, so looking at if a patient's going to have a procedure, who's with them to help along in their recovery, what is the impact of that person? How does that person deliver what they need to the patient to have a better recovery?

Jennifer Brenczewski: Comorbidities, how can we optimize? Every patient's going to have something come up at some point. If an elective patient has a list of comorbidities, how are we going to manage that on the front end so it doesn't affect them negatively later on? And then I would say that improved pathways overall has helped us. And what that means is just making sure the patient understands what the next necessary level of care is. It's just not, "Oh, because my neighbor had this procedure and she spent 12 nights at a skilled nursing facility, that's what I should do." It's really, what is the need for that and what can we show you to explain that need and whether it's needed or not. We've really developed some formulas that allow us to have a better pathway to explain this to patients and then help all of the staff reiterated as well. So it's coming from multiple areas, the communication part of it, so it really makes sense to the patient and has better outcomes.

Jennifer Brenczewski: And then finally I touched on a little bit in that last part was just that we do have a pre-op physical therapy visit that we utilize that has a risk stratification survey in it, and it's about 11 questions that spits out a score zero to a 100, and we have our physical therapist deliver this. But they also use their clinical judgment that just because the score of 60 or 70 may mean maybe just home health outpatient afterwards or something like that, they use their clinical judgment based on what they're hearing from the patient too to help make that pathway postoperatively the best to suit the patient for what the patient's feeling. But also what they're seeing clinically and what the patient's up against socially from a medical comorbidity standpoint and just safety overall. I think those things have helped us to have really good success in implementing all those tactics.

Mira Friedlander: I have a few probing questions for you, Jennifer, coming from the chat. It sounds like you have a lot of coordination between your surgeons and the care teams, but how did you work with your surgeons to make sure that they're following and more or less playing along when they don't want to get involved with the program or when they are having patients who they need to just keep telling to go to rehab or do surgery to help optimize those patients?

Jennifer Brenczewski: That's a great question, because to this day, and we've been in this since 2014, and that is the hardest part of it I think, is we also have a very large organization. Perhaps it would be easier on the smaller scale sides, but I think in any time you're going to ... It's just a difficult task. But I think the best thing has been, like I said, education on it from the front end, reeducating all the time we meet with the administrators of our different divisions and we pop into meetings that the surgeons are having. We have developed a one-page cheat sheet to kind of help them. We've put it up in their pods, we've given them the quick and dirty tools for success, communication points to have with the doctors. We've developed a playbook that they actually give their patients that has some additional information, kind of our partner facilities and what it means to be a partner and what a three star versus a five star Medicare rated facility means and why it's important.

Jennifer Brenczewski: Just tools that can make them understand why they're recommending a certain thing versus another, and how it's beneficial in the long run. I think just continual education, continual resources, continual meetings to get in front of them. We do have a chief medical officer in our organization as well and he helps deliver those points also. And he dives himself into areas that he sees if certain surgeons are teetering on, on their adherence. We want to say he helps guide them from a medical perspective. And then I think just also seeing the data as it's coming out so that they can see how they're doing and how they're doing in relation to their groups or whatever it may be. And then if they aren't doing quite as well, we give them a lot of education on where they fell short and how they can bring that back up and what happened with those patients and how we can curtail them. So, there's a lot of data involved in that. And then we also enlist our chief medical officer to look through some of that with us.

Mira Friedlander: Great, thank you for that, Jennifer. Before we move on to your other question, we did have a question for you just regarding how many TINs you have involved in your group to get some frame of reference. Wanted to see if you could comment on that?

Jennifer Brenczewski: How many what we have in our group?

Mira Friedlander: TINs.

Jessica Dawson: The taxpayer identification number.

Mira Friedlander: Yes.

Jennifer Brenczewski: I don't know if I know that answer.

Mira Friedlander: Okay. We can always circle back.

Jessica Dawson: We can circle back. Then my next question, and it sounds like you've already touched on this in your last answer, but based off of what you shared, IBJI's work is in line with CMS's vision and mission and a theme to drive your programming. Can you share a bit more in detail about the focus and impact of that alignment?

Jennifer Brenczewski: Yeah, I think at the core of it it's really about delivering the care that the patient needs. And that's what we try to focus on is we know that a certain group of patients may need skilled nursing facilities, so send those patients. But let's have a reason why and give them expectations around it that they're not going to stay a 100 days necessarily if they don't need it. We want to talk to them about what's realistic and we know this from what we've seen. Again, I brought it up before, but the data helps guide some of this of what we know can be achievable and have a better outcome, or an excellent outcome based on certain length of stays. I think it's understanding payer policies, I think it's understanding what's reasonable and what the best next step is needed for the patient while also staying in alignment with what the patient's showing us in front of us to see what they need.

Jennifer Brenczewski: And then I think we just redesigned some things to have partner networks and we have redesigned and added and we've had to remove partners too. If they slip below a certain Medicare rating that we are acceptable, we had to remove them or we've added partners that have shown us that they've been able to show good care. We have to be willing to pivot and move with the program and with our regions and our surgeons and adding new surgeons. And so I think it's really just looking at the data, looking at what's out there nationally, seeing where the program's headed and then trying to plan for it on the front end to stay relevant and do well on the back end as well.

Jessica Dawson: That's helpful and that makes a lot of sense. And so with your experience, like an overall success as a part of the model, what advice would you impart to potential applicants?

Jennifer Brenczewski: I think the main thing I would say is you don't have to have a large organization and a lot of research resources and a lot of players in it to make it successful. As long as you have some sort of organizational structure on the front end to start on it and then you can always build on that. You can always add pieces that you think are missing. I think the biggest part from the organal structure is who's going to educate somebody on everything? Somebody has to be kind of the educator facilitator, coach on things. Data's helpful, but you don't have to be a data analyst to do it. I'm a physical therapist by trade and I do a lot of our data stuff. I do look at a lot of our data on my own and I wouldn't consider myself a statistician by any means, but I can figure it out clinically what happened here and then what we're seeing there.

Jennifer Brenczewski: I think just aligning some of those things together, having those structural tools in place. And then I will say, since we're a larger organization, we do have regional case managers that help. That was part of the organizational structure we implemented in the last two years that's helped a lot, because as we give more information, you might get more questions back or what are we going to

do if this happens or something like that. Having regional case managers to help answer questions from surgeons and their clinical staff or help guide patients that might be asking questions about their program. I think you'll find, we didn't have that before, but I think that what I was saying is you could start small if you're worried about it because you're small and always just grow with the program for where you see it.

Jennifer Brenczewski: And I think the nice thing of that is, some people that are clinical maybe just want a little outlet to do something different. Maybe they want to do something that's coaching or educating or looking at data aside from just doing patient care or something like that. You probably have those individuals in your organization anyways. Because the biggest thing like I said, is really just the surgeon buy-in, educating the surgeon. And most clinicians or most people in your organization are pretty good at educating and coaching probably anyways, and so they'd be happy to do it.

Jessica Dawson: That is all really helpful information. Thank you so much, Jennifer for everything sharing your experience. Now we're going to move forward speaking with Signature Medical Group, and Matt, I have two questions for you too. An organization located in cities across the Midwest and part of the spine and orthopedic service line group. What do you believe has attributed to your success in the BPCI Advanced model?

Matt Civili: Hey, thanks Jessica. I think Jennifer did a really good job, because there's a lot of similarities between our two organizations of expressing what has made them successful and I think that I would echo a lot of those same things. When we started the strong start demonstration project, one of the first things we did was to bring social workers on and embed them into our OB practices, because that was an OB model. When we started the original BPCI program, we sort of took a similar hands-on approach with that and we brought on a few different RNs. One was already on staff and then we had some that we brought in from the outside specifically for the program to help put together a clinical team that would be dedicated to working with the beneficiaries as they moved through the model.

Matt Civili: And then one of the things that we did next was we really had buy-in from everyone on the orthopedic side. We had a tremendous team of medical directors that were sort of the lead orthopedic surgeons here at the time that put together, helped design the program, helped get all the other surgeons on board with this is something that we believe in. We feel like medicine is changing, that we have to get in front of the change and the shift from fee-for-service to value. And how do we do that? Because we know we want to be on the forefront of it, so what do we need to do internally?

Matt Civili: And one of those things is really, Jennifer did a good job of talking about education and one of the things that we did first was to try and educate our staff on why we wanted to participate in these models. And then next we sort of ... Internally we call it the triangle approach of staffing, so you have to get the administrative team on board, the physicians and then the clinical team. And they form a pyramid triangle type of model that everybody can either juggle certain roles and wear multiple hats or help the boat steer in the right direction.

Matt Civili: We set up a program that started all the way from our scheduling staff to help. As soon as the patient was identified as a BPCI potential patient and they got scheduled, then that communication starts all the way back with the scheduling team to the mid-levels that work with the surgeons in the ortho realm, and then the education all the way up through not only the surgeons themselves but also our hospital partners. Being a private orthopedic group and not having a direct relationship with any hospital or health systems ourselves, we had to do a lot early to even explain and educate what the BPCI model was and what the goals of the model were and why we were participating. We went in and did a lot of education where we brought our physicians along to help educate the hospital, the discharge planners at the hospital, the hospital administration, the skilled nursing centers that the hospitals had affiliations with, all the way down the line to those post-acute providers that were in our different communities in St. Louis and Kansas City.

Matt Civili: We had meetings with all of them to educate the skilled nursing centers, the home health organizations, the physical therapists in the outpatient setting on why we were in the model, what we were looking to do from a protocol standpoint. The medical directors and our team put together some standardization of protocols that they felt were in the best interest of patients as they moved through the 90-day episode to help streamline some of the things that in the past just got taken for granted when it came to the patient's journey through the recovery phase. And so that education in the community with our community partners and trying to align goals really is what we tried to do initially.

Matt Civili: And I believe that any organization should do when they start this model is really lay that foundation of communication as Jennifer stated earlier, to be able to talk through not only why you're participating but what your goals are for not only your organization but for them as partners in the program as well as ultimately what the goal is. And that's to decrease costs while increasing patient satisfaction as well as the patient experience and their outcomes.

Jessica Dawson: Thank you, Matt, thank you for all of that helpful explanation. You actually spoke to a lot of the question that I was going to ask around communication and buy-in. I do want to ask you a question about your involvement in the BPCI initiative, or what is more commonly known as BPCI Classic. Based on your robust experience and the longevity of your experience in bundle payments, what advice would you share with potential applicants?

Matt Civili: Advice, I think that being a risk-based model, you really need to speak internally around getting everybody on board if they want to do this or not. And I think it's been a tremendous experience for us as a medical group and as an orthopedic group to be able to take a look at ourselves internally, and through that process I would say be able to do some evaluations of yourself upfront to understand what infrastructure you already have. That Jennifer kind of touched on as well. Do you have the ability to repurpose some folks internally to dedicate time to the program to really understand the different components and dig all into it?

Matt Civili: There's aspects of the program that are in the participation agreement that require you to make some changes on your side, like putting together a compliance plan, being able to make sure that the quality portion of the program is meeting the standards that's required to be a participant in this

model. Putting together that team of care coordinators that are willing to invest in the beneficiaries to really be able to ensure that they're the focus of the model and not just the financial piece.

Jessica Dawson: That's really helpful, thank you so much for explaining that, Matt. And now we're going to go to Dr. Loeffelholz with Bozeman Health.

Mira Friedlander: Perfect, thank you. Dr. Loeffelholz, as a rural organization located in Montana and part of the cardiac care CESLGs, what do you believe has attributed to your success in the BPCI Advanced model?

James Loeffelholz: Well, Mira, I can have a pretty brief response because Jennifer and Matt did such a good job and there is so much overlap and repetition when it really comes down to the idea of staff buy-in and interdisciplinary communication. I will say though that by being a smaller organization, I'll use the analogy that a smaller ship is easier to turn and it is more nimble, so it's a heck of a lot easier for us to get all the crew on deck than for a much larger organization. We have, I think four ambulatory cardiologists and two inpatient interventional cardiologists, so it's a much smaller team in that respect.

James Loeffelholz: But just to follow through or to go take off of where they left off, that idea, one of my adages is that we need to make sure that everybody is reading from the same playbook. And in our instance, that went all the way up to the board that the actual board of directors of the organization signed off on our participation knowing that there is downside risk from the get-go involved. But otherwise, just the same things that we've already heard, the importance of the staff buy-in at various levels, multidisciplinary teams, and really the identification of a provider champion specific to our service line group, cardiology.

Mira Friedlander: Okay, I think that's perfect and you segued us nicely into, as a smaller organization you can be financially impacted by outlier patients a little more easily. Like you said, there's the advantages of being able to switch more nimbly, but you also might be impacted a little more harshly. What workflows or tactics has your team implemented to address these barriers?

James Loeffelholz: Yes, exactly. And then same analogy, that smaller ship is more affected by the occasional rogue wave or that sort of thing being the outlier. The patient that's an outlier in spend, really it comes back to appropriate monitoring and use of the data, the claims data that we're given regularly. And through that we rapidly identified that where we surpassed target price was really more often than not had to do with readmissions. And within the cardiology service line group, because we just had so much more of those with congestive heart failure, that's really where we've focused an awful lot of attention.

James Loeffelholz: We are an Epic shop, so we are able to look at our own data. Epic has various risk calculators for patients as well, but we didn't want to take them just at face value. Epic has their flags of when patients general risk score turns red, but we actually looked at our own historical data to find

what cutoff did we ... Was there a cutoff when we identified one where we saw were patients beyond a certain risk score within the coming year were at significantly higher risk of readmission or death frankly.

James Loeffelholz: So, getting a bunch of different tactics deployed, including for those patients at higher risk. We have a very robust palliative care team and getting them involved early. And communication across the team, both again, as I said earlier, a little bit easier sometimes being a smaller shop both between inpatient and outpatient, between primary care and cardiology nurse navigators. And that really led to developing a tighter focus on overall care navigation and also on still a goal that we still want to continue to refine to optimize follow-up appointing prior to discharge for patients.

Mira Friedlander: Great, thank you for that. Kind of similar, I know that with the smaller organization there can be different benefits but also challenges. Can you share a little bit more about how your organization determined the right approach for how you enrolled in the model? I know that you guys are a Non-Convener Participant and then also PGP and ACH, so you want to talk a little bit about how you guys came to that decision making?

James Loeffelholz: Yeah, that's interesting. I'd encourage people to think a little bit about it and or organizations to reflect on how they might want to use the model to their own strategic growth and where they want to be. Are you a relatively high-value provider to begin with? Looking at things like your typical Medicare spending per beneficiary, your lown institute rankings for value, for instance. If you are already a high-value provider, jump in, take advantage of it. If you're not, maybe participation in something like BPCI A is the impetus that you really need to spur change towards more of a value-oriented care delivery model. Again, if that's part of your strategic imperative.

James Loeffelholz: We did, actually early on we worked with a large national convener and thought, "Do we want to join up with them? Do we want to go this independently?" Obviously, we ultimately decided to go on our own and figure it out on our own. As such we put a smaller toe in the water, just signing up initially with a single episode pneumonia and simple pneumonia respiratory infection. And then with the conversion of the service line groups pivoting to cardiology. But we think figuring out on our own has been helpful. That and coming back again to the idea of the don't want to understate the importance of being able to utilize the claims data as best an organization can.

James Loeffelholz: And ultimately though it's important still to remember what we're all still here for, which is really patient care. And I get, as I communicate with primary care providers, letting them know that one of their patients is in an episode and when the end date will be. I remember one provider contacted me back to say, "Oh well, they were in for a congestive heart failure, there were some continuing questions I was going to get another, get a follow-up echocardiogram, should I not?" It's like the answer is, "Do the right thing for the patients. If your focus is on patient safety and patient outcomes, you have to have some faith that the dollars will flow."

Mira Friedlander: Perfect. Thank you for that Dr. Loeffelholz. You're transitioning us quite nicely into the next slide where we open it up for all of the panelists. We've had a few questions come in that we want

to get to and then I know we had a few other ones that we wanted to open up. But first of all, for an additional context, we did have an audience member wondering are all of the panelists conveners or non-conveners and how do you use outside data to help with the CMS data? I'll pass that to you, we'll go in a reverse order, so I'll start with you Dr. Loeffelholz, then we'll go Matt to Jennifer.

James Loeffelholz: Yeah, so I guess I didn't touch on that a little bit in your previous question too, Mira. I guess sort of dive into the weeds just a little bit. Originally when we signed up for simple pneumonia and respiratory infection, we signed up both as a physician group with our ... Oriented around our integrated physician group, which compromises about half of our medical staff, and as an acute care hospital. And the reason for that is because we still had one family practice group that was doing their own inpatient care and that was independent and not part of our integrated group, and we wanted to have a collective approach to it.

James Loeffelholz: And furthermore, we had and continued to have a strong relationship with that independent family practice group and wanted to use BPCI as another way in which we were working together. Now ultimately they did, since that time they did convert their practice to ambulatory only and they dropped their inpatient privileges. That allowed us to again, pivot nicely to the cardiology service line group and we had been thinking about expanding into congestive heart failure, taking that one on anyway.

James Loeffelholz: And I'd like to say, I was stressing earlier the importance of being able to manipulate claims data. And I'd like to say, boy, we've got that nailed too. And unfortunately we don't. Just last year we had a conversion to a different instance of Epic. We were previously hosted by another organization, now we're on our own independent model, so we're still rebuilding a little bit there. And unfortunately, we had a very nice robust accelerator to be able to take in the claims data and digest it for us. And now we're coming of back to old school manual manipulation of those Excel files as we're rebuilding, so more to come.

Mira Friedlander: Awesome, thank you for that. And then Matt, did you want to share a little bit about your convener, non-convener status and how you utilize data?

Matt Civili: Our orthopedic group entered the model originally as a Non-Convener Participant PGP. Throughout or early on in that process we did pivot a little bit to create a business segment that was connected to Signature that also convenes nationally for other orthopedic groups or PGPs primarily that would like to participate in the model. When it comes to the data, we learned very early on that we were going to have to build something internally to be able to process that raw data and then be able to turn it into something actionable that really would help us with what we were trying to do from a care redesign perspective.

Matt Civili: We invested in a team of individuals that fell under our IT department to ... We decided to build a platform internally. And I know that's not something that, it sounds a lot scarier than what it actually was to think about that infrastructure investment, but what it did is it allowed us to build a dual

facing platform called CareMOSAIC. Our nurse navigators use it today, and it is a software platform that we use not only to help manage beneficiaries through the 90-day episode to do risk scores optimization, track them through their journey of the post-acute recovery phase, but also intake the CMS claims data and use it to create actionable reports at the physician level.

Mira Friedlander: Awesome, thank you for that, Matt. And then over to you, Jennifer.

Jennifer Brenczewski: Yes, so we do a little bit of both. And mind you, we're really large. We have 140 surgeons and a whole bunch, we're big, and we've been in it a long time, so we have a lot of data. We have enlisted an outside group to help us with the Medicare claims data, to bring it in to our company and kind of sort it in a way that's usable. And then we do have an analyst within our company that takes that data and makes it more usable so that me and the two other case managers who are clinical in nature can look at it and from a nice easy view pick out what we see. "Oh, this surgeon has a lot of readmissions, we'll go look at that a little bit deeper from a clinical perspective. Or this surgeon has a lot of length of stays in a skilled nursing facility. Let us dive into that."

Jennifer Brenczewski: We have an outside person take the data, then we have an analyst separated out by our regions, and then me and the other case managers can dive into it and look at it clinically and then educate on what we see. That's kind of how we've taken it. And then we also have a separate platform that we use called Spotlight, which is case management, to where we enroll those patients and then they're in for 90 days and we can track their care that way too. So, we kind of have two different data tracking platforms.

Mira Friedlander: Awesome, thank you for that, Jennifer. I think Jessica, you had a few questions come in that you wanted to share out?

Jessica Dawson: Yeah, so there's actually a question that just came in chat mentioning that there are some large PGP representation here and as an ACH hospital looking to be an episode initiator, what would your recommendations be in approaching a surgical PGP? I go on to say their impressions that it's easier to have that conversation for a PGP when they're an EI, but posing that question to our panelists. We can start in, I guess the first order.

Matt Civili: I'd like-

Jessica Dawson: Yeah.

Matt Civili: I think that being a private orthopedic group, we've been on the other side of that table where being in the model as the participant ourselves, we had to go to our hospitals and engage those conversations. From a reverse perspective, I think if the hospital is going to be the participant and needs to engage their community partners, I think that the model is set up to allow things from an incentive standpoint to be aligned to make sure that there's ways to make sure that you're achieving your goals as the participant. And I think having conversations around potential gain share, ICS gain share setting the

... I would start there from a hospital perspective to engage a PGP, and also let them know why you are participating in the model, what their role would be, and what sort of support you're going to offer them as they basically support you. Since they would be the ones who would be performing the episodes, I would assume that they're surgical episodes in your facility.

Jessica Dawson: Thank you for the answer, Matt, that's very helpful. I'm wondering if Jennifer or Dr. Loeffelholz, you guys have anything to answer that question?

Jennifer Brenczewski: I don't have as much on my end, but maybe Dr. Loeffelholz does.

James Loeffelholz: Yeah, not, there again, more from a strategic standpoint, maybe a little bit less specific to BPCI Advanced, but because our participation in BPCI as it stands currently, as I was relaying earlier, now basically all of ... Any episode would really be initiated only by physicians that are part of our employed medical group at this point. However, we've taken what we've learned from BPCI and we've been applying it working with community orthopedists to build basically elective joint replacement bundles patterned right after BPCI and comprehensive CJM model for our direct to employer contracting and negotiation.

James Loeffelholz: And it's just, as Matt says, I'm thinking of a larger orthopedic group that we have that they really concentrate more of their joint replacements to one or two of their providers. And the other providers that are more sports medicine oriented, less interested, to be honest. But at least we can get the ones that are active with the joint replacements at the table and I think after a good connection with their leadership about, let's just not all just sit on our laurels, fee-for-service for how things are right now, make sure we're looking ahead and preparing for more of a value-based reimbursement.

Mira Friedlander: Okay, thank you for that, Dr. Loeffelholz, you tapped on the next question we were going to ask around the importance of partnering with other participants or organizations. We're going to skip that because I think you covered that one pretty well. But we do have two more questions that are a little bit more logistically for you all of, how many staff members do you have manage your BPCI Advanced census, and then tapping onto that, what is your process for using the beneficiary notification letter and ensuring that gets out to the patients appropriately?

Jennifer Brenczewski: I can-

Mira Friedlander: I'll let you guys all ... Yeah, go for it, Jennifer.

Jennifer Brenczewski: We have five members on my team. There's three of us case managers that are present, and then we have regions. We have about 35 to 50 surgeons per region and then that includes other case or clinical people with their teams and everything else. I have one intake personnel and what she does is she calls and schedules, all of our pre-op, PT pre-op evaluations that we do for all of our elective total joint surgeries. And then I have an administrative person that helps in between all of that. That's where we have, and then I have a part-time data analyst that also works on the rehab side. Like I

was saying before, he helps streamline some of the data we get in. And then like I said, we work with that outside organization that helps with our data.

Jennifer Brenczewski: That's who is involved in it. But then I would also say, we have 45 to 55 physical therapist evaluators at all times that help with the pre-op evaluation, so they're, I guess part of our program, but they're also full-time PTs as well. But they deliver patients their PT pre-ops, so they're also part of the program as well, I would say too. It's on the bigger side, but it's manageable, for sure.

Jennifer Brenczewski: Oh, and second part of that, the beneficiary letter, when we get fractures that come through, when a surgeon does a fracture, he enrolls them, he or she enrolls them into our platform and we see that immediately that day of or the next day and we physically mail them the letter then and we rate that in our little sticky note. We have a little communication tool in there that the letter's been sent. So we do it that way. And then for any electives that are coming through, when we send them via email their pre-op assessment they do nine questions on their own before they come into the eval, the letter's attached to that, and they have to check off that they've read it. Otherwise we give it to them in-person.

Jessica Dawson: Jennifer, I know you mentioned earlier that you started a smaller organization, you got to the point where you are now. My follow-up question for you is, how did you get to the point where you have all these people to help you with the BPCI Advanced program and how long did that take for you?

Jennifer Brenczewski: That's a good question. It's been an up and down process. When we were part of the Classic program, there were actually I think eight nurse case managers that were a part of, and then COVID happened and we kind of shut down elective surgeries, and the team kind of got small. There was only, I think of the five people that there went down to three and there was only one case manager, one director of the program and then one intake. And then now since I've become director at the start of COVID and trying to ... Or toward the middle end of COVID and we started to ramp up again, I was thinking, to do this properly, it's really about the education piece. Honestly is just reeducating, educating, finding more pathways went off or care plans deterred. Having me asking for my two additional case managers to come back has been made all the difference.

Jennifer Brenczewski: I think just we've pivoted where we've seen certain surgeons fall off or say, "I didn't know that I was supposed to do it that way." Or groups saying, "Well, I didn't know that that was part of what I was supposed to be doing." We realized there was a hole or a gap and we tried to fill it by adding more staff that way. I think we're always evolving and I think it's just a nice thing to try to use your resources well, but also just see where you have more opportunity for improvement.

Jessica Dawson: That is really helpful and it's such an amazing amount of growth you've had in what seems to be a short period of time. I want to put the same question to our previous peer leaders as well, but thank you for giving us that answer, Jennifer. Can you restate the question for the other peer leaders?

Mira Friedlander: Yeah. So how many people do you all have working on your BPCI Advanced patient population, and then also, how are you navigating the beneficiary notification letter? But I do see a follow-up question in the chat around just, what is your attribution of how many patients per case manager? If you want to add that in too I think that would be helpful context.

Matt Civili: Sure. This is Matt, I'll go, and I don't know, Jennifer, if you want to chime in on how many patients per case manager you would recommend. From our perspective, I think we try to keep it at around 300 annually for a case manager. When we started BPCI with our two orthopedic groups in St. Louis and Kansas City, we started with one case manager for each location, so we started with two. And then as well as we had the physicians decided before they even went into the model that they were going to invest proactively in resource development to be able before we went live, so we did repurpose some roles internally. At Signature for the orthopedic group, our CFO and the billing team handles a lot of the payment-related things early on. We have our general counsel and our compliance officer dedicate time to make sure that we have a compliance plan put in place that is in compliance with the participation agreement and that all of our agreements with our downstream providers are in compliance with what is required as well from a legal standpoint.

Matt Civili: And then we have a data analyst, financial analyst as well as director of IT manages the platform and the analysts intake the data, create all the reports. So initially starting out, I'd say around five or so when you take those repurposed roles. And then we also have an additional subset of folks who work on the program at a national level as well. For the beneficiary notification piece, similar to what Jennifer said, so when we do elective cases for the orthos, when they come in for their pre-op visit, if we feel that they're going to be qualified based on Medicare standing to be in the bundle, we hand them the letter as part of a packet of pre-op information that they would get with regards to their procedure as a whole. Fractures similar approach to what Jennifer echoed. So when doctors do those cases in the hospital and it's determined that they're a Medicare beneficiary, then either they'll get that as part of their discharge packet from us if the physician rounds on them before they leave, or it'll get emailed or sent over through our platform, either email or text.

Mira Friedlander: Okay, awesome. Thank you for that, Matt. Dr. Loeffelholz, we're going to skip your answer on this one. I know that we've had so many good questions for the panelists and we have a few more, we have one last question to get to before we wrap up and close out. I feel like this time really flew by, so again, really appreciate all of your insights that you've shared. If you have one sentence, one final piece of advice for people who are thinking about applying for BPCI Advanced, what would your life final piece of advice be?

Jennifer Brenczewski: I can start. I think it's, do it, try it. I think you have more people than you think that would be willing to take a stab at helping manage this program. It's creative. You can make what you want of it. If you like people that are just good educators, good coaches, it's a fun thing to try to do. I enjoy doing it a lot and it's providing patients with the care that they need. It really is, it's directing them toward the care that they need at the end of the day, which is just good healthcare. And so I think it's something that is a really good thing for our patients, our providers, for everyone, so.

Mira Friedlander: Thank you, Jennifer. Dr. Loeffelholz?

James Loeffelholz: And Jennifer put it well. It's a focus on the right care at the right place at the right time. I'd say the same. It's, remember that you don't need to be all things to all people. And you don't need to participate in everything that's included in BPCI A. But if you believe that that fee-for-service is at some point is going to be put on the trash heap of history, try it out, take on something and take a step.

Mira Friedlander: Thank you, Dr. Loeffelholz. And then to you, Matt.

Matt Civili: Yeah, I think my advice would be, if you're on the fence or you're considering doing this, move forward and get your application submitted in the next two weeks. You're going to have time between the end of this month and when the data comes out later this year to be able to start putting together the infrastructure that's needed to be able to move forward and be successful in this program. You don't have to have it in place in the next two weeks to be successful. I would just advise to take the leap, jump in, and be able to take the next couple months to be able to put together the staff and the resources and the protocols in whatever clinical episodes you would want to move forward in. And also, really invest in the data. Be able to make sure that you're taking a dive into your specific market data to really understand what your costs are and where you have the ability to be successful in the model.

Mira Friedlander: Awesome. Thank you for that, Matt. Want to give you three a big thank you for all of your insights. I know we had a few extra questions come in the chat that we didn't get time to answer, so we'll circle back with that internally and see if we respond to the group either by a communication or maybe in one of the upcoming open forums. But I will pass it to Jessica to close us out for the day on such a successful panel. Over to you, Jessica.

Jessica Dawson: Thank you, Mira, and thank you again. We had quite an engaging discussion. I just want to clarify the next steps for application process and also see a question in chat about another session. We will be having our office hours, which will be taking place next week and the week after. Those will be on the 18th and May 25th. Please register for those if you have any additional questions. Also, just want to note that the materials from our previous live event will be available on the website. They're on the model's webpage under applicant resources. And please take the opportunity to look at all of the resources that we put out around the application period, including but not limited to our application portal guide, how to apply for newer applicants, and our model year seven options for active model participants. That is all that I have. I just want to thank you all again for joining us. We have quite an engaging discussion, so we're hoping that you'll join us for our next event. And please engage in our post-event survey.

Mira Friedlander: Thank you all, and a big thanks to our presenters again, really appreciate all of your insights and your experience. Thank you all.

Jessica Dawson: Thank you guys. Bye.