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VOICEOVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Dr Adam Striker, your host and editor. Today we're discussing alternative payment models with two guests. Both are well situated to shed light on this complex topic. First, Dr. Jonathan Gal, Associate Professor and System Medical Director of Off-Site ASC Anesthesia at Mount Sinai. And secondly, Dr. Gordon Morewood, Professor and Chair of the Department of Anesthesiology at Temple University. Drs. Gal and Morewood, welcome to the show.

DR. JONATHAN GAL:

All right, great to be here.

DR. GORDON MOREWOOD:

Thanks for having us.

DR. STRIKER:

Let's start with the basics. What are Alternative Payment Models? Dr. Gal, can you give us a big picture introduction to Alternative Payment Models or APMs?

DR. GAL:

Sure, I'm happy to. So, alternative payment models are essentially any sort of payment models that go beyond the traditional fee for service method. Fee for service is what most of us, as anesthesiologists, are used to. You provide a service, anesthetic services for a surgical procedure, or other sort of procedure, you wind up sending the different CPT codes that are associated with that, and those get

reimbursed based on the conversion factor – base units, plus time units, times the conversion factor. That's what you get back. That's your fee for service.

Alternative Payment Models are ones that can start off at the individual level with pay for performance or even penalties. They can even escalate into episodes of care, such as bundled payments for things like total joint replacements. Or they also include alternative models at the population level, too, such as accountable care organizations or capitation payments.

And so, in each one of these types of methods, one of the most common areas that most providers are familiar with is probably the ones that are associated with government payers such as Medicare and Medicaid. When it comes to Medicare, they have this thing called the Quality Payment Program, which was an act and is part of MACRA, the Medicare Access and CHIP Reauthorization Act of 2015. That really accelerated this, this whole transition in provider payments from fee for service, volume-based payments, to payments increasingly tied to quality or value-based metrics.

Inside of MACRA, there's two main tracks. There's the MIPS track, the Merit-based Incentive Payment System, which has multiple different measures and a couple of different categories. And then there's also MIPS APMs, so MIPS Alternative Payment Models and then advanced APM, which are a whole nother part of that track then. The advanced APMs take not only the upside risk of potential bonus payments, but also downside risk as well. Whereas if you came in above a certain cost metrics, you'd wind up having to pay penalties back.

Going back on that, that individual level, anesthesiologists since 2017, when they were eligible to submit measures for MIPS based on certain volume thresholds as far as Medicare beneficiaries and, and dollars and stuff, would submit six quality measures, a couple performance improvement activities, interoperability, things of that sort. You'd do that each year, and then you wind up getting bonus payments relative to your total score on those MIPS payments two years later, so you submit your measures for 2017, your 2019 claims to Medicare will then come back with a certain bonus, depending on how well you performed in 2017. And that same two-year gap has gone forward, so 2018 performance, you get paid based on those on your 2020 claims and so on.

DR. STRIKER:

Can you explain bundles?

DR. GAL:

The bundles are the episodes of care, which essentially take an, an entire episode revolving around usually a, a surgical procedure, although they've also done it around medical cases too, such as congestive heart failure admissions, end stage renal disease, and that sort. But the ones the most relevant anesthesiologist would obviously be surgical ones. So, for a bundle for a total joint procedure, the main activating procedure would be the, let's say, a, a total hip replacement. So, anything that happens relative to that total hip replacement, usually in the first 30 days before that, pre-op testing, consults, EKGs, all that sort. The services that are rendered during the actual episode of care inside the hospital, the surgeon's fees, anesthesiologist, physical therapy, the facility, implants, all those things get rolled into that. In addition, things post-op-care wise then too, whether they go home with a home health aid, they go to a skilled nursing facility, suppose they have a readmission, unplanned ED visits or whatever it might be, pneumonia, could be anything. All those then, inside that episode of care, which is usually a, a 90-day period, would all get pulled together as a target price that, that your facility and your geographic area, the target price for the total joint would be $30,000, and so you'll do total joints all throughout the year, suppose you do 1,000 of them throughout the year. Each one of those you want to have the average be at least $30,000 or less. If you came in below $30,000, suppose the average wound up being $26,000 for all of your episodes, that included all those different services, you know, the readmissions, skilled nursing facility, the facilities and stuff like that, then you'd have $4,000 in savings. The target price was $30,000, your actual price wound up being $26,000, $4,000 in savings. Half of that would go to Medicare. Half of that would go to the individuals on the care side, so, you know, surgeons, the facility and hopefully the anesthesiologist too, hopefully they've been at the table to negotiate those (sic) sort of metrics.

At the population level, the most common type of Population Based Alternative Payment Models would be Accountable Care Organizations. So those are often most commonly with, with the Medicare Insured Savings Program. They again do, very similar to the bundles where there's a target price, however, it's a target price for all expenditures for the beneficiaries for the entire year. So instead of it being like just a thirty $30,000 target price for a total joint, it's more like you have about 10,000 beneficiaries attributed to your accountable care organization. They're supposed to cost about $100,000,000 in total beneficiary expenditures throughout the year, including pharmaceuticals, all sorts of hospital admissions, outpatient care, whatever it might be. Your Accountable Care Organization then tries to manage specific care coordination to try and limit costs as much as possible and come in below that $100,000,000 target price.

Hopefully, let's say, 90 million dollars in care total, there's $10,000,000 savings that again, you'd wind up sharing. Medicare takes about half, you take about half, and the amount that the, the ACO gets to take versus Medicare usually revolves around how well you do on certain performance metrics. And those things can be around, such as readmissions or other sorts of patient safety indicators that are part of these agreements.

I know I've mentioned quite a few governmental payers, you know, Medicare and Medicaid being some of the primary ones to involve in these Alternative Payment Models with providers and facilities. But commercial payers are also getting into this mix now, too. Many commercial payers for, especially large health systems have gotten at, at least the pay for performance metrics, which usually revolve around those quality measures, either at the facility or the provider-base level and so forth. And so that's kind of a, I know that sounded like a lot of details, but that really is a, a high-level version of just how nuanced some of these Alternative Payment Models can be.

DR. STRIKER:

Dr. Gal, thank you for that. That was a lot of specific information and incredibly helpful. Why should our listeners care about APMs? Dr. Morewood, do you mind answering?

DR. MOREWOOD:

Well, what's important for all physicians to understand, but particularly anesthesiologists, is that we are in the middle of a paradigm shift for compensation. The payers, the major payers, led ostensibly by Medicare, but the commercial payers are also getting into this space now as well, they have all realized that fee for service is a loser for them. There is no way for them to control the costs of health care, using fee for service and incentivizing physicians simply to provide discrete components of care.

What they want to do is shift to a system whereby health care systems and groups of physicians team work to develop the necessary infrastructure to produce a, a total comprehensive package of care for a patient, and APMs are sort of a stepping stone in that direction. So, the compensation is moving away from, did you touch the patient, did you touch the patient for 15 minutes and did you do three different procedures to…? Did you contribute some way to their care overall so that they actually get better and get out of the hospital faster? And this is actually a positive, I think, for physicians. A lot of physicians are, you know, reluctant to look at any change in their compensation system. But what this system will do is allow physicians to move away from focusing simply on those discrete actions that they get compensated for and towards participating in the overall planning of patient care and, and management of the systems of patient care

that were never compensated before, but were, which can truly contribute to improved patient outcomes and, and better patient experiences. So, it's, it's, it's an economic imperative that this is going to happen. These APMs are simply the first signs of, of this new compensation system, but it's a positive for physicians, so they really need to look at it that way. It's going to allow them to step away from simply focusing on billing for discrete actions that they take and focusing on the whole patient.

DR. STRIKER:

Where is anesthesiology in all of this? Dr. Gal, what do you think?

DR. GAL:

So, anesthesiology is kind of intertwined in every level of this, and what I mean by that is, I was mentioning before that there's different levels of the Alternative Payment Models, there's, there's individual or provider level, there's episode level and then there's population level. So just, you know, starting at the, the provider level, that's often where you most likely see the pay for performance type of Alternative Payment Models and, and MIPS as part of MACRA is probably the one that I think it would be most familiar to most anesthesiologists. And that's where you're, you're providing these, you know, different performance measures, you know, quality ones such as perioperative temperature management, prevention and post-op nausea vomiting, PACU and ICU transfer of care notes, smoking abstinence and so on. And those are measures that revolve around the perioperative area and, and arena and, and that you're trying to show good, adequate compliance with those measures. And then other things like interoperability having twenty-four seven electronic medical record access, patient satisfaction scores, things of that sort.

And so, you submit those sorts of measures to, you know, in that instance to CMS, to Medicare, get a performance score on that, hopefully get a bonus payment associated with it for two years later. You build that up over a certain amount of practice, and those wind up adding some substantial dollars onto your annual income and revenue for your practice.

Bundles would be the next level there. And so, in bundles, anesthesiologists really have quite a bit of involvement, especially in the surgical areas and on surgical bundles like I was mentioning for total joints. So, some practices, they have peripheral involvement in that, they're really just, they're not at the table, they're not negotiating on, you know, being part of the game sharing or potentially they're even getting ignored in those conversations, which is unfortunate. And that's why it's really important for anesthesia practices to realize how significant being at the, at the table is when these first

negotiations are happening, because inevitably a total joint can't get done without anesthesia providers being involved, right? So, certain quality measures around total joints that anesthesiologists can wind up having an impact on, regional anesthesia for them, neuraxial anesthesia for them, helping prevent readmissions, helping prevent surgical site infection with antibiotic prophylaxis, helping prevent, you know, unplanned ED visits and things of that sort. These are all areas where anesthesiologists can help contribute effort towards, you know, being involved in, in pre-op education and counseling there, being a part of the care coordination, the post-op arena, helping out with pain management post-op with rehab and things of sort. These are all different areas where anesthesiologists can show value and where many practices across the country already are. And it's important that all practices start showing that same sort of value and being, and showing that same level of participation.

And the same thing can be said then at the population level with Accountable Care Organizations that, you know, many of the measures that ACOs fall victim to are, are much more in the primary care setting, things like colonoscopy screening, flu vaccine, mammography screening, things of those sorts. But they also have quite a bit of stuff revolving around readmissions and especially around surgical types of procedures. And there are certain sorts of surgical procedures like total joint or coronary artery bypass (sic) things of the sort that are also part of ACO measures. And those are areas, obviously, you know, those cases can't be done without anesthesiologists and with anesthesiologists as the gatekeepers toward the perioperative arena, it really is imperative to get their involvement in these Alternative Payment Models.

DR. STRIKER:

What does involvement in an Alternative Payment Model look like at the level of individual anesthesiologists? For example, are there direct or indirect benefits for individual anesthesiologists who participate in these models? Dr. Morewood?

DR. MOREWOOD:

Yes. I think individual anesthesiologists are going to realize two distinct changes in the way they practice in response to these Alternative Payment Models. The first is that an, an increasing proportion of their professional effort for some anesthesiologists is going to be diverted away from bedside work with patients in the operating room and towards participating in team-based management and work on the systems that the patients travel through. So, this is going to involve sitting around the conference table with the surgeons and the internists and the nursing staff, and monitoring data for the systems that, that help take care of patients and figuring out how they need to make iterative improvements in patient care overall. And this is all about process management, and

that is going to be just as valuable as the care that we deliver to the patients at the bedside in the future. So certain members of the practice are going to have to be freed up to do that.

The other thing that is going to be quite distinct for practices participating in APMs, is the manner in which care is standardized. Standardization is a fundamental aspect of improving system performance. You have to make sure that everybody is doing the same thing before you can really figure out what are the optimal practices, and so physicians need to just sort of step back and say, you know, the value I bring to the system is not necessarily deciding whether to give vecuronium or rocuronium to this particular patient. Those kind of individual judgments probably don't add that much value. My value is making sure that the system is running minute by minute and day by day the way it's supposed to, and being able to step in when off-normal conditions occur and be able to rescue the process and rescue the patient.

So there's going to be a lot more standardization for, for individual physicians, and, and everybody's got to get on board that you've got to have team players, you know, there's always somebody who wants to do it their way. But increasingly, it's going to be difficult to provide high quality of care and the outcomes that the systems expect if you have 50 different people going in 50 different directions.

DR. STRIKER:

And what would you say to people who feel, the, the ones who might be resistant to that, the idea that this change is coming, and I'm used to practicing a certain way and I don't want to, I don't want to have to alter that much and I don't believe in it. Is there anything you can do to convince these individuals that that is coming or is it just going to be a reality that, that hits them head on at some point?

DR. MOREWOOD:

I, I think some will, will only be convinced when they feel the bumper of the bus hit their rear end. But, you know, I think a lot of people will be convinced by looking at the high performing systems around the country. When you look at the, the health care systems that are grappling with these issues and are really starting to produce top-notch patient outcomes with very low rates of readmission and very low rates of patient complications, this is how they operate. So, we all like to be rugged individuals. But the fact is, if we're not working together, if we're not working in a team, we simply can't deliver the care that our patients want and need. And that's going to come out in the statistics for the health care system in which you work. So, even, eventually the proof will be in the pudding.

DR. STRIKER:

Well, I know the ASA has prioritized the development of a MIPS value pathway for CMS consideration. Can you share what the MVP workgroup has accomplished to date and where they're going? Dr Gal?

DR. GAL:

Yeah, absolutely. So the MVPs, the MIPS Value Pathways, the framework for that essentially aims to align and connect the measures and activities across the, the quality, cost, promoting interoperability and improvement activity, those performance categories that were part of MIPS, but for different specialties or conditions. So, in addition, the MVP framework incorporates a, a foundation that really leverages the promoting interoperability measures and a set of administrative claims based quality measures that focus a little bit more on population health and, and public health priorities, and reduce reporting there then to. One of their main focuses here is that with MIPS and at the individual level for providers there, there were really quite a bit of reporting in, in silos that a patient would come in for an episode of care, say cardiac surgery, and the cardiac surgeon would report their MIPS measures, the anesthesiologists would report their MIPS measures, consultants, maybe the ICU physicians would report their MIPS measures, and it was all kind of in silos. And so now they're really trying to bring it together that for those episodes of care, such as a surgical procedure like that, it should be a, a MIPS Value Pathway where it's more reporting as a team, as a report as opposed to reporting its individuals.

And so, so ASA, they, they brought together quite a bit of the multiple committees within the ASA to help address this with CMS. There was the Committee on Performance and Outcomes Measurement and the Anesthesia Quality Institute in Economics and our Alternative Payment Model Workgroup, which both Dr. Morewood and myself serve on, and the Perioperative Surgical Home, as well.

So, the ASA MVP Work Group developed two different models for this. There was a, called a Plug and Play Model, that would be a, an innovative solution for all surgical MVP candidates to include measures specific to anesthesia, to make sure that we were always at the table for those.

And then we also coming up with another one collaborating with the American Association of Orthopedic Surgeons, one called Improving Patient Outcomes and Decreasing Cost in Total Joint Replacement of the Lower Extremity MVPs. That's a mouthful, but these are the different measures in MVP's that were proposed towards

CMS there. And so one of the seven MVPs proposed in the rule of, of 2022, just released back in July, was our Plug and Play model. It got rebranded as the Patient Safety and Support of Positive Experiences with Anesthesia MVP candidate. And so, this was rather exciting, given that only seven MVP's were proposed and ASA's anesthesia specific Plug and Play wound, wound up being one of those seven. So, by any other surgical MVP's that get promoted in the years to come, we can always have our, our ASA Plug and Play model associated with it.

CMS is looking to implement these MVP's in calendar year 2023, so we're about a year away from that happening. So, you know, come January 1st, 2023, we're going to have to start doing these. And then this all comes on the heels of, they're also trying to sunset the traditional MIPs by calendar year 2027. So they're really going to be pushing people away from the individual silo MIPs reporting into these more team based MVP types reporting.

So, I guess even for more example, I was mentioning some of the measures before about preoperative temperature management, prevention of post-op nausea, vomiting, even multimodal pain management. Those are all some of the quality measures within that Plug and Play model that we're referring to, and that is going to be one of the one that I believe that we should all be most proud of, being able to, to report that as anesthesiologists, as part of any surgical procedure that might come forward and other models with the CMS in the years to come.

DR. STRIKER:

Well, I understand the site has also been working on new resources to help anesthesiologists plug into APMs more successfully. A newly released assessment framework, for example, is designed for anesthesiologists struggling to identify whether a particular APM is appropriate for their practice. Dr. Morewood, can you tell us a little bit about the assessment and how you expect members to use it?

DR. MOREWOOD:

Sure. You know, I think this can be a really daunting task. I don't, I don't want to underplay the intimidation factor that can come into, into effect when anesthesiologists are first considering, you know, it's like approaching a new surgical procedure with a new surgeon that you've worked with before. You know, you don't know what you don't know. And these APM can be complicated. They're a completely different way of approaching patient care. They use a completely different language. And, and until you get some familiarity with, with the questions that you need to ask, it can be very intimidating.

So, the framework that's been published by the ASA is meant to lead individuals who are considering these types of models through the process, show them which questions they should be asking of themselves and of the APMs to determine whether or not it's an appropriate opportunity for them and how to structure the opportunity in a way that they can actually contribute meaningfully and succeed and, and make the patient care better and get rewarded for doing so. But it's really meant, it's meant to smooth the process out and avoid some of the trial and error that might otherwise be involved.

DR. STRIKER:

Well, Dr. Morewood, could you shed a little light on the risks involved? Can you give us an example of these risks?

DR. MOREWOOD:

Yes, it's important to understand how these new models work. Physicians have traditionally approached pay for performance as simply pay if I perform, and that was kind of the training wheels version of free market economics coming to health care. Now we're moving into an area where the payers are going to enhance the rewards that are available to us for doing a good job, much like the rest of the economy. The rewards are proportional to the risks. And so, if you don't perform, there will actually be penalties. So not only are you going to get paid to do a good job, but if you don't meet the objectives that you set for yourselves and for your group, you may actually lose money. And some of these sums, relative to the size of your practice can be, can be substantial. And so you need to approach these, these, these models with, with a sense of caution. You know, for those of you who are into finances, this is a little bit like trade, trading in derivatives so you can make lots and lots of money with some of these models if you're doing a very good job. But do not underestimate the risks of the amount of money that you might have to pay back if your performance doesn't measure up.

So, you need to be very, be very careful about how the plans are structured. You need to be careful about monitoring your performance as time moves on and making adjustments if, if things are not meeting their goals. And at the outset, look at your practice and decide how much risk are we really interested in taking on? It's, it’s not a choice that you can take lightly. If you don't participate in these models, if you don't start to tie your, your practice to performance and, and earning money, that way, you're going to be left behind economically because this is in the future, all increased spending in health care is going to be going into these types of models. So, this is where the market is going. This is where you want to be. You shouldn't pass it up lightly, but you also

need to have a, an appropriate sense of caution as you approach these, these types of models.

DR. STRIKER:

Well, Dr. Gal, can you give me an example specifically of what this risk looks like, just so that maybe everybody has a better understanding of what we're talking about?

DR. GAL:

Yeah, absolutely. I think I almost want to, I want to build on the example I was giving earlier about the target prices. So, for an episode of care for a, for a total joint, the target price for, let's say, for my institution, it's $30,000. That includes all the, the pre-op stuff, all the provider fees, surgeon, anesthesiologist, consultant, et cetera, the facility fee for the, the inpatient admission or the ambulatory surgery facility fee. And then all post-op things such as, you know, physical therapy, equipment, skilled nursing facilities, readmissions, things of that sort. And so, the target price for that would be $30000, let's say.

So, there's two methods that the payment models might play right now. They're, they're the two most common. One would be a prospective one with, with one payment to the accountable entity. So, let's say my hospital and then all the providers that are, you know, contracted with it. They would upfront pay the $30,000 and then hopefully we get all the care done under that $30,000 metric and, and we'd come out ahead.

The other one would be really on the back of fee for service, so, you know, all the providers send in their fee for service bills, the facility sends in its, its, its facility claim to (sic) the DRG payment. That's a Diagnosis Related Group Payment through the Inpatient Prospective Payment System or an inventory payment classification payment for the ambulatory surgical fee for the facility there, too. And do all that retrospective reconciliation then after the fact and see how all those, you know, payments stacked up for each episode and make sure that they all came in under $30,000 as well. And if they came in, you know, below it, then there's savings. If they came in above it, then there's losses.

So as an anesthesia practice, how do you then sit at that, at that table for those first kind of conversations, right? So, the surgeon is going to know their fees. The facility is going to know their fees. They're going to know that their readmission rate is, let's say, 20% and that the average cost of each readmission is $15,000, so they're going to be working that into their, their metrics and stuff. They typically discharge to nursing

facilities around 40% of the time. But in order to hit a target price of $30000, we're going to decrease that SNF discharge disposition to more like 15% of the time, et cetera. And they're going to be asking the anesthesia group, what are your typical fees for these types of cases? And so ,you're going to have to go back to, you know, your own spreadsheets and say, OK, it's usually these CPT codes, we've had these base unit values, and for these six surgeons that do it, they, they average this many hours to perform each procedure. So that's as many time units and that if we're doing this through Medicare, we're going to use the Medicare conversion factor for us. And then I got to keep in mind, well, you know, how often do I do arterial lines? I've got to think about those codes. How often do I do, you know, nerve blocks, peripheral nerve blocks and those post-op analgesic codes, and figure that out and say that this, this one ends up being the average anesthesia professional fee for these sorts of cases on a, you know, rolling basis. And let's go with $2,000 or something like that. And that's, so that's your contribution to the $30,000 target price.

And now, OK, if we're going to come up with savings, now we've got to find ways like, well, we can't really save too much on our professional fees, but we can help save on some of those avoidable fees. So one of the, you know, methods to help get patients, you know, home without having to, to go to a skilled nursing facility would be our peripheral nerve blocks and the ability to do, you know, physical therapy on, on the day of surgery. So you have a, you know, surgery at 8:00 a.m., trying to do physical therapy before, you know, around dinner time that night for the patient and our, you know, peripheral nerve blocks can help facilitate those sorts of things. Now this kind of ties in some of the perioperative surgical home and reducing variations of care and standardizing things to, to really help show value in all these other areas.

So those would be some of the, probably my, my best examples to dive into the risk of those sorts of things, and that, that you don't want to shave any of your professional fee, but you do want to try and contribute value in other areas that helps your, your accountable entity really reach those target prices.

DR. STRIKER:

Well, I know ASA is offering another new resource, a calculator for price modeling of prospective bundle payment. Dr. Morewood, can you tell our listeners just a little bit more about this?

DR. MOREWOOD:

Yeah, the, you know, as alluded to by Dr. Gal, the big money in these alternative payment models really comes from the cost savings that physicians can contribute to.

So, you want to reduce readmissions, reduce length of stay, reduce complications, all those sorts of things. Those all add up to big dollar cost savings, which can then flow back to the physicians. But as you're setting up these APMs, you have to make sure that you establish the price of your baseline services, your core services, appropriately. If you don't appropriately value the services that you're contributing to the care of the patients, what ends up happening is you have to eat the costs of the extra care that you forgot to include at the baseline.

So, when you're negotiating these APMs, often they'll ask you to come up with the total cost of care for a population of patients undergoing a certain type of procedure and they'll give you a certain number of patients. And what you have to do is work backwards from that and recognize that your cost of care is not just the cost of care of an individual patient undergoing atypical surgery in terms of their anesthesia time and their anesthesia base units. It also includes those other things that you bill for separately, such as invasive procedures, arterial lines, central lines. Some of these patients, depending on the type of procedures that you're talking about, may actually have true preoperative consultation, so you have to take that into account.

And then finally, you have to recognize that these Alternative Payment Models are built, as has been alluded to, mainly around episodes of care. So, they talk about a patient undergoing a total knee replacement and all of the care that's associated with that total knee replacement. So you need to figure out well, how many times when we're looking after a patient for a total knee replacement, do they come back to the operating room at some point in the 90 days after their surgery? And what does that look like? How many times do they come back to the operating room? Are they having repeated (sic) or washouts because the prostheses got infected? You have to price all of that in because if you don't, when you enter the APM, any extra care that then becomes necessary for the care of these patients, you will be paying out of your own pockets. You're going to be providing that care for free. So really, the calculator is there to assist individuals once they're at the point in the APM negotiations to figure out what their sticker price is for the, the care they're going to be providing to these patients. They have a calculator there that will help trigger their memory and remember all the things that they contribute to these patients care outside of just base units and time units for a standard case, because if you don't take those costs into account, you'll end up eating them.

DR. STRIKER:

Well, how can listeners access these resources? Dr. Gal?

DR. GAL:

So, the resources are, there's the ASA's APM Assessment Framework for Anesthesiologists and that is, along with the calculator, are soon to be released on the ASA's website at asahq.org/macra/qualitypaymentprogram/apms. That sounds like a whole mouthful. Basically, the, the easiest way to find that is on the ASA website. There's a menu bar across the top, and one of the options there says Managing Your Practice and under there, there's one that literally says APM Alternative Payment Models as an option to click. You click on that. It'll take you to the website that, that then has all these other resources for Alternative Payment Models, including these, these updated, the framework, the calculator and other sorts of resources for our ASA members.

DR. STRIKER:

Well, before I let you go, I'd like to get your thoughts on how physician anesthesiologists who are not in a leadership role might participate in the development of an APM for their organizations or their practices. Is there a role for individuals to play at the local level?

DR. GAL:

Absolutely. When it comes to an APM, it, it takes a village. You know, although you might have a Chairman or a practice President or someone else who will hopefully be at the table for all those discussions with the C-suite. They can't do it all on their own. They can't care, you know, provide the care for every one of the patients. They can't create every one of the, the care pathways and contribute to that. It's going to take, it's going to take a village, it's going to take a practice. And so there's going to be other individuals who, you know, I myself primarily take care of patients for spine surgery. I give anesthesia for a lot of lumbar fusion, scoliosis, et cetera. So, you know, I've, I've helped contribute to the care pathway for both anterior and our posterior scoliosis patients. We have leaders from our pain medicine physicians who are also involved in that. Some patients in the wards for the patients who wind up getting discharged from the PACU go on to leadership from the PACU, et cetera. It's getting all the different stakeholders that have all the different touchpoints with patients during their care while they're here in the hospital. And then also the pre- and post-op care coordination as well, and, you know, providing support as a, a two way direction not only from the C-suite and, you know, leaders of your practice on downwards to the ones who were doing a lot of the care on a day to day basis on upwards, too. It, it really is that that whole practice that it takes to, to perform well on each one of these Alternative Payment Models.

DR. STRIKER:

Well, thanks to you both for an enlightening discussion and really an informative

presentation on what is here now, and it's certainly going to be part of our practice for the foreseeable future. And so, thank you for, for sharing your, your insight and your expertise with us today.

DR. GAL:

Yeah, thank you very much, Dr. Striker. This is, it's been a pleasure. I, I know that this it's a, it's an innovative change that's coming across the specialty and in fact, coming across all of the, the health care landscape here, not only are providers dealing with it, but so are our hospitals and facilities. And I think it's crucial that anesthesiologists, just as they're at the forefront of many other areas of health care, they need to be at the forefront of payment models as well.

DR. MOREWOOD:

Yeah, thanks for having us on. The more people who understand these models and are participating actively within their institutions, the better off the specialty will be.

DR. STRIKER:

Absolutely. And, and I certainly appreciate all the hard work because I think the more people understand this, the more they hear it, it's just not going to be such a foreign concept. So the more we hear, the more we understand, the better off we're all going to be.

Well, thanks everyone for tuning in to another episode of Central Line. Please join us again next time. Take care.

(SOUNDBITE OF MUSIC)

VOICEOVER:

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