CJR: Comprehensive Care for Joint Replacement

Arnie Cisneros, PT

30+ year Post-Acute Provider (Hosp, SNF, HH)
30+ year Home Health rehab clinician
Home Health Strategic Management (2004)
Hospital 2-Home Strategic Management (2014)
Pioneer ACO (x3) – Post – Acute Strategist
Model 2 BPCI Award – DMC – DRG 469/470
JUMP – Joint Utilization Management Program

Comprehensive Care for Joint Replacements (CJR)
Comprehensive Care for Joint Replacements

The CJR model tests bundled payments for lower extremity joint replacements (MS DRG 469/470) across a broad cross-section of hospitals. The goals: better care through increased coordination, healthier patients by connecting hospitals and PAC Providers, & smarter spending by holding hospitals accountable for ALL episode costs.

Comprehensive Care for Joint Replacements

CJR seeks to rewire the acute episode for Total Joint Replacement patients through an Episodic Bundling model that alters the entire philosophy of today’s Care Continuum. By creating care programs that seek the most efficient care path in terms of the cost/value ratio, CMS can standardize care for these types of patients in terms of clinical content and costs for a complete episode.

Comprehensive Care for Joint Replacements

Through a natural evolution of the PPS model, CJR eliminates care transition restrictions, unnecessary acute inpatient volumes, silo behaviors, and vacillating cost levels. By focusing on the least restrictive and cost effective treatment, and modifying programming in response to care in real-time, new program pathways become functional.
Comprehensive Care for Joint Replacements

CJR places all clinical and financial responsibility for the entire episode with the anchor hospital. By managing all care and associated post-acute costs, care is streamlined, value is sought, and silo behaviors are eliminated. Pilot programs identified Home Health as the Provider of choice for the treatment of TJR patients. Savings are shared – CMS, MD, Hosp, PAC.

Accountable Care Organizations

An ACO is a healthcare organization characterized by a *payment and care delivery model* that seeks to *tie provider reimbursements to quality metrics* and reductions in the total cost of care for an assigned population of patients.
Care Transitions Management

Care Transition refers to the movement patients make between health care settings as their condition and care needs change during the course of a chronic or acute illness; each shift from care providers and settings is defined as a care transition.

Episodic Care Delivery
Episodic Care Delivery

The re-engineering of the acute episode derived from acuity-based expectations of patient care requirements, devoid of Provider preference, and driven by the least restrictive/costly care environment.

Silo Effect of the Care Continuum

The Silo effect refers to the lack of communication and support often found in acute care episodes. Provider types focus primarily on their own goals, often ignoring the needs of others.
Alternative Payment Methods

Alternative Payment Models (APM) are the basis of the ACA – mandated shift from the fee-for-service programming of the PPS era.

By tying programs and payment to quality and value, ACA goals are achieved and the shift from volume to value begins, and will mature and refine over time.

CMS APM projection – 90% by 2018.

Alternative Payment Methods

Alternative Payment Models represent a new set of incentives that build on the progress of healthcare over recent years. They are slated to improve the efficiency and personalization of care programming by emphasizing care coordination and outcomes by controlling costs. Early returns from APM trials or pilot programs demo improved quality/cost results.
CJR – 2016 Alternative Payment Model

- First ACA Alternative Payment Mandate
- CJR slated for 4/1/16 Kick-off
- BPCI Pilot – Model 2 – MS DRG 469/470
- 90-Day Total Joint Replacement Bundle
- Mandatory for 75 Metro Statistical Areas
- Over 700+ Hospital systems nationally
- Involves Hospital/MD/Patient Buy-In

CJR – 2016 Alternative Payment Model

- Anchor Hospital fiscally responsible 90 day
- Hospital becomes both Provider & Payer
- *CMS Target Prices limit PAC selection*
- Data – Based Approach includes silo history
- Utilization Review (UR) Model Required
- Clinical Indicators manage PAC Utilization
- Mimics Acute Care DRG Model Evolution

How Does an Episodic CJR Bundle Work?
How Does an Episodic CJR Bundle Work?

- Ortho Surgeon determines surgical candidate
- Informs patient of Episodic Bundling for this diagnosis
- MD sells positives – decreased LOS to goals
- Surgery scheduled with anchor hospital
- Hospital Admission assesses post-DC status
- Care Managers/MD/Rehab – CJR protocol
- Family/Patient educated throughout care

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How Does an Episodic CJR Bundle Work?

- Multiple DC sites chosen pre-surgically for patient
- Post – Surgery performance decides placement
- Care Transition Management – post-acute
- SNF – managed for clinical content, LOS, RUG
- HH – managed for clinical content, LOS, HHRG
- Outpatient – transportation, clinical content, Part B
- Daily Reporting required for coverage of care

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How Does an Episodic CJR Bundle Work?

- Patient management via hospital UR team
- Home Health - Flexibility, Cost, In-Home Care
- Home Health – Caregiver, Home layout, Equipment
- SNF – Traditional Concern – Cost, Re-admission, Infection
- Silo – SNF (21 days), HH (Generic Protocol)
- Silo – SNF RUGs, HH – MV, Skill issues, Re-admission
- Clinical Acuity Management - value/volume
Development of a CJR Episodic Bundle

Elements of an Episodic CJR Episodic Bundle

- Establishment of a Governance Committee
- MD Participation - Buy-in and Support
- Post-Acute Vendor Selection – Vet for CJR
- Selection of Vendor Roster – Agreement, $$
- Reduction of Post – Acute Silo Behaviors
- Development of a CJR Clinical Protocol
- Addressing Re-admissions for PAC management

90 Day Bundle Concerns – Acute vs. Sub-Acute
- Patient and Family Education & Participation
- Addressing CMS Target Pricing
- Schedule for Ongoing CJR Utilization Review
- Outpatient Management Issues
- Equipment, Care Transitions, CT Protocols
- Maturation of CJR over time
Services and Costs included in a CJR Episodic Bundle

Episodic CJR Bundle Services and Costs

• Inpatient Hospital & MD Services
• LTCH, IRF, SNF, Home Health
• Outpatient Part B Services
• Laboratory, DME Costs, X-Ray, ER charges
• Part B Drugs
• Hospice Care
• Inpatient Psych Services

J. U. M. P.
Joint Utilization Management Program

Detroit Medical Center/HHSM
J. U. M. P. - Joint Utilization Management Program

- The Centers for Medicare and Medicaid Innovation’s (CMMI) Bundled Payment for Care Improvement (BPCI) initiative
- Detroit Medical Center (DMC) was awarded BPCI Model 2
- MS DRG 469/470 – Lower Extremity Joint Replacements
- Includes acute and post-acute claims
- Three-year project that will involve pre-operative care transition planning; ends December 2016
- Straight Medicare cases (no Medicare Advantage included)
- ACA CMS MANDATE - All acute care DCs Bundled 1/1/18
- Effect on Care expected to mimic DRG Evolution
- Basis of CMS Comprehensive Care for Joint Replacements (CJR)

**CJR Fiscal Breakdown re PAC Costs**

<table>
<thead>
<tr>
<th>Statistics for DRG 470</th>
<th>30-day episode</th>
<th>60-day episode</th>
<th>90-day episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Medicare spending*</td>
<td>$18,383</td>
<td>$20,343</td>
<td>$21,125</td>
</tr>
<tr>
<td>Mean payment for PAC</td>
<td>$6,835</td>
<td>$8,339</td>
<td>$9,122</td>
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*Spending hours per hospital discharge (Acute+PAC+Physician)

**Skilled Nursing Facility (SNF) Bundle Utilization**

<table>
<thead>
<tr>
<th>Using Clinical Indicators to Reduce Post-Acute Utilization</th>
<th>SKILLED NURSING FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to BUNDLE Program</td>
<td>Initial BUNDLE Program</td>
</tr>
<tr>
<td>LOS</td>
<td>average 21 days</td>
</tr>
<tr>
<td>Average Therapy Utilization</td>
<td>600 mins/week</td>
</tr>
<tr>
<td>Cost/episode</td>
<td>$12,000 - $14,000</td>
</tr>
<tr>
<td>RUGs</td>
<td>Very High/Older High</td>
</tr>
<tr>
<td>DC Focus</td>
<td>Patient managed at Day 20</td>
</tr>
<tr>
<td>DC Focus</td>
<td>able to safely DC to HH</td>
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Home Health (HH) Bundle Utilization

Using Clinical Indicators to Reduce Post-Acute Utilization

HOME HEALTH CARE

Prior to JUMP Program  | Initial JUMP Program
--- | ---
Standard total joint protocol | Acuity based on total joint protocol
Average HHRG Total | Average HHRG Total
10-14 | 7
DC Focus | DC Focus

Average HHRG Total

1,300/episode | 1,300/episode

Reduction in Cost 40%

DC Focus

Omnibus protocol

DC Focus

ability to safely DC to OPF

Review of BPCI Pilot Program Results (How It Worked for All Participants)

Review of BPCI Results – Anchor Hospital

• Takes on responsibility (and burden) of episode
• Must add staff/costs to manage post-DC care
• Must manage MD staff as per DRGs
• Receive income loss – Re-admits, 3-day SNF
• Must establish inter-communication protocol
• Redesign challenge – Betrays Hospital DNA
• Fail to recognize Post-Acute realities re care
Review of BPCI Results – Orthopedic Surgeon

- Concern; limited exposure/role in episode
- History: post-DC care managed by case workers
- Comfortable w case worker/family/patient preference
- Reluctant to enter Bundled Episode management
- History of generic post-surgical ortho protocols
- Reluctance re Gainsharing proposition
- Some current ortho responses - uninterested

Review of BPCI Results – Sub-Acute (SNF)

- Historic TJR Post-acute Provider of choice
- Historic 21-day SNF admission LOS
- Multiple RUG billing level costs ($300-650/day)
- Concerns w SNF placement: Re-admits, Infect
- Global SNF rehab costs compare poorly to HH
- Concerns re SNF placement; DME, HH, Acuity
- Significant SNF LOS/cost reduction under CJJR

Review of BPCI Results – Home Health

- CJR Post-Acute Provider of Choice
- If focused, HH compares favorably for CJR
- HH appropriate for TJR patients on acuity basis
- Concerns re HH value proposition exist – GLOBAL programming
- 24 hour SOC – Missed Visits – Non-compliance
- Documentation for coverage – ongoing
- Focused clinical content replaces ortho protocol
- OPT movement managed outside of HH
Areas of Focus for Home Health Providers preparing for CJR

- Intake management: CJR readiness – Liaison?
- Scheduling – 24 hour SOC – Care Transitions
- OASIS accuracy essential – PPS HH value
- Control Nursing Volume and Costs – PT SOC?
- Maximum of 21 day POC – all disciplines
- Daily clinical reporting managed – coverage
- Assertive scheduling eliminates missed visits

Areas of Focus for HH Preparing for CJR

- Compliance established asap in all disciplines
- Concern re front-line clinical compliance
- Care redesign stresses all HH participants
- Ongoing clinical management required for CJR
- In-episode clinical POC modification necessary
- Internal clinical management required at kickoff
- Reinforce positive clinical performances
- Provide feedback for success