WE'RE CLINICIANS TOO!
SPINE CARE AND SPINE SURGERY:
The Payor's Perspective

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Objectives

- Describe what we experience in reviewing the surgical requests we receive
- Describe our organization's approach to developing a better "system of care" for spine care
- Explore the important mutual issue of ***information*** – what do all of us need more of, to improve the quality and value of patient care?

- Goals by 2016:
  - Cut spine costs 50%
  - Provider satisfaction
  - Change FFS to other systems

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The Spine Surgery Review

- Based on documentation submitted by the surgeon to Health Plan doctor like myself
- Considerable variation in quality of documentation
  - History; e.g., "back and leg pain"
  - Complete neurological exam
  - Imaging interpretation: surgeon vs. radiologist
  - Specific rationale for approach; e.g., facet removal/fusion decision

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The Spine Surgery Review (cont.)

- The denial/phone call/appeal process
  - Use of clinical peer reviewers – an imperfect solution
  - Sharing actual imaging: a work in progress

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What Constitutes Appropriate Non-Surgical treatment?

- Tremendous variation in documentation of non-surgical care
- Uncertainty on everyone's part as to what is appropriate – modalities, duration
- Classic example: NASS criteria for fusion for lumbar DDD

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Criteria within Criteria

- Legitimately debatable surgical indications
- Facet removal/fusion
- Repeat decompression/fusion
- Pseudoarthrosis
- Lumbar DDD/fusion
- Listhesis – how much is relevant, how unstable is it?

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Cost Drivers – More Than Just Surgical Rates

- Both utilization (# of operations/1000) AND unit cost ($ per operation) are on the rise
- What are the factors that are driving each?
- What are the roles of the payors and surgeons in managing and controlling these costs?

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From Unsystem to System

- We currently have an unsystem of spine care
- Excellus BCBS is engaged in two major initiatives
  - Accountable Care Organizations – risk-sharing between payor and provider group
  - Spine Health Center – emphasizes front-end care that is evidence-based and emphasizes self care
  - Brian will discuss this in detail in a few minutes

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The Imperative of Information Sharing

- We support and follow current emerging research on QALY for surgical procedures
- We support the registry concept and are currently studying the N2QOD Registry very carefully
- We are considering a scenario in which
  - We provide incentives for surgeons to participate
  - In return, they share their individual outcome data with the Health Plan, to guide future coverage determinations

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From Contention to Collaboration

- Excellus BCBS recognizes that there is enough uncertainty to go around
- The current contentious utilization management (approval/denial) process has serious limitations
- Shared clinical, cost-sharing, and data-sharing initiatives can transform the relationship between payor and provider communities

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Value (Quality / Cost): What Brings It?

- Quality

  Starts with agreed upon outcome measures

  - Pain (Poor choice)
    - VAS, "Pain as 5th vital sign"
  - Function (Better choice)
    - ODI, NDI, Roland Morris
  - Quality of Life (Even better choice)
    - PROMIS (NIH), SF – 36
- Cost
  - Direct costs ("medical")
    - Cost silos (PCP, surgery, chiro, Rx, injection, imaging…)
  - Indirect costs (lost work days, lost productivity….)
    - How do we capture?

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Patient Engagement/How We Talk With Patients

- Meaningful shared decision making
- Minimize fear provoking language
  - DDD becomes "I have a degenerating back"
- Patient preference matters
- Motivational Interviewing

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Psychosocial Measures

- Best Predictor of spine fusion outcomes is . . .

  Psychosocial measures

- Pain is a whole person response to nociceptor firing
  - Anxiety
  - Depression leads to perception of pain
  - Fear
  - Beliefs / attitudes
  - Distress

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Finding and Fostering Provider Value

- 20x variation in spine fusion rates! (Dartmouth Atlas)
- Organizational self-policing is a worthy goal but is rarely achieved

- We need a consistent, clear evidence-based, patient-centered approach
  - **Pathways** give opportunity for employers/payors to:
    - Reward high value providers
    - Marginalize low value providers

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From Unsystem to System

Introducing the New

Lifetime Health Medical

Group/Excellus Health Plan

Spine Health Program

Spine Care Pathway - Process

- Evidence-based (NCQA, research based, evergreen)
- Process driven (Lean Six Sigma)
- Enhanced communication (EHR, meetings/community)
- Feeder pathways for PCPs, ERs, UCCs (Pt point of entry)
- Primary Spine Provider (manage, treat and triage skills)
- Classification systems (coordinate diagnosis, treatment, education, outcomes, data collection)
- Cost efficiencies, necessary resource allocation
- Clinical benchmarks with other programs (Spine, 2011)
- Contextualizing care, respect patient expectations
- Aligning the interests of all stakeholders

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Quality Through 'Front End Efficiencies'

- Efficient Delivery Systems
  - Primary Spine Practitioner is the "Hub of the Wheel"
  - "Feeder" Referral Pathways from ED, UC, PCPs, Medical Home, ACQA, Employer Groups
  - Standardize evaluation and management across provider groups and clinical settings (minimize variation)
  - Strategic Partnerships with high performing specialists across multiple disciplines: spine surgeons, pain specialists, neurology , mental health, Physical Rehab (MOUs)
- Public Health Campaign – self triage (ED?), self care, prevention

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Primary Spine Practitioner (PSP)

- Trained Specialists:
  - Evidence based approaches in Hx, Px and Rx (biopsychosocial/relational model, r/o 'red flags', identify/address 'yellow flags', specialized 'tool box')
  - Motivational interviewing and communication, emphasizing self directed care
  - Accurate / quick triage for surgical and pain intervention consults ('Fast Track') awa imaging
  - Knowledge of manipulation and exercise
  - Knowledge of appropriate use of opioids and steroids
  - Knowledge of full spectrum Dx/Rx options to effectively and efficiently coordinate care
  - Promote a public health perspective for spine care

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Quality/Outcome Measures

- Provider Quality (checklists, pathway adherence – red flag prior to imaging)
- Clinical Outcomes (pt. satisfaction, pt. directed goal attainment, functional measures, referral rate, return to work, recurrence rate, global health measure, patient registry?)
- Community Satisfaction (all stakeholders – industry, PCPs, referral network, subscribers w/o spine pain through public health initiative)
- Value Measures (internal costs, visits, imaging, referrals/episode; cost savings data; ED diversion)
- Benchmarking against non participating spine pain pts and other plans.

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Value Add: Efficiencies

- Patients
  - Clear consistent care pathways, less cost (time and $), quicker return to activity/work, less unnecessary care/test
- Community
  - Lower per capita costs, less disability, greater productivity
- Payors
  - Appropriate surgeries, imaging, pain intervention, no reduplication of care/tests, increased subscriber satisfaction, decrease ED visits, minimizes variation
- Providers
  - Classification simplifies care decisions, $$ in risk sharing models, lessens clinical burden, EHR driven quality metrics/guidelines

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