

**Center for Medicare & Medicaid Innovation
Bundled Payments for Care Improvement Initiative**

**Accelerated Development Learning Session #6:
Building An Effective Gainsharing Program**

Friday, April 6, 2012, 11:30 am – 1:00 pm ET

OPERATOR: Good day, ladies and gentlemen, and welcome to today's webcast titled, Bundled Payments for Care Improvement, ADLS Session #6.

To submit a question or comment at any time during the webcast, please click on the Ask-a-Question button at the bottom of your screens, simply type your message into the box and click the submit button.

At this time, it is my pleasure to turn the floor over to Weslie Kary. Ma'am, the floor is yours.

WESLIE KARY: Thank you very much, Patrick. And welcome, everybody. Good morning and welcome to our session on Building An Effective Gainsharing Program.

Before we get started, just a couple of things as background information. First, we will have these slides posted on Monday at this website, <http://cmmi.airprojects.org/BPCI.aspx>. And I will show you this link again at the end of the presentation.

The other thing that you should know is that the views that are expressed in these presentations are the views of each speaker and do not necessarily reflect the views and policies of the Centers for Medicare and Medicaid Services. And the materials provided are intended for educational use only, and the information has no bearing on participation in any CMS program.

Our objectives today, as always for these ADLS sessions, are to support practitioners in their efforts to successfully implement bundled payment in support of the three-part aim.

And, today, we will be looking directly at the issue of physician, hospital, financial alignment in support of improving quality and efficiency, the gainsharing which is at the heart of many bundled-payment programs. We will share expert knowledge and lessons learned by early adopters.

We have two speakers who were leaders in the Continuum Health Partners participation in the Medicare gainsharing demonstration. So they have been doing gainsharing since 2006, which is about as far back as it goes, I think most people understand. So we are very lucky to have them with us today.

And our third objective is to set the stage for continued collaborative learning during the implementation process.

I'm going to go ahead and introduce our agenda. As I said, we have three presentations. We're going to do two of them. First, we will hear from Ruth Levin and Dr. Michael Leitman from Beth Israel, and we'll do a short Q&A. Then, we will have another presentation from Dr. Alexander, and then we will do a Q&A for all presenters.

And, as Patrick mentioned at the beginning of this presentation, the way to ask a question is through the chat function, Ask-a-Question. At the bottom of the screen, there's a little button and you can ask a question. Please feel free to send your questions in as they occur to you, so that we have them queued up at the point that we do these Q&A sessions.

All right. Our three speakers today, I will introduce all three of them and then turn it over to Ruth Levin to start.

Ruth Levin is currently a management partner at Managed Care Revenue Group, but we asked her to speak today for her experience when she was at Continuum Health Partners, which is the parent company to Beth Israel Medical Center, St. Luke's Roosevelt Hospital Center, Long Island College Hospital and New York Eye and Ear Infirmary.

And at Continuum, Ms. Levin directed all hospital and employed-physician managed-care contract negotiations, implementation and compliance, and, also, most relevantly today, the CMS-sanctioned Gainsharing, Pay for Performance Project, which had over 500 physicians.

Next, we will hear from Dr. Michael Leitman who is the Chief of General Surgery and Graduate Medical Education at Beth Israel Medical Center in New York City, and he has been one of the physician leaders for that same gainsharing program, Beth Israel's Gainsharing Program since its inception in 2006. Dr. Leitman is also a professor of clinical surgery at Albert Einstein College of Medicine and maintains an active surgical practice. So we are getting the benefit of hearing from the practitioners as well.

And our final presenter, Dr. Gordon Alexander, currently serves as an advisor to the Association of Academic Medical Colleges on their bundled-payment initiative.

Previously, he was President and CEO of Children's Hospital of Central California, and, before that, he led the formation of a 750-physician hospital organization with Fairview Health Services, and subsequently became the Chief Medical Officer of Fairview and then president and CEO of the then newly-created University of Minnesota Medical Center at Fairview.

So that's our speaker lineup, and we are very delighted to have all three of you with us today.

I'm going to queue up Ms. Levin's slides. Can you see your slides?

RUTH LEVIN: Yes. Thank you. Weslie. I'm very pleased to participate in this webinar, and I will be giving you all my perspective on how we operationalized a gainsharing program at Continuum and my work with other hospitals in implementing similar gainsharing programs and hope that it is informative to all of you.

So I know that one of the pieces that a lot of you are interested in learning about is why do this. You know, what about gainsharing is going to help you achieve your ultimate goals?

And, from our perspective, gainsharing, when I use that phrase, our programs are an up-side sharing of the rewards of reducing costs and improving quality with physicians, hoping to align our incentives and motivate behavior changes.

So our gainsharing programs are focused on up-side benefit, sharing of those up-side benefit savings rewards with the physicians. There is no down side. No sticks. It's all carrot, so to speak. And, as we walk through this, I think you'll understand more about how this works.

So, why gainshare? You know, what is it that you have as a goal in implementing this kind of a program and what do you need to do to communicate these goals?

Clearly, ours was to achieve greater efficiencies, cost savings and higher quality by aligning our hospital and physician incentives. As I think most people would agree, the financial reimbursement system that's out there now does not necessarily allow for aligned incentives, and implementing a gainsharing program was going to move us towards greater alignment.

We also wanted to see a reduction in the variation in practice. For the exact same DRGs, we saw wide swings in how the services and care was rendered within our hospitals, and we wanted to see the variation shrink.

We wanted to reward physicians for improved performance and get meaningful collaboration out of our providers. I think most hospitals would agree they have many efforts underway with their physicians in which you believe you're getting true understanding, true performance, really engaged doctors working on length-of-stay initiatives and quality initiatives, but until we implemented this gainsharing program, that was really the first time we understood what meaningful collaboration was.

We saw a real change in performance, and, instead of just heads nodding around the table, there was a much higher level of engagement amongst our doctors. And, obviously, rewarding the physicians for this change in performance helped the program continue to be meaningful.

We also believe that it's important that the program have a quick startup, an element that was very important in order to keep the doctors engaged. They were able to see payments come back, shared savings with them quickly, and this, obviously, enabled the improvements to begin to become evident very fast.

We thought it was important for the design to be simple. You want not a lot of complexity. You want it to be easily understood when you go out and present the program. And it was also important to maintain flexibility. There are a lot of variabilities between practices, between specialties, and to maintain flexibility and be able to shape the program according to the needs of your hospital, particular physician groups was very important.

And we needed to deliver, obviously. Data. Data, data, data. The physicians are scientists. They want to be able to understand what it is that you're pointing to in terms of cost data, some of the clinical reporting data quality issues. And being able to, on a regular basis, provide them with the information they need that would give them the insight and guidance on where to change their behaviors so that they could reach the goals was highly important.

So what are the targets for improved performance? Ours in our gainsharing program was shorter inpatient stays. And most of the items that you're going to hear me talk about, because our program was focused on the inpatient side of the equation, that's where the largest cost-savings opportunity was for us.

And I believe in any of these bundles, perhaps other than Model 3, the inpatient dollars is where I think most of us would see the opportunity to have the greatest sharing of savings, so that you'll hear me talk, obviously, with a focus on the inpatient side of the equation.

So our targets for improved performance were shorter inpatient stays, when appropriate. We wanted to see fewer marginal, but costly diagnostic tests. There was certainly a review of what was being done in terms of testing on an inpatient versus outpatient, what could be done post-discharge versus while the patient was in the hospital, but understanding what all of those diagnostic tests were and why they were being done, what day of the stay they were being done.

Reduction in pharmacy expenses, using generics, using the formulary; efficient use of ORs and reduction in turnaround time was a key target that we knew we had as an issue.

The cost-effective use of critical-care and telemetry units was a big item for us, as well as evidence-based selection and purchase of medical devices. You know, while physicians were participating in our negotiation and in selection criteria for implants, there was a new vigor that we found once we implemented the gainsharing program as to how involved our physicians were in making sure that the most appropriate implant was selected for their patients and assistance in the negotiation and the management of costs of these devices.

We wanted to see a reduction in duplicative services, obviously an improvement in discharge planning, and we wanted to, overall, see an improvement in our quality scores on process measures. That is an overriding, very important element to this program that you will hear about throughout.

So you heard me touch upon it, but, clearly, the inpatient gainsharing benefits extend to post-acute and ancillary providers. Depending on how you're setting up any of these bundles, the savings that are achieved for more efficient acute services, the inpatient side, will increase the likelihood of more appropriate and perhaps earlier use of post-acute services.

For the bundled-payment models, clearly, fewer resources that are used on the inpatient acute portion of the bundle will likely mean there'll be sufficient funds or shared surpluses in addition to pay for all of the post-acute services and professional services that are involved. So, clearly, the inpatient gainsharing benefits do extend throughout the bundle to be able to make sure that there are dollars available.

And data on the best practices for all of the anticipated services within the bundle will provide guidance on how the cost and quality metrics can be achieved.

So what you are going to see is how we outlined our program and used data in this regard. I would suggest that many of these same data resources could be used for services beyond the inpatient side.

We did consider a number of patient protections and various methods, the design of the program. There were certain decisions that had to be considered. Clearly, one of the most important was the adjustment for severity of illness to ensure that the correct amount of resources were used in setting the benchmark targets.

The physicians who would come to us to say, "Well, my costs are higher because my patients are sicker," did not extend that argument once they saw that we were adjusting for severity of illness. We used APR-DRGs, as you will see, and that really addressed the issue of the cost for more complex patients. And it eliminated the incentives to cherry pick or stint or steer patients that might have been more complex.

We used best-practice norms that were derived from the community. At Continuum Health Partners, the hospital was large enough, had a sufficient number of discharges throughout the system that we were able to use specifically the data from our own hospitals to move this forward and set our best-practice norms.

But I have been working with hospitals in other areas that are much smaller that were able to use the community-based data in order to help. And you'll obviously, in the Medicare bundles, have access to broader data.

The incentive amounts are reasonable. They were enough to incentivize the doctor, but they were consistent with the Medicare rules, and you'll see what some of them were like.

There had to be a limit on incentive payments to discourage new or untried practices. You know, we certainly didn't want to make them so high that physicians were going to, you know, make practice decisions that perhaps would not want to be encouraged. And there were certain limitations, as you'll see, on some of these payments.

And the physician incentives were all conditioned upon compliance with quality measures, so that while a physician might have seen the potential to share in savings, if they had not met certain quality metrics, they were not entitled—are not entitled to their checks.

So how do you secure physician buy-in? Clearly, you want to make sure that physicians are interested in participating, engaged and really working side by side with you.

We did make the program strictly voluntary, so this was not something we obligated our physicians to participate in. It was their choice. There was no change in the process or form of current physician payments. So they would continue to bill the payers and get paid their normal fees. There was no change in that process.

The detailed data that we would give to the physicians were on an individual basis, so that they were able to see their own performance adjusted for severity of illness, and that's very important.

The ongoing regular feedback to physicians is also important, so that these reports were given on a regular basis. The program does encompass non-clinical and clinical opportunities. You want to make sure that you recognize that it isn't just the physician behavior that might have to change, it's the hospital's behavior.

There are certain processes that the hospital will have to get involved in to make changes in order to support this kind of a program, and they aren't always, you know, clinical in nature. There may be some administrative issues that will help you move in the right direction to reduce costs, be more efficient and improve quality.

The quality evaluation is based on overall performance, and, as I mentioned before, this was an incentive-only program, no risk or penalties based on—and it based on individual performance.

The program provides a loss-of-income protection. What you're going to hear me present on was a program that was focusing on the commercial managed-care patients as well as Medicare. And for those physicians who bill on a daily basis, as the length of stay came down, they obviously could not continue to bill for those days, and so there was a loss-of-income concern as the length of stay dropped.

There were dollars built into the equation, the bonus program, to compensate for that loss of income, so that the physicians didn't have to be concerned about that anymore.

And transparent. Very important to make sure that everyone knew about this program. We were perfectly transparent. There were notifications to patients about the program in every admission package.

Continuum Health Partners started the pay-for-performance program back in 2006, as I mentioned, on commercial, managed-care patients, so that did include Medicare managed care and Medicaid managed care, as well as, you know, the other commercial insurance patients.

It was designed to compensate physicians who did improve quality and patient safety and implemented efficient practice patterns. And in 2008, CMS did provide us with a waiver to begin the same gainsharing program on Medicare patients at Beth Israel, one of the hospitals in Continuum Health Partners.

The basic framework, to get into specifics, is that the inpatient cost savings were shared with physicians. Physicians were rewarded for reaching benchmarks—and I'm going to show you what some of those look like—or for making significant improvement in performance.

This is obviously an important element when you start up any program, because it may be difficult for your physicians to hit the benchmark right away, and so you need to make sure that you can show them that you will reward them for just making improvements moving towards the benchmark.

All of the cases were severity adjusted to four levels, using APR-DRGs, and the goal, the best-practice norm was set at the top 25th percentile lowest-cost performers. So for each APR-DRG, there was a benchmark. There was a target. It was communicated with the physicians, and it was based on the top 25th percentile of the performance within our own hospitals. So the physicians knew that it was possible to reach because their peers were hitting it. In fact, most physicians had at least one or two cases amongst their own list of cases that were hitting it.

Monies to pay the bonus came from hospital savings. If the hospital didn't achieve a savings, there were no bonus payments, and, as I said before, payments were withheld from physicians who did not meet the quality standards.

We did, obviously, look very closely at the quality data, things like infection-prevention practices, other infection indicators, all the core measures, medical-record completion and OR dictation completion. Many of you may not be surprised how quick those were cleaned up when they knew that their checks were going to be held if they were not complete.

Patient complaints were looked at, mortality, readmission rates and other quality initiatives were included in our review.

I'm hopeful that you all can read this slide, but this is a sample report that a hospital would get that would indicate, by clinical area, product lines on the left, where their largest savings opportunity is.

Along the top line, you see a number that says Admissions, and it's a little over 10,000. This was for a year's period for a hospital that we took all of those 10,000 admissions and what we said was, what's the cost now versus the cost at the 25th percentile if all of these same APR-DRGs that this hospital had were actually performed at the cost of the top 25th percentile? What would the savings opportunity be?

And over on the right you see Savings Opportunity, the second column in, was \$25 million. So if all of the bottom 75th percentile performed like the top 25th percentile, this hospital would have seen a savings of \$25 million.

We then break it down by clinical area so that the hospital could focus in clearly on those clinical departments where the greatest opportunity existed.

This report is what the individual physician would receive. They'd be able to see every patient that was included in the gainsharing program. They'd be able to see what their cost was, what the actual length of stay was versus the best practice length of stay, the 25th percentile length, where their cost variances were and what the incentive payment was that the physician could have received.

Where you see a zero over on the right-hand column, that was a circumstance where the doctor didn't hit the benchmark, was nowhere near the benchmark and therefore they got nothing. Remember, our program is an up-side bonus only. There's no penalties, no punishment to the physician. They simply would not get a payment if they did not come close to the benchmark. They'd get something for improvement. They'd get the full amount of the bonus if they hit the benchmark, but there was no penalty. They simply just didn't get paid if they were far from the benchmark.

I'm moving through these relatively quickly because I know I have a limited amount of time.

This was a dashboard that each of the physicians get. The pie chart over on the right-hand side tends to be what the doctors look at most quickly. The number in the middle shows the doctor what they could have earned had they hit the benchmarks on all of their cases. In this case, it was a \$10,000 check, but, instead, the doctor only got \$3,600, and, typically, the first question the doctor asks is, Well, what can I do to get the rest of the money?

And down at the bottom of this dashboard, we show them exactly by cost-center area where their issues were. Room and board. That's obviously length of stay. Their OR cost. CAT scan use. Perhaps they were not using or are using more CAT scans than the typical doctor for their APR-DRGs in the top 25th percentile; intensive-care use, etc. And this helped to guide the doctor as to where to focus their efforts.

We have many detailed reports that we would be able to share with the physicians. This is just one of them, which breaks down the cost even further by APR-DRG that shows them what the best-practice cost was for each of the cost-center areas. And they could then drill down even further whether their issue was in radiology or in drugs or in cardiopulmonary use. Really providing as much detail as possible we found very helpful in moving this program forward and in working with our doctors.

Some sample practice changes that obviously contribute to improve efficiencies and improvement in quality of care, increased detail and accuracy of documentation. Clearly, using APR-DRGs, we ended up seeing that physicians learned more about coding and making sure that they were documenting everything appropriate to that patient to ensure that they were coded at the right level of APR-DRG and that they were being compared to the right level of cost. Otherwise, they had a more difficult time hitting the benchmark.

So we did see an improvement in documentation, an improvement, obviously, that led to more accurate coding and, therefore, assisted the physician in their comparison of costs.

We saw earlier consultation with discharge planning. We saw rounding and writing discharge orders sooner and on weekends. You heard me mention before an interest in the implant costs, understanding demand matching and implementing demand matching, a decrease in time between the request for consultation and the occurrence of consultation. This was clearly important as well.

You know, physicians would call in a consult, but didn't really pay too much attention as to what day they might have shown up or followed through. Now, they do. Now, they make sure that the consult happens as soon as possible, since that will affect their overall efficiency. And we've been seeing earlier transition from the ICU to the standard acute floor.

So you want to engage your physicians, obviously, in programs like this, and sustain their interest. And we found that regular meetings, attending grand rounds, having one on ones was very important. Reviewing the data by physician, by APR-DRG cost center, really giving them as much information as possible, helping them to drill down and identify where behavior changes were going to have the greatest impact was very important.

Identifying key physician leaders. You're going to hear from Dr. Leitman next. He was clearly one of our key physician leaders, speaking physician to physician and making sure that it isn't all just coming from administration is very valuable.

And, obviously, involving physicians in the design of the processes and renegotiating of vendor contracts, all of the elements that are going to help you be more efficient.

Remaining flexible as well. If departments wanted to use their funds for something, if they wanted to focus on a particular quality initiative, knowing that you have that flexibility in these models to be supportive and creative in how this is designed and distributed is going to help you be more successful.

And I think that's my last slide. Okay?

WESLIE KARY: Thank you, thank you very much.

RUTH LEVIN: Oh, I'm sorry. There was one more slide, but it really just is getting closer to, you know, reduction in variation of practice and moving towards greater acceptance of clinical guidelines and care maps. Thank you.

WESLIE KARY: Okay. All right, thank you very much. And we're now going to move to Dr. Leitman's presentation, and he can speak to some of these same issues from the perspective of the physician champion. Dr. Leitman, can you see your slides?

I. MICHAEL LEITMAN, MD: I can, Weslie. Thank you very much, and good morning to those of you on the West Coast and good afternoon to those of you on the East Coast, and thank you for inviting me to participate in this webinar.

My focus is going to be not only to define the role of the physician leader in this program, but also to share, really, the mature, gainsharing program that we've had at Beth Israel since 2006. We have data from well over 100,000 discharges, and, hopefully, by the end of my presentation, you'll get a sense of where the opportunities are.

In my slide deck, I have some contact information, so if anybody has any questions after the webinar, you can feel free to contact me.

And just to kind of illustrate what Beth Israel is, we are a 1,000-bed system. We have two campuses, a Manhattan campus and a Brooklyn campus. We have over 2,000 physicians on staff.

Our Manhattan campus has 750 beds and it's a teaching hospital. We have 36 residency programs and fellowships here. And while it is a teaching hospital and an affiliate of a medical school, 60 percent of our staff are voluntary.

Our Brooklyn campus, on the other hand, is a small community hospital with almost all physicians being voluntary. And, as I mentioned before, today, I'm going to present to you approximately six years of experience in our program.

The way our program has worked—and Ruth Levin was one of the designers of the program and has worked extensively with our organization when it began—the program really credits the physician who discharges the patient. That's the physician who receives the individual payment for that admission.

We do exclude Medicaid cases. We exclude psychiatry, neonatal, OB cases, ambulatory cases are also excluded, and then any patient that dies during the admission, that case is also excluded from gainsharing.

Now, there are a number of physicians who can't participate in this program. I have listed a few of them here—anesthesiologists, radiologists, pathologists.

Initially, our intensivists and our hospitalists were not part of the program. I'm going to go into an area where we have since included them. And our emergency-medicine physicians are also not included.

You might also understand that our consulting physicians—While the discharging physician is the one who's credited for the case, consulting physicians are not credited on individual cases.

So just a little timeline that Ruth already started was that we began the program in 2006, and in 2008, among our commercial gainsharing program, we were also given a status for a demonstration project from CMS, and that allowed us to increase the number of cases by about 25 percent.

We began a real effort to have physician peer-to-peer meetings in 2009, so that physicians would really understand how the program worked for them to be able to decipher their dashboards that Ruth showed you a few minutes ago, and also began to—they began to understand how it was they could change their behaviors to enhance their gainsharing revenues.

Also in that year, we upped the ante a little bit because we were very focused on length of stay. And so we created a threshold whereby in order for physicians to receive gainsharing payment, 20 percent of their discharges had to be at the best-practice norm; that is, again, the top 25th percentile.

In 2009, we also added hospitalists, and then last year, we began a program where we added intensivists, and I'll show you how we do that in a few minutes.

We also recalibrated our best-practice norm a couple of times. Most recently, we used 2010 data to look at 2011 gainsharing performance. Also, in 2011, we increased the threshold further to now require that 25 percent of discharges hit length of stay at the best-practice norm.

And then also this year, we required that all cases reviewed hit core-measure compliance. Whereas, before we had an 80-percent requirement you'll see in just a minute.

Ruth alluded to the quality measures that are really so much a part of our program, and we actually have a relatively robust quality aspect of the program, and I've listed on this slide and the next various ways in which we measure individual physician performance.

And this is more or less an all or nothing situation; that is, physicians don't hit these benchmarks in terms of quality—and I'm not going to read through all the measures—but if they don't hit all these benchmarks on quality, their entire payment is withheld.

Many of these quality measures are tied to core measures, and so, again, while we initially had it at 80 percent, clearly, our goal was to be at 100 percent for our organization, and so we've now moved it to, in terms of core measures, to 100-percent compliance.

Each physician, on an every-six-month basis, their quality profile is examined as part of this program. And, again, if they don't hit certain benchmarks in terms of quality, the gainsharing payment is withheld.

So the physician leader, like myself, has a role in actually sitting down with each individual physician and reviewing their report with them. They receive their dashboard. They receive their check and a letter. But, really, we have found that the individual meetings have really allowed us to achieve the goals that we wanted to achieve in terms of savings.

Physicians begin to ask the questions, as Ruth mentioned, what can I do to perform better? And, really, the session is more or less prescriptive in terms of things that this individual or that individual can do to improve their performance.

In some instances, it may be reducing OR costs or reducing implant costs. In others, it may be reducing ICU costs, while other physicians may have overuse of various radiology or laboratory facilities.

About a year-and-a-half ago, we published our experience in gainsharing in the Journal of Hospital Medicine. For those of you who are interested in reading the article, I have it on this slide right here. That was our three-year experience, and, now, as I mentioned before, we have almost six years under our belt.

So I'm going share some of the outcome measures that we've identified. First of all, we have enrolled a large percentage of our physicians. We're currently at about 70 percent of our eligible physicians are now enrolled in the program.

The program started out rather slow. When we first began, it was about 25 to 30 percent of physicians enrolled, but, over time, we've made a concerted effort to enroll as many physicians in the program as we possibly could.

This slide really indicates the cumulative savings over the course of the program. This particular chart just shows from 2008 to 2011, but you can see we've actually enjoyed savings not only in the cases run by participating physicians, but even non-participating physicians have allowed us to save dollars.

And one might ask why is it that non-participating physicians have also—have been able to allow us to save dollars, and the reason is because we have identified cost-saving strategies that not necessarily are affected by physician behavior, but by reducing costs across the board for purchasing medical and surgical supplies and things of that nature or, as Ruth mentioned, having the ability to have social workers see patients over the weekend, having certain services available over the weekend, this touches physicians in the program as well as the physicians that are not in the program.

But we've enjoyed a tremendous amount of savings over the years, and the biggest bunk, if you will, happened to be when physicians became engaged in the program, and so this is a big part of our objective.

The slide that I've just put up shows, over time how much savings there were per physician over the course of a year. These are average savings for our Manhattan campus. Participating physicians saved the hospital \$19,000 per year, and non-participating physicians also saved some money, \$4,000 per year. But you can certainly see a separation between the participating and non-participating physicians.

Our core measures have remained relatively flat or improved a little bit. So that's why we focused even more on core measures most recently, to try to use the program to help us move them even further.

Ruth alluded to medical records, and while it may seem Draconian to hold back a check for incomplete medical records, clearly, it has had a tremendous effect. Participating physicians now have a very small percentage of incomplete medical records, compared to non-participating physicians. And so this was really a benefit that we saw early on.

When you look at other data, such as hand hygiene, we saw improvement in hand hygiene in our Manhattan campus during the growth of this program.

We've also seen reduction in central-line infections. And so compliance with a central-line insertion bundle compliance has remained very, very high as a result, not only of this program, but increased awareness of how important it is.

In our ICUs, we've had a reduction in ventilator-associated pneumonias, and, again, it's not entirely due to our program, but we feel that, again, the alignment of goals between the physician and the hospital, getting physicians and hospital people to work together is certainly good for patient care.

As far as our mortality rates and our—our mortality rates, both at our Manhattan and our Brooklyn campuses, they have remained relatively flat during the period of time.

But what we've seen the greatest movement in is in length of stay, and this is our Manhattan campus and a timeline of when gainsharing began in 2006. And while it was relatively slow to start, once we got the Medicare pilot project on board, and once we also began our one-to-one physician liaison peer-to-peer meetings, we began to really see a reduction in length of stay. That was very important to us as length of stay really was—one of the central themes in our program was to reduce length of stay.

This was not only true at our Manhattan campus, but, as you can see here, a very similar trend at our Brooklyn campus.

So just giving you a sense of the numbers, our physicians have enjoyed payments totaling 8.8 million dollars to date. This is monies paid out to physicians for commercial cases. There's a smaller number paid out for Medicare cases during our demo project.

Actually, Ruth gave this slide, so I'm going to go to the next slide and just talk about what has happened with length of stay. This slide illustrates our Manhattan campus, and, again, our length of stay between participating physicians and non-participating physicians has clearly separated. Our participating physicians do have a much shorter length of stay.

The numbers in parenthesis, if you can see them, is our CMI. And so you can see at the end of the graph that 2011, the CMI for par cases as well as non-par cases, for commercial cases, at our Manhattan campus is the same, but there is clearly a shorter length of stay in gainsharing participating cases.

This is also true from Medicare cases. For some reason, the non-par cases had a CMI in this diagram of 2.57 compared to 2.11 in our par cases. But we did have a shorter length of stay in participating cases.

So the average savings per admission is about \$1,800, and the average annual incentive payment per physician is \$4,500, but there's a wide variation of payments. We have some physicians, because of what they do, have earned more than \$25,000. And we've had some physicians get checks for \$5 or \$10. So there's a wide variation, but the average is \$4,500 per year.

To give you another example of how we've used these data, we've actually used them—the data, not only to meet with individual physicians, but we've used the data to meet with groups of physicians.

I mentioned our hospitalists, and we used specific DRGs to compare the performance of our hospitalists compared to best-practice norm, and we identified opportunities to reduce ICU costs, reduce MRI costs and also reduce the use of CAT scans for specific DRGs when compared to best practice.

We had a similar discussion with our general surgeons here. We had significant opportunities to reduce length of stay, to reduce OR costs, and also to reduce the use of CT and ICU costs for specific DRGs that general surgeons treat.

And with our orthopedic surgeons, again, we saw some opportunity, when comparing best practice, to reduce the length of stay, and, in particular, implant costs were over \$1,000 greater among our orthopedic surgeons on the commercial side of things, compared to best practice. And so we were able to reduce those costs by having those particular conversations with those individuals.

And likewise with interventional cardiology, we identified opportunities to reduce ICU costs.

Now, as I mentioned before, our intensivists were not part of the program, and so we identified, while we were saving money overall for hospital stay, we actually analyzed specific DRGs that went to the ICU, and, actually, our ICU costs went up during this period of time. We had to figure out a way to engage our intensivists.

And so what we did early in 2011 was to identify specific DRGs that went to the ICU and came up with really a substantial opportunity to save dollars by saving ICU costs. And so we brought the intensivists into the discussion. We carved out the ICU costs for discharges and made the intensivists responsible for this. We also married this to additional quality measures, protocol-based opportunities to reduce glucose—hypoglycemia, rather, ventilator days and a protocol for sedation. And so we've used this now to reduce our ICU costs.

And so my last slide is really just how to sustain change. The program has to be flexible. We have to use the data that we have to be able to understand opportunities to continue to improve the performance

of our physicians and of the hospital. We have to consider an opportunity to enhance incentives for physicians perhaps at the expense of procedure-based specialists.

We are now challenged to create a mechanism to reward other physicians involved in the care of our patients, consultants, emergency-room physicians. We haven't quite figure out a way to do that yet.

We are now looking at no-pay readmissions, MI, CHF and pneumonia, to try to bring this into the program to minimize those readmissions, and other quality measures as well.

And then, finally, we really believe that pay-for-performance is going to become pay-for-outcome. We're going to look at longitudinally other outcome measures to determine whether our program of gainsharing can improve our performance down the road. Thank you.

WESLIE KARY: Okay. Thank you very much. We're going to do just a very short Q&A session now, and there's a couple of general questions that I wanted to answer.

So, first of all, if you want to queue up a question, please go ahead and do so using the Ask-a-Question button at the bottom of your screen.

Secondly, the slides will be posted on Monday, and it's on our AIR site. I will read you the—and show you again the website URL a little bit later.

But let's maybe do two questions for Ms. Levin and Dr. Leitman. Maggie.

MARGARET SAVAGE: Sounds good. So this first question can actually be answered by either one of you all, but how long did it take you to put the program in place?

RUTH LEVIN: I guess I'll jump in. This is Ruth. It actually took probably a year, but that was because we were getting all of the legal opinions, doing fair-market valuations of the bonus payments. We were designing it from scratch.

Getting the program now up and running, which I've helped to do at many hospitals, is a much shorter timeframe, really, you know, three months, four months, getting the proper legal opinions, making sure that the handbooks are developed, some education is done, so that the timeframe now benefits from the earlier program development.

MARGARET SAVAGE: Great. And, Ms. Levin, this is also for you. How is cost defined for the gainsharing with the physicians? Did it include overhead? Didn't this result in prolonged discussion about allocation methodologies?

RUTH LEVIN: It did bring up discussion about allocation. We did have to look very closely at what charges were being entered into what cost centers, and we made some decisions about not including every cost center. Some cost centers—and, obviously, the associated charges, we knew there wouldn't be a lot of opportunities for the physicians to have an impact in, and so we eliminated those cost centers.

So, as I've mentioned and you've heard Dr. Leitman mention, this program is very flexible, and we were able to select those cost centers where we knew the greatest variability existed and the greatest opportunity for a physician to have an impact on the change in cost, and those are the ones that we focused on.

So you do have that option to include or not include particular cost centers, so that the physicians felt that their behavior changes would be evident in the cost savings that they could have an impact, and, therefore, gain from making those behavior changes.

MARGARET SAVAGE: Great. And, Dr. Leitman, can you speak a little bit to the main factors that kept physicians from enrolling in gainsharing?

I. MICHAEL LEITMAN, MD: Yes, it's interesting, when we asked physicians who didn't enroll in gainsharing why they didn't, initially, there was some skepticism, there was some concern, there was some fear that if they enrolled that somehow it would either affect their patient's care or that they would be perceived as being perhaps too mercenary and not professional.

But I think as more and more of their colleagues began to enroll, you know, the coffee-room chat certainly was helpful to get them to participate.

The other concern that physicians had was that people were watching what they did if they participated, when, in fact, we tried to reassure them that we're watching all physicians anyway. Whether you participate or not doesn't mean that, necessarily, you're being watched anymore or any less, that we have data. We have data on participating and non-participating physicians.

And then, finally, there are a number of physicians who could enroll, but they have so few admissions that they just didn't feel it was worth their while and so they just decided not to enroll.

But I will say that the majority of the physicians that have a large number of discharges have enrolled in the program.

WESLIE KARY: Okay. Thank you very much. That's all the time we have for questions and answers right now, but we will come back to a Q&A session.

Right now, we're going to move to Dr. Alexander, who's going to tell us a little bit about the journey that the AAMC has taken towards gainsharing. Dr. Alexander, can you see your slides?

GORDON ALEXANDER, MD: I can. Thank you, Weslie. Can you hear me?

WESLIE KARY: We can.

GORDON ALEXANDER, MD: All right. So as we entered into this bundling initiative pilot with the Association of American Medical Colleges, it became evident that almost all gainsharing is kind of a one-off approach. This is focused on a bundling initiative, not on specific cost-saving initiatives or even just internal cost savings for the hospital.

And so we attempted to design a custom approach, so that the model could be run from your own shop and with the data sources that you have, so you don't need additional data sources, be it Premier, UHC Crimson, others, internal sources.

And, basically, I first started in administrative medicine in the 90s, because I had the belief that getting physicians and hospitals on the same page was good for patients. And I think the pilot offers an opportunity with a more global look at—with the bundling—to start going down that path of being on the same end of the rope, on the same page or in the same boat or whatever your metaphor is.

So, again, this is focused on the bundling payments and not on specific initiatives.

So our objective is, not surprisingly, to use gainsharing to improve all aspects of care. By gainsharing we mean just aligning incentives by sharing financial upside. It's come about because of effective and efficient care.

I am going to talk a little bit about losses, and, you know, the idea about getting skin in the game is commonly talked about. So we'll talk about that a little bit.

People talk about incentives. Are they a good idea? Are they a bad idea? Are there disincentives and so forth? We believe that the experimentation around this is going to be very valuable.

So just to quickly talk about AAMC, there's over 405, 410 teaching hospitals that are in the AAMC and well over 100 medical schools. So you can understand that there are many different physician relationships. Even within those that have an employed group, frequently, the faculty, there are differences.

There's salaried physician, pure salary, pure productivity models, and so trying to come up with a model that works for everyone was a challenge. There probably will be no two applications of this model that are exactly alike.

Our approach to development was, you know, we had 20 active participants, 20 AMCs that were active participants, and so we started with hearing everyone's approach, worked on a principle—developed a set of principles.

Then we surveyed the members, and, based on that survey, we came up with many decision points that I'm going to talk about today.

We test drove two models. One was on a—it was kind of a fixed-fee model where there's a certain opportunity available that you could—if you hit your performance on that, you got the fixed fee and quality multipliers and so forth.

And then the model that we ended up with or that I'm presenting today is more based on just a percentage model on the Medicare. And we'll talk more about that.

So we finalized the set of principles, and then what we will do, as the convener of these 15 to 20 sites, we will put down our principles, and then each AMC will have the detail of their own approach, and so they can or won't have to work on this baseline model, but that's where we're starting.

So there are areas of divergency. Everyone thought that physician gainsharing was a good idea, but what about gainsharing in the post-acute provider? What about sharing losses?

And so I'm going to go through these individual components, because I think what you will find is that when you are going through your own gainsharing approach you will have to answer many of these questions.

So one of the questions is wouldn't it be simpler if we just had a fixed fee. If you use this implant to reduce our costs, we'll give you X number of dollars or if you reduce your length of stay, we will give you Y number of dollars.

And so we thought that probably for a specific action, a fixed fee might work. However, when we were redesigning care models, there's going to be multiple decisions in the episode, multiple providers, and so many of us felt that it would be more important if we just said let's use a percentage, and then everyone, the more work that was done, the more results, the higher that—you know, the more gain would be available.

Now, admittedly, finding an appropriate percentage presents its challenges, but once it's chosen, it seems like everyone's on the same page. We're a little worried that if you had a fixed percentage based on a guess of how much savings there might be and either the savings were far exceeded or fell way short that there may be a disconnect between the institutional and individual providers.

A second question that came up is should we just have the discharge or accountable physician or should we get all in; everyone who takes care of the patient should be a part of it.

The single accountable physician works for straightforward surgical cases, ones without complications, probably very well. However, many of the cases that we are seeing had—the surgery almost became the easy part, the more predictable part. And it was the ICU stay, the hospital stay which was where much of the variation occurred.

And so the idea of this team sport—healthcare being a team sport caused us to think that perhaps an all-in—all that take care of the patient are in, and it's not a—there's no turtle race. It's just if you take care of a patient, you're in the model.

The next decision point, which is a critical one, is what about the post-acute situation? Given the importance of the post-acute provider, do you include them in your gainsharing plan? And if you do so, how?

Now, it's complicated. Some of our members work with over 50 independent post-acute providers. Some have a home health agency as part of their system and a few even have a post-acute facility as part of their system. We did feel that gainsharing was different with post-acute providers and with physicians.

As I noted above here or on the slide, the costs that the post-acute provider have can be profoundly affected by the actions of others, both positively and negatively. And there are a couple of causes of that, people start using lower-cost settings and so there can be volume—all of a sudden volume surges on some of these. And then, again, there can be a real loss of length of stay from active physician participation.

But there is also an ability of the post-acute provider to reduce costs by their own actions, either working hard to reduce length of stay, reducing readmissions and not just sending the patient back to an acute-care setting. So there's lots of—it's a different situation we felt.

So what we thought perhaps made the most sense is to agree on a set of payments to the post-acute providers based on their actions or their outcomes. A specific reduction or length of stay in a sub-acute facility would be one example or a specific payment for getting the first home health visit within four hours of discharge.

And so having probably more like, you know, a fixed-fee perspective and then just go with it, and we'll learn how to do this, but we certainly want to get the post-acute provider in the boat.

I'll probably shift between multiple metaphors here and apologize about that.

So I did mention I was going to talk about sharing losses, and this is really a thorny issue. There are people who believe that, for post-acute providers or physicians, having skin in the game is really critical. We do believe that thoughtful conversations are critical in this thing. There are challenges. How do you get money out in Models 2, 3 or 4 from the physicians?

And so I think that, for now, we've elected to say probably losses are not in, but, over time, we may find a case.

The quality—I won't mention a lot about quality because it's been covered well in the two previous presentations. We are developing patient scorecards for all of our patient-condition groups, and we would use these same quality scorecards with the potential of adding other scores. For instance, you could put a medical record score. You could put a speed-of-consultation score, many, many things.

So, at the end of the day, all providers are in. We share—generally share with groups who could make the split within their groups with individual providers. Loss is not in, percentage of the gain for physicians, and you can read the rest of them that I've gone over.

Members can choose to go—as they make these decisions, they will go through various—they will modify the model. Probably—need to get my slide here. There it goes.

The one thing that I will touch on is what's the size of the initial pool, and with Model 2 and 3, the reconciliation is pretty straightforward. For Model 4, you have to have a shadow accounting system. For both of them you can use your traditional cost-accounting models to come up with internal gainsharing for this group of patients.

And then it's very straightforward. You just take how much you want to pay to the post-acute providers, and then the rest goes to the physicians of the gainsharing pool. You can size the gainsharing pool on how much traditionally has gone to physicians. Say they get 17 percent normally of Medicare payments. Okay. Let's give them 17 percent of all the gains.

And so you just work through these slides here, this model. You add a quality modifier. The hospital may say, you know, we'd like to double the—if we hit UHC top or Premier top decile performance, we will double the pool. The hospital—the awardee has the opportunity to do that.

So I'll call it quits on that and take any questions, if anyone has any.

WESLIE KARY: All right. Thank you very much. Let me just—I want to show everybody where they can get the slides, which is always a common question. So the slides are at—going to be posted on Monday at <http://cmmi.airprojects.org/BPCI.aspx>.

Okay. I'm going to—oh, and one other thing, if you're leaving before the questions are done, I'd really like for people to complete the survey, and I am particularly interested in any feedback that you give us on where you would like for us to go from here.

We've covered most of what we consider the core issues of building bundled payment programs, so if there is anything you would like us to address in a future ADLS that we have not or people that you would like us to bring back, please use the Survey button at the bottom of your screen to let us know that information.

Okay. We have about—a little under 20 minutes for questions. And I'm going to turn this over to Maggie to pose some questions here.

MARGARET SAVAGE: Great. We're going to start with you, Dr. Alexander. And a question came in asking you to elaborate on the statement that losses are in and what that means to the participants on the phone today.

GORDON ALEXANDER, MD: I'm sorry if I said losses are—I meant to say losses are not in the first year. There is—One of our members was hoping to ask all of their providers to take a three-percent hit. They are trying to figure out how to—up front, so that—they're trying to figure out since, on Model 2, which is their proposed model, they are trying to figure out how to get physicians to voluntarily take three percent of their fee-for-service payments and put them into some sort of incentive pool. They have not figured out yet how they are going to do that.

And that's one of the challenges of—in this retrospective assessment of getting the physicians or anyone else paid on a more traditional basis to put some sort of withhold back in when it's not being taken out by CMS.

So I meant to say losses are not in. I think that, given the challenges of individual versus institutional dealing with losses, I think dealing with losses is going to be a real challenge going forward.

MARGARET SAVAGE: Okay. And one more question for you right now. Are gainsharing payments for high-volume physicians greater than for low-volume physicians, and how?

GORDON ALEXANDER, MD: Yes. Well, basically, in the model, if half the work is done by one doctor and the rest is split out among everyone else, the one doctor—because we would split by the amount of payments, that one doctor would get half the payment.

Admittedly, there is a potential disincentive or inappropriate incentive. People might worry about churning. However, if people churn, the whole pool goes away. And so with transparency and having everyone see the metrics of everyone else, I think that we can mitigate that risk. So, basically, the pool, then, for physicians is split by the amount of work they do.

MARGARET SAVAGE: Great. Thank you. And we're going to move to a question for Dr. Leitman now. Dr. Leitman, what percent of the gains did you share with the physicians? And was the gainsharing predicated on first covering all the additional costs of the program, such as administrative costs and discounts?

I. MICHAEL LEITMAN, MD: Right. We allocated 20 percent of the savings to the program. Part of that 20 percent went for the administration of the program and part of it went to the payment to physicians.

I would say it's probably about 10 to 15 percent of the dollars actually went directly to the physicians. There were obviously some costs that we had to incur, but in almost every quarter there were savings to distribute to physicians, at least some savings to distribute.

MARGARET SAVAGE: Great; and another question for you. A common perception of gainsharing programs is that it is a short-term strategy. Once the costs are stripped out, there are no more gains to share. Can you address this?

I. MICHAEL LEITMAN, MD: Yes, we clearly saw that, you know, getting toward 2010, 2011, that, as you saw on that slide that I showed, where cumulative savings—things did begin to peak out. And so that's why, having a program like this, that you have to continuously be innovative and look for opportunities to save.

So we really felt that we, again, stripped out the savings in terms of length of stay. We looked at other things. We looked at ICU costs. We looked at OR costs, and you have to be, you know, constantly looking at the data to identify new opportunities. And there are changes made in the program, you have to keep physicians aware of those changes as you move forward.

GORDON ALEXANDER, MD: I'd like to add, this whole question about sustainability, the gainsharing approach is really critical to deal with.

One of the reasons we hope a percentage of our—just a percentage of performance improvement might help. We don't know yet. I don't believe that we are very close to finding a perfectly efficient healthcare system yet.

And so if you get the physicians to help identify the savings opportunities and have reduction from an inflationary trend is where the gains come from. We're hoping that that might provide ongoing incentives, but Dr. Leitman is right. This is a really big challenge. If you are relying on gainsharing to produce savings, then you better be very innovative.

MARGARET SAVAGE: Great. Thank you. And the next question is for Ms. Levin, and it asks, timeliness of reporting seems to be critical. What types of systems are you tapping to get the data for your dashboards and reports?

RUTH LEVIN: Well, we felt it had to be a simple process, and requiring the hospitals to come up with new ways of generating data was not going to be workable or sustainable.

So this program actually just goes off of UB data, so it's data that the hospitals already produce and have readily available. That's what makes it so simple.

The timing and how regularly that hospital can produce the charges and pull them, submit them for running through, you know, we used a system with a company called AMS, who was able to take the data and move it into—because we weren't on APR-DRGs when we started.

They would move each of the costs into APR-DRGs, obviously assign benchmarks, compare them to the cost. But the data that is used is simple, UB data that the hospitals are already producing. They don't have to do any additional work.

MARGARET SAVAGE: Thank you. Dr. Leitman, in one of your slides, the cumulative savings really shows an uptick after about two years. Can you comment on that?

I. MICHAEL LEITMAN, MD: Sure. This is actually where we began a concerted effort for physicians to meet with physicians to understand their particular report card, their particular dashboard.

Prior to that, physicians would get a dashboard in the mail. They'd get a check in the mail and a letter. And I must say that having spoken to them since that time; they really didn't understand the program.

This is the time when we began face-to-face meetings with our physicians and really allowed them to understand not only how they perform, but ways in which they can improve their performance. And, likewise, they advised us in terms of things that we could do, obstacles that they had in terms of getting patients through the system and through the hospital more efficiently.

So we use that peer-to-peer interaction to not only have a dialogue, but also to get some feedback in terms of things that the hospital could do to facilitate the care of their patients.

MARGARET SAVAGE: Thank you. And so, next, we have another question for you. As a free-standing, skilled nursing provider interested in reducing readmission rates to the hospital, and the fact that many patients are sent to the emergency department of the hospital, what role can emergency rooms MDs play in reducing readmits and working to send the patients back to the skilled nursing facilities?

I. MICHAEL LEITMAN, MD: That's a little bit difficult for me to answer. You know, we haven't had an experience or a track record of emergency room physicians in this program, and we have discussed it, and, certainly, there are lots of efficiencies that they could provide, not only to our organization, but to referring organizations, such as skilled nursing facilities. But I'm not sure that there are any programs out there that have addressed this particular need.

GORDON ALEXANDER, MD: There are a couple of spots that have gotten physicians more active in rounding podiatrists and other folks in the post-acute facilities that seems to hold some promise.

But I think this is going to really challenge all of our systems as we redefine care models to include beyond the acute-care facility. And I think getting the people, the experts in those areas engaged is going to be critical.

RUTH LEVIN: We did have readmissions, though, as one of the criteria that was evaluated as part of the, quote, "quality program", to ensure that, as part of this program, we didn't see a change to the negative of readmissions happening for the patients that were involved in this program.

Obviously, that isn't addressing the specific issue of a nursing home, perhaps sending a patient that didn't need to be admitted and could have gone back to the nursing home. But it does address—you can involve some of the data on readmissions and use that in your evaluation.

MARGARET SAVAGE: Thank you. And this question, I believe, can be answered by Ms. Levin or Dr. Leitman, but if quality—if there is a gain, but quality metrics are not met, you've stated that these gains are withheld. So what ultimately happens with this gain that is withheld? Does the hospital keep it? Is it reinvested into other care redesign efforts, etc.?

RUTH LEVIN: Yes, the hospital retains those dollars as part of the overall savings that it's obviously using to pay out the doctors who didn't have quality issues.

So, you know, it is monies that still saved, and how the hospital reinvests it or uses it, you can be creative about it, you know. If it is a particular department and you want to share the savings with the department in some way, but the physicians themselves didn't get it because of the quality issue, you know, it's really up to the individual hospital to decide.

MARGARET SAVAGE: Great. And, Dr. Leitman, have you seen your savings correlate to changes in patient satisfaction?

I. MICHAEL LEITMAN, MD: We actually have been tracking—I didn't mention it, but we have been tracking HCAP scores along with the program, and we haven't really identified any correlation between patient satisfaction and the program.

I believe it was mentioned by Ruth that patients are made aware of the program when they are admitted to our medical center. But patient satisfaction, you know, it's a tough thing to correlate with anything specifically in the organization. But we haven't seen any correlation, no.

WESLIE KARY: This is Weslie. I just wanted to make one point about our losses in. If we went way back to the very first one of these sessions that we did where we had Dr. Evan Benjamin and Dr. Steven Schutzer present, Dr. Schutzer, in particular, they were talking about a model in which it wasn't a traditional gainsharing model. It was a physician co-management agreement.

And they had made a point that they thought it was very important that everybody participate in the gains and losses equally. That was the way that they had specifically structured that.

So it may be that these gainsharing programs that we've described today are more about the carrot than the stick, as Ms. Levin said, but there are arrangements out there also that include the losses in a different structure.

Maggie, do we have one more question that we want to ask? Are we—you've been very efficient in your question responses.

MARGARET SAVAGE: Indeed. One question that came in and was asked in a couple of different forms were for Ms. Levin around what recommendations and lessons learned from physician hospital gainsharing do you maybe have for implementing gainsharing between hospitals and independent post-acute facilities?

RUTH LEVIN: Well, I think, clearly, understanding the processes of each of the diagnoses, the day-to-day activities that are involved in the most efficient care of any of these patients, whether it involves post-acute or not, are universal.

So that the lessons that we've learned, focusing on the step-by-step detail analysis of what a patient needs, what they get on day one, day two, and day three, compared to a best practice can be implemented even with post-acute providers involved, so that the same methods of analyzing costs, quality, benchmarks, establishing benchmarks based on best practice for any one of the diagnoses that would be involved in any one of the bundles—and that includes, obviously, analyzing the costs post-discharge, you know, what physicians are consulted post-discharge, what post-acute services are used, what facilities, perhaps, whether it be a nursing-home PT, etc., understanding what the best-practice goal is, having a way to monitor the actual utilization of those services and reporting back to all the providers involved and knowing the costs of each and when you've achieved the benchmark that's been established—really crosses all gainsharing programs, whether the focus is just on inpatient or does involve all of these services.

So it comes down to sharing data, having the data, setting a benchmark, communicating that benchmark, and then giving regular feedback to all the providers involved as to, are you hitting the benchmark? What are the obstacles to hitting them? How far are you from the benchmark? and making sure that the goal is communicated, the doctors, the PT, whoever it is that's involved knows what their

opportunity is to get a bonus and really, you know, keeps an eye on that and how they're performing, I think really translates across several of these bundles.

WESLIE KARY: That strikes me as a very nice closing remark, and so we're going to stop with the questions right now.

I want to thank all of our presenters one more time, and I'm going to, one more time, show you where the slides will be available come Monday at <http://cmmi.airprojects.org/BPCI.aspx>.

I need to also say, again, that the views expressed in these presentations are the views of the individual speakers and do not necessarily reflect the views or policies of the Centers for Medicare and Medicaid Services.

The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.

I also want to give you, one last time, the email address where you can send suggestions about the curriculum, and we are very interested in hearing from you about other topics that you would like to hear addressed in a future webinar, and I hope that every one of you will complete the survey when you close out today. Thank you very much to everyone and that concludes our webinar for today.

OPERATOR: Thank you. That does conclude today's webinar. We thank you for your participation. You may now disconnect your lines and have a great day.

END OF TRANSCRIPT