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Value-based Healthcare

Value-based Healthcare: Part 1—Designing and Implementing Integrated Practice Units for the Management of Musculoskeletal Disease

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Patients, payers, providers, and policymakers have expressed a need for care delivery models designed around patient-centered value, and are actively pursuing payment structures to encourage this approach in musculoskeletal care. When analyzed with respect to value (defined as health benefits that accrue to patients per healthcare dollar spent), most current models of practice fall short due to: (1) An inability to measure outcomes that truly matter to patients, (2) limited transparency around the clinical and financial outcomes that are measured, and (3) a lack of care coordination across providers involved in the patient's musculoskeletal care cycle [4].

While bundled payment initiatives such as Medicare's Comprehensive Care for Joint Replacement (CJR) are concrete steps toward addressing these challenges, their scope is limited, as they are designed around procedures rather than conditions. These payment initiatives do not address the underlying misalignment in incentives that encourages greater emphasis on more resource intensive care, rather than improved health.

It has been noted [5] that there is a need for more-comprehensive bundled payments covering conditions, as well as delivery models that enable providers to succeed in that environment. A few institutions (such as MD Anderson Cancer Center and The Dell Medical School at the University of Texas at Austin) have started to trial co-located, multidisciplinary teams of clinical and nonclinical providers (eg, case managers, social workers) to treat conditions over the full care cycle. We call these teams Integrated Practice Units (IPUs). In Part 2 of this column, which will be published in next month's issue of *Clinical Orthopaedics and Related Research®*, we will take an inside look at an IPU team

A Note from the Editor-in-Chief:
We are pleased to present to readers of Clinical Orthopaedics and Related Research® *the first of a two-part series on Integrated Practice Units (IPUs), a novel, patient-centered, value-based, multidisciplinary care model piloted at a small number of institutions. Part 1 will cover how to design and implement an IPU. Look for Part 2 of this series in next month's* CORR®, *which will cover obstacles to implementing this new approach, as well as concrete examples of tools, clinical flows, and organizational approaches to surmount them.* Value-based Healthcare *explores strategies to enhance the value of musculoskeletal care by improving health outcomes and reducing the overall cost of care delivery. We welcome reader feedback on all of our columns and articles; please send your comments to eic@clinorthop.org.*

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working together across the full cycle of patient care, describe the potential roadblocks to this team-oriented approach, and suggest ways to overcome them. In this column, the first of this two-part series, we will discuss how to design and implement IPUs [3], as there is currently little practical knowledge on the subject. Some questions we need to consider: (1) What are the principles for designing a musculoskeletal IPU? (2) What are the potential benefits of this strategy in the fee-for-service environment? (3) How can orthopaedic surgeons prepare for value-based payment?

Designing the Musculoskeletal IPU

The first step towards building a successful musculoskeletal IPU is to choose a symptom, condition, or patient segment on which to focus. This can be a challenge, because being too inclusive will dilute the team's ability to provide focused, high-value care for that condition, while picking a condition that is too rare or narrow makes it difficult to justify the upfront investment in resources. The condition must lend itself to management by a multidisciplinary team of providers (eg, mid-level providers, orthopaedic surgeons, nutritionists, physical therapists, and social workers for a lower extremity joint pain IPU) who should have heavy input into the design and iteration of the IPU team [3]. The condition should also have a high prevalence, burden of disease, and cost of care across the patient population in order to maximize the opportunity for value improvement. For this column, we will use the example of lower extremity joint pain.

Next, the clinical design team must clearly define the scope of the IPU in managing the condition. Ideally, this would encompass the full breadth of care over the entire care cycle and patient psychosocial needs that will impact both patient-reported and clinical outcomes for the condition. There must also be a clear definition of the "graduation moment"—the point at which a patient will be transitioned back to the primary care environment.

The next step is to define the multidisciplinary clinical and nonclinical team that will be held jointly accountable for managing the condition. This requires distinguishing between the physical IPU (that is, the co-located providers under one roof) versus the "virtual" IPU, which includes any and all services provided throughout the cycle of care. For example, the multidisciplinary team could decide that they will impact the patient's experience in the primary care setting by being available for E-consults with the primary care physician. For simple issues, this can save a trip to the specialist and provide treatment at the point of care. Alternatively, the team could decide to start their responsibility at the time of the first physical appointment, or at any point in between depending on the condition. One must also apply principles of high-value care in defining the various roles on the team. For a lower extremity joint pain IPU, all patients are evaluated and initially managed by well-trained orthopaedic mid-level providers, while surgeons are available to provide clinical "backup" and to discuss surgery with those patients who meet appropriate use criteria and feel that surgery is consistent with their functional goals and preferences. This allows all providers to function at the top of their license (also known as "downstreaming care" [1])—a challenge we will cover in more depth next month in Part 2.

Other important principles include engaging and activating patients throughout the care cycle, incorporating patients goals and preferences in important treatment decisions (via shared-decision making), and ensuring all staff are trained in empathetic listening and communication skills geared towards improving patient self-efficacy. These principles and the IPU scope (clinical services and patient needs) will ultimately guide who will

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be part of the core team, as well as their roles and responsibilities.

The team will require strong clinical leadership from an orthopaedic surgeon or other musculoskeletal provider to promote teamwork, collaboration, and joint accountability for patient outcomes and overall cost of care. Prospective data collection and early feedback reports available in real-time will foster a "learning health system" that constantly iterates and improves.

The final step is to identify opportunities to improve value, and then redesign care to capitalize on them. Across conditions, such opportunities include ensuring appropriate utilization of diagnostic and therapeutic interventions, addressing patient psychosocial needs to improve overall health, reducing utilization of low-value health services, and maintaining greater patient engagement through robust two-way communication with the care team. While different conditions will require different core teams and clinical flows, certain IPU qualities will be common across conditions. Some examples include downstreaming care, patient-risk stratification and needs assessment prior to the visit, shared-decision making, and regular team communication to discuss and update each patient's care plan. The IPU design team must also delineate the tools necessary to accomplish these myriad tasks, including patient engagement and outcomes collection platforms, robust shared-decision making tools, and personalized risk calculators.

Benefits of Moving to an IPU-like Model in the Fee-for-Service State

Although IPUs are designed to function under value-based payments, there are multiple advantages to adopting elements of these models in the fee-for-service world. By measuring PROs before and after each patient interaction or intervention, orthopaedic providers have the opportunity to market their results to patients, primary care physicians, and payers in order to increase market share. Payers are similarly focused on understanding which providers deliver the highest value of care as evidenced by the inclusion of PROs in Medicare's CJR model. Further advantages of IPUs include offering more integrated care, engaging patients virtually, addressing modifiable risk factors, and better performance in procedure-based bundled-payment programs. The latter is accomplished via preoperative risk factor modification, which will yield higher rates of patients discharged to their homes, fewer unplanned readmissions, and fewer reoperations [2]. Lastly, orthopaedic practices that consistently measure and demonstrate better value will be best-positioned to contract with employers and payers for quality designation programs with various levels of risk-sharing.

Despite these notable benefits, shifting to an IPU model must be viewed as a long-term investment in higher value care rather than yielding near-term financial benefit. Going forward, providers that are equipped to compete based on the value of care they deliver to patients, rather than the volume and intensity of services they provide, will be well positioned for long-term sustainability and success.

Next month, through a real-world example, we will describe in greater detail the kinds of tools, clinical flows, and organizational approaches required to implement and deliver greater value to patients through the IPU approach.

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