"Bad news, its curiosity"

Effect of Bundled Payments on Hospital Readmissions

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Overview

MY PERSPECTIVE

SKILLED NURSING FACILITY ADMINISTRATOR VIEWS

LITERATURE REVIEW

SUMMARY AND QUESTIONS

My Perspective

- Began practice in 2002.
- Primarily outpatient.
- Skilled nursing patients 20-30% of time.

- Patients were well stabilized in the hospital prior to transfer to SNF.
- Then sent to SNF for rehabilitation with management of medical condition.
- Typical stay “a month.”
- That was the norm for just about any hospital transfer.
- Patients knew and desired first 20 days that are 100% covered by Medicare.
- Then usually stayed another 1-2 weeks with the 80/20% coverage.
- Then home with Home Health.

- Around 2005, patients were getting discharged from the hospital “quicker and sicker.”
- Became more common to see TPN, surgical drains, PICC lines, tracheostomies, etc.
- Evolved into a Med-Surg Hospital floor of the 1990’s.

- 2016 typical stay = 8 days +/-3 days.

Skilled Nursing Facility Administrator Views

Antioch

Concord

Danville

Martinez

Pleasant Hill

Walnut Creek

Skilled Nursing Facility Administrator Views

What was the LOS for a joint replacement 10 years ago?

- "21-30 days."
- "20-45 days . . . some SNF's took advantage of it."
- "100% of patients got their fully covered 20 days."

What is a typical LOS for a joint replacement now?

- "A week."
- "12-15 days with a very near future goal of 7-10 days."
- "10 days or sooner."

How is it that patients are able to go home so much sooner?

- "Complements to the surgeons!"
- "Because the health plan case managers get them out."
- "Patients don't want to be in a nursing home.
  They would rather be home and are motivated to get there."

Skilled Nursing Facility Administrator Views

Are bundled payments a good thing or a bad thing?

- "SNF's don't want payments to come from acute hospitals."
- "The federal government needed to do something to save money,
  I'm just not sure this is the right way."
- "It's making all the postacute services coordinate with each other better,
  and that is a good thing."
- "It's good for the country and Medicare to save money,
  potentially good for patients because home is better for them if they have support,
  not-so-good for nursing homes due to the turnover and all the pressure."
- "We don't get included in the cost savings, but we sure get a lot of pressure."

Skilled Nursing Facility Administrator Views

What kind of pressure and from whom?

- "The obvious one. Having to get patients out fast, but not let them get readmitted. It's a double-edged sword."
- "Pressure to attract patients directly or via hospitals and orthopedists . . . pressure to hire an associate orthopedist."
- "Pressure to do it all so perfectly: Meet and greet, expedient rehab and discharge, but better not let the patient get readmitted."
- "No room for error. Can't allow any complication . . . blood too thick, blood too thin . . . post-op knee is red and hot in a patient with a fever, but we have to be sure it's just a post-op fever and not an infection."
- "Pressure from the elderly patients claiming they have rights to stay longer."

Skilled Nursing Facility Administrator Views

- “Hospitals, managed care plans, HMO’s, case managers, orthopedists, SNFists patients, families. It really is from every angle.”
- “Hospitals and government systems are keeping readmission statistics. But, if a patient comes to my SNF for 10 days, then goes home, then 1 or 2 weeks later gets readmitted to the hospital under Home Health care, it counts as a SNF readmission. We have no direct control or responsibility over those cases, but we are held accountable.”

Skilled Nursing Facility Administrator Views

How is this going to affect the free choice of patient's to choose their SNF?

- "That's already bad and is only going to get worse."
- "Hospitals already tell patients where to go."
- "Some hospitals tell people where to go, some do soft lobbying, some suggest you go closest to home, which is the right thing to do."
- "Hospital provides a list . . . but only some of the names are highlighted."
- "Some hospitals are good about encouraging patients to rehab closer to their home, so that their family and friends can visit, and that's important."
- "Patients are supposed to have free choice by regulation, but it really doesn't play out that way."

Skilled Nursing Facility Administrator Views

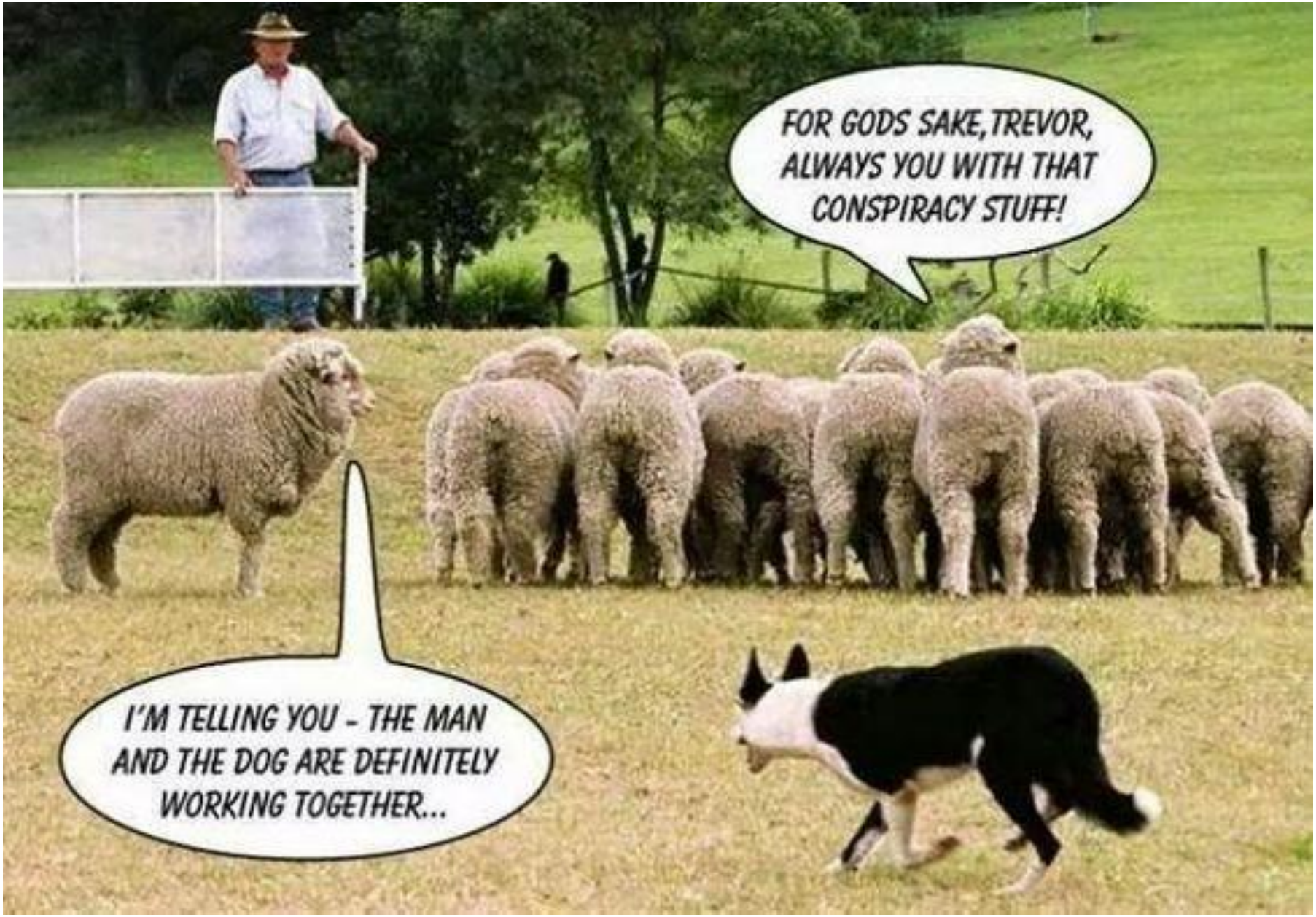
Are patients getting skimped on their care?

- "Yes. Being rushed from the hospital, then from the SNF, doesn't let them focus on strengthening, balance, range of motion, and pain management at their pace. They are individuals, not protocols."
- "No. Psychologically getting home faster is better for patients if the continuity of care is there."

Skilled Nursing Facility Administrator Views

Any closing thoughts?

- "It will be really helpful if the Medicare mandatory 3-day hospital stay is eliminated."
- "I can't believe patients are going straight home after a major joint replacement."
- "Think about it… If the health plan sends home 10 patients early, and only 1 gets readmitted, then they come out ahead."
- "We really need Medicare to do TV commercials to educate the public about all these changes. The way it is right now, we have to educate each patient and family one-at-a-time."
- "I'm just as nervous about the coming cardiac bundled payment."


FOR GODS SAKE, TREVOR, ALWAYS YOU WITH THAT CONSPIRACY STUFF!
I'M TELLING YOU - THE MAN AND THE DOG ARE DEFINITELY WORKING TOGETHER...

Literature Review

INTRODUCTION

Mandatory Bundling Has Everyone Talking

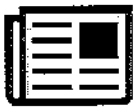
"Healthcare's Latest Game Changer: Medicare's Comprehensive Care Joint Replacement (CCJR) Program"

Forbes

"Medicare Keeps Test of Joint-Replacement Bundles Mandatory"

Modern Healthcare

"Medicare Plans to Fix Rates on Knee, Hip Replacements"



THE WALL STREET JOURNAL.

"Providers Voice Concerns About Bundled Payment Proposal"

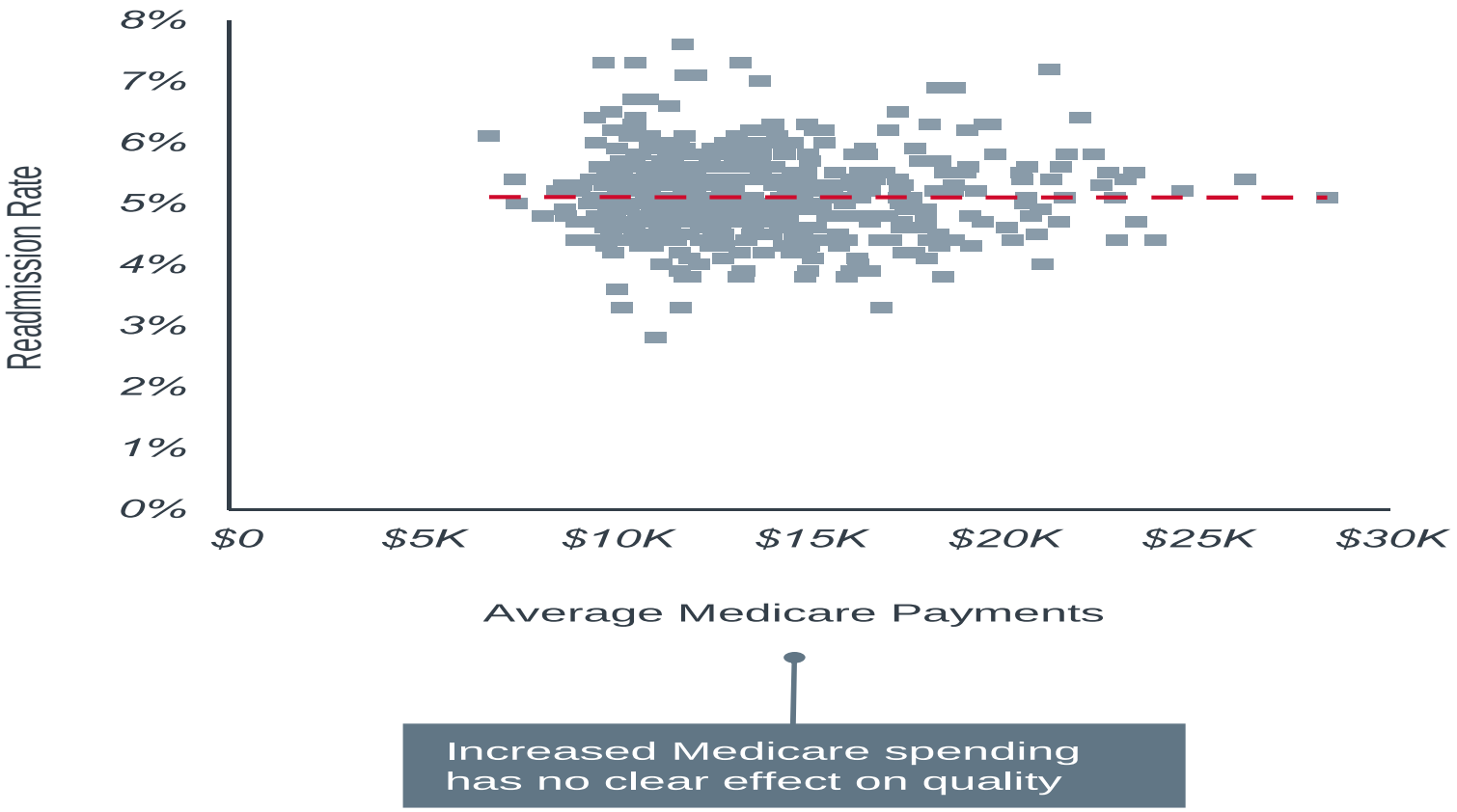
McKnight's
LONG-TERM CARE NEWS

Martyn, Paul, "Healthcare's Latest Game Changer: Medicare's Comprehensive Care Joint Replacement (CCJR) Program," *Forbes*, October 14, 2015, www.forbes.com/sites/paulmartyn/2015/10/14/healthcares-latest-game-changer-medicares-comprehensive-care-joint-replacement-ccjr-program/; Radnofsky, Louise, Armour, Stephanie, "Medicare Plans to Fix Rates on Knee, Hip Replacements," *The Wall Street Journal*, July 9, 2015, www.wsj.com/articles/medicare-plans-to-fix-rates-on-knee-hip-replacements-1436485058; Dickson, Virgil, "Medicare Keeps Test of Joint Replacement Bundles Mandatory," *Modern* Healthcare, November 16, 2015, www.modernhealthcare.com/article/20151116/NEWS/151119907; Morgan, Emily, "Providers Voice Concerns About Bundled Payment Proposal," *McKnight's*, September 9, 2015, www.mcknights.com/news/providers-voice-concerns-about-bundled-payment-proposal/article/437655/; Post-Acute Care Collaborative interviews and analysis.

Medicare Payments and Readmissions

MS-DRG 469; Hospitals in New York, California, and Texas

n=505 hospitals; 76,098 episodes



Source: Hospital Compare, https://www.medicare.gov/ hospitalcompare/search.html; Service Line Strategy Advisor research and analysis.

CJR's Mandate for Hospitals is Clear…

…Reduce Downstream Costs While Maintaining Quality

Two Major Goals Relating to Post-Acute Care

Reduce Costs

Rationale: PAC is a large, variable part of LEJR spending; a reduction will help hospitals meet their target prices

Likely Strategy: Shift patients to home health, place downward pressure on PAC LOS, avoid readmissions

Improve Quality

Rationale: PAC quality influences both total cost and the ACH quality metrics that determine reconciliation eligibility

Likely Strategy: Encourage patients to choose high-quality PAC providers, offer downstream clinical support

The Hospital's CJR Post-Acute To-Do List:

1. Identify High-Quality Post-Acute Providers
2. Understand Parameters for PAC Partnership
3. Design 90-Day Care Pathway
4. Manage Downstream Escalations

Source: Centers for Medicare and Medicaid Services, "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services," www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals; Post-Acute Care Collaborative interviews and analysis.

Post-Acute Industry Change 101

Three Things Direct Patient Care Staff Really Need to Know

Understanding the rapidly changing post-acute market can seem overwhelming—but it doesn't have to be. All direct patient care staff really need to know about value-based, post-acute care are the three concepts below, along with the answers to three questions about each concept.

Three Key Questions

- Why is it happening?
- How will it impact my work?
- How will it impact my patients?

CONCEPT 1: MARGINS ARE TIGHTENING

Why is it happening?

Significant cuts by CMS[1] across the board

$120B
Cuts already implemented under the ACA[2] for SNF,[3] home health, and hospice

$79B
Additional cuts over 10 years in proposed 2014 presidential budget

How will it impact my work?

You can find critical savings

1. Identify waste — Take note of areas of potential inefficiency and waste
2. Improve efficiency — Make a plan to solve the problem or elevate it to a leader
3. Generate cost savings — Help your organization operate more efficiently—and reinvest in patient care

How will it impact my patients?

Improved care efficiency → Lower overall cost of care → Savings passed on to patients

1) Centers for Medicare and Medicaid Services.
2) Affordable Care Act.
3) Skilled nursing facility.

CONCEPT 2: PATIENT ACUITY AND COMPLEXITY ARE RISING

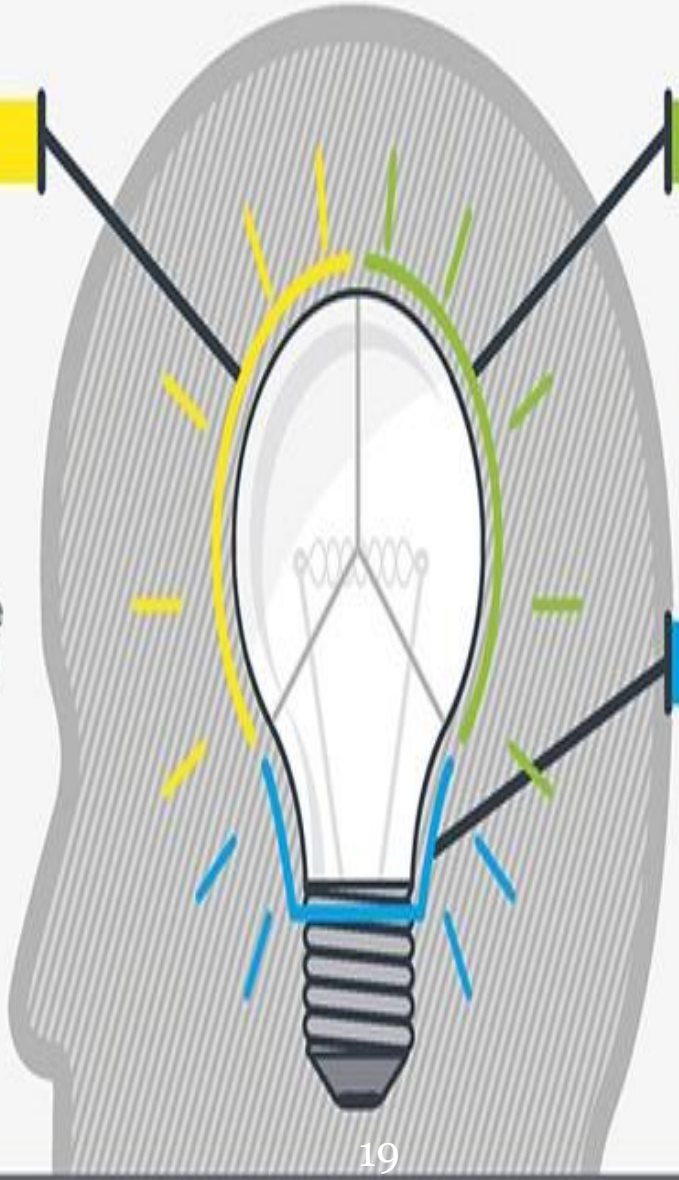
Why is it happening?

Aging population

Population is growing older, with more chronic conditions

New payment models

Changes in reimbursement are incentivizing shorter acute care length of stay, delivering care in lower-cost settings



How will it impact my work?

Sicker patients require changes in practice

- Improve medication reconciliation
- Drive cross-continuum collaboration
- Promote family education
- Obtain technical training

How will it impact my patients?

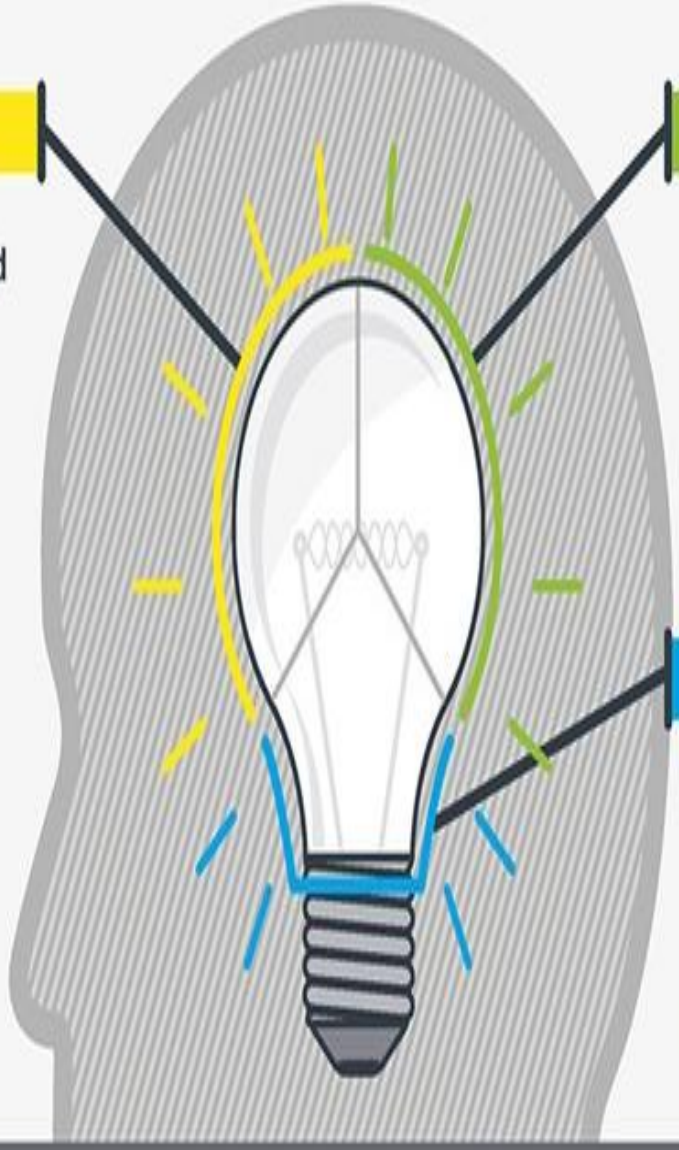
Treating complex patients on site minimizes transfers

Nursing home residents with one or more burdensome[4] transitions at end of life

n=90,228

4) Includes physical trauma caused by the transfer, confusion due to unfamiliar providers and caregivers, and inconsistent communication with patients and families about the patient's plan of care.

CONCEPT 3: PROVIDERS ARE INCREASINGLY ACCOUNTABLE FOR OUTCOMES



Why is it happening?

The old standard → **Today's new standard**

A *for effort* → A *for outcomes*

Reasons organizational accountability matters

- Value-based incentives
- Inclusion in narrowing networks
- Patients focused on value

How will it impact my work?

Priorities shift to drive outcomes

- Adopt new documentation requirements
- Support seamless care transitions
- Follow evidence-based pathways and protocols
- Enhance critical thinking skills

How will it impact my patients?

Incentives now aligned with doing the right thing

- Improve clinical outcomes
- Deliver an excellent patient experience
- Promote elevated care quality

Is Post-Acute the New Acute?

> "We have to accept, as an industry, the paradigm shift. What used to be hospital med-surg unit work five years ago is now going to be the typical short-stay patient in SNF."

Richard Tuvell, Director of Quality
Reliant Senior Care

CMS Charting a Path Toward Greater Risk

CJR, MSSP Track 3, and Next-Gen ACO Filling Out the Continuum

Continuum of Medicare Risk Models



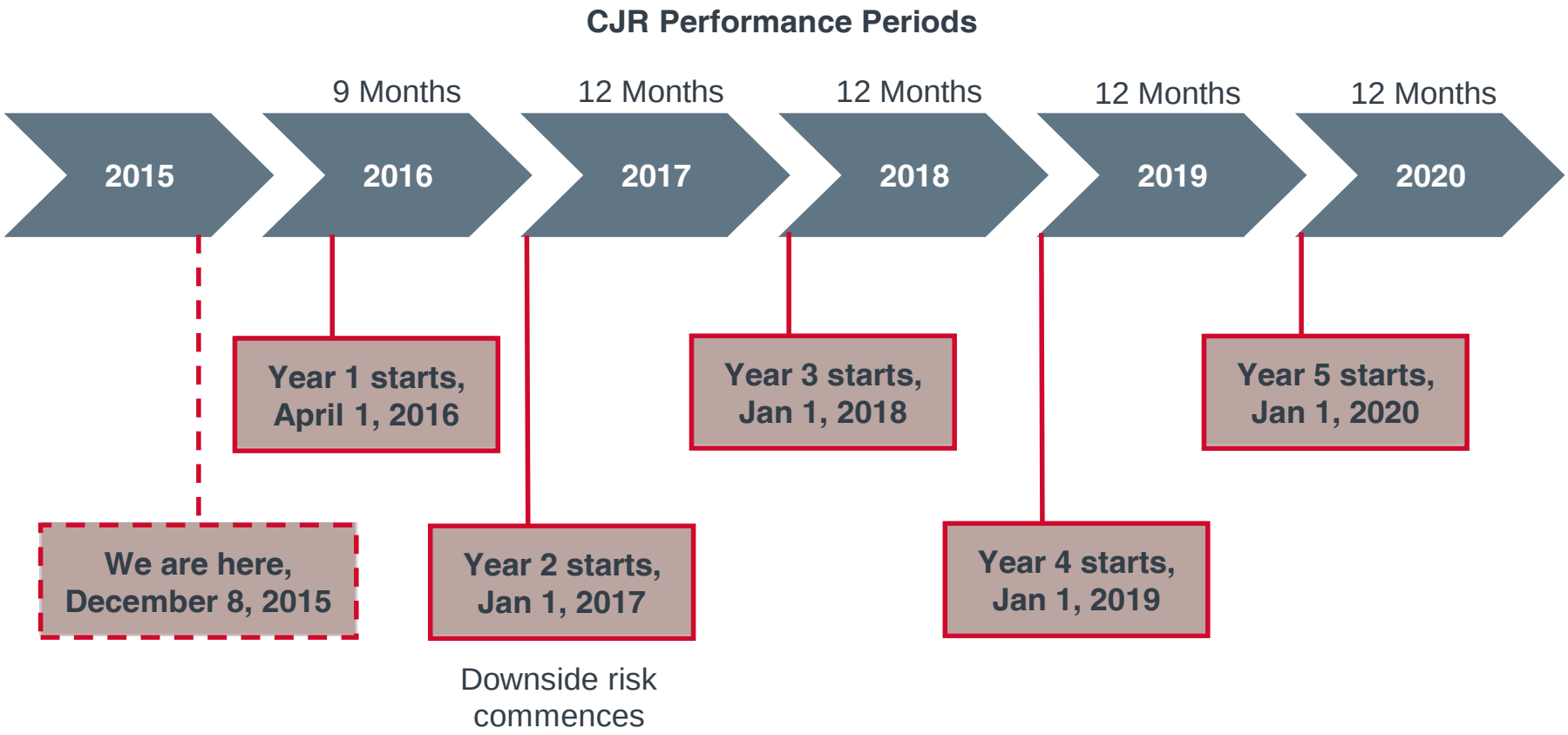

Pay-for-Performance	Bundled Payments	Shared Savings	Shared Risk	Full Risk
• Hospital VBP Program • Hospital Readmissions Reduction Program • HAC Reduction Program • Merit-Based Incentive Payment System	• Bundled Payments for Care Improvement Initiative (BPCI) • Comprehensive Care for Joint Replacement (CJR) Model	• MSSP Track 1 (50% sharing)	• MSSP Track 2 (60% sharing) • MSSP Track 3 (up to 75% sharing) • Next Generation ACO Model (80-85% shared savings option)	• Next Generation ACO Model (full risk option) • Medicare Advantage (provider-sponsored)

Increasing Financial Risk

Source: CMS, Financial Leadership Council analysis.

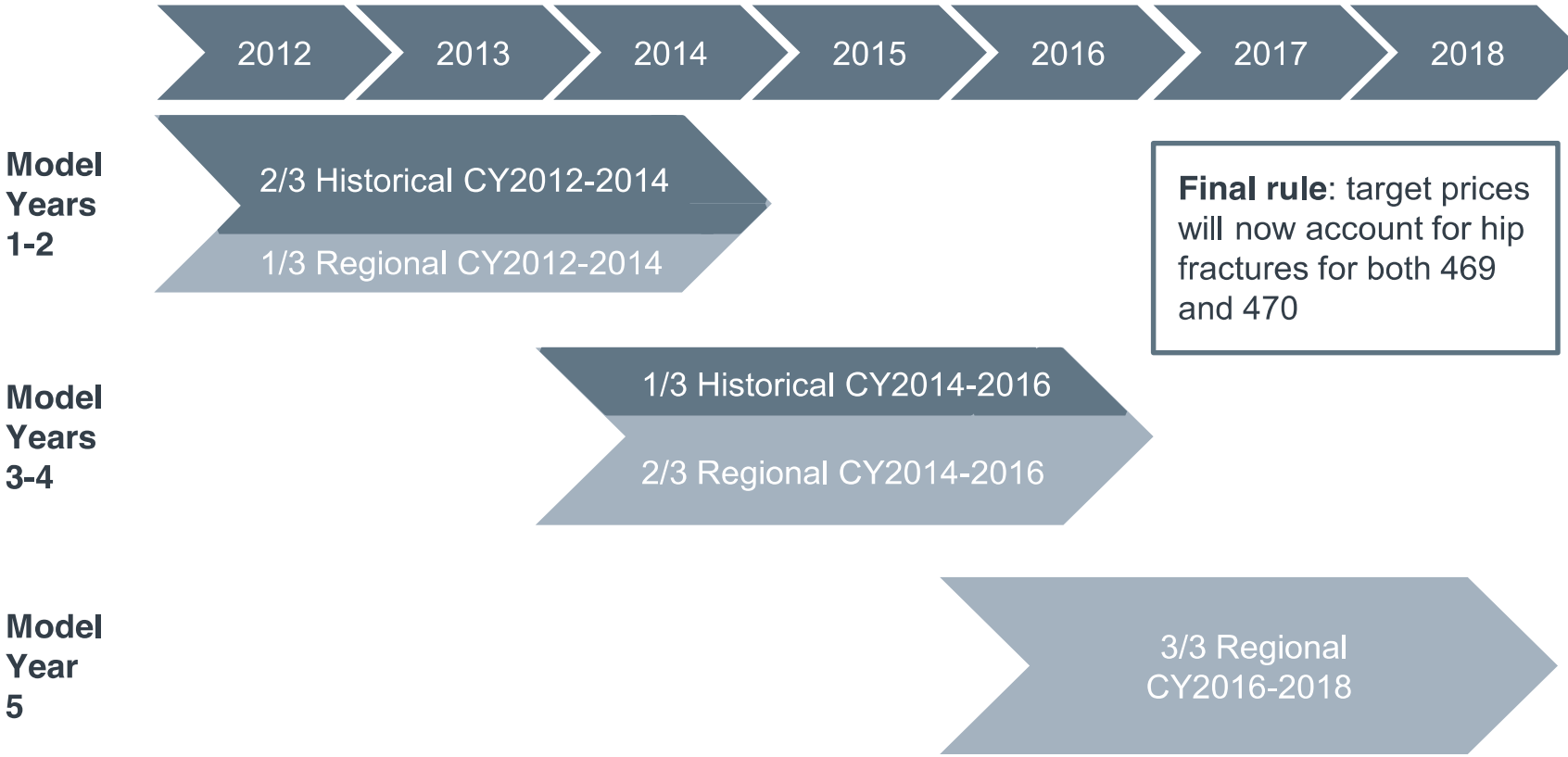
Program Starts April 1, 2016

5-Year Pilot with View to National Expansion



Target Price Based on Historical, Regional Blend

CMS Phases out Your Historical Performance from Target Price by Year 5



Target Price Updates

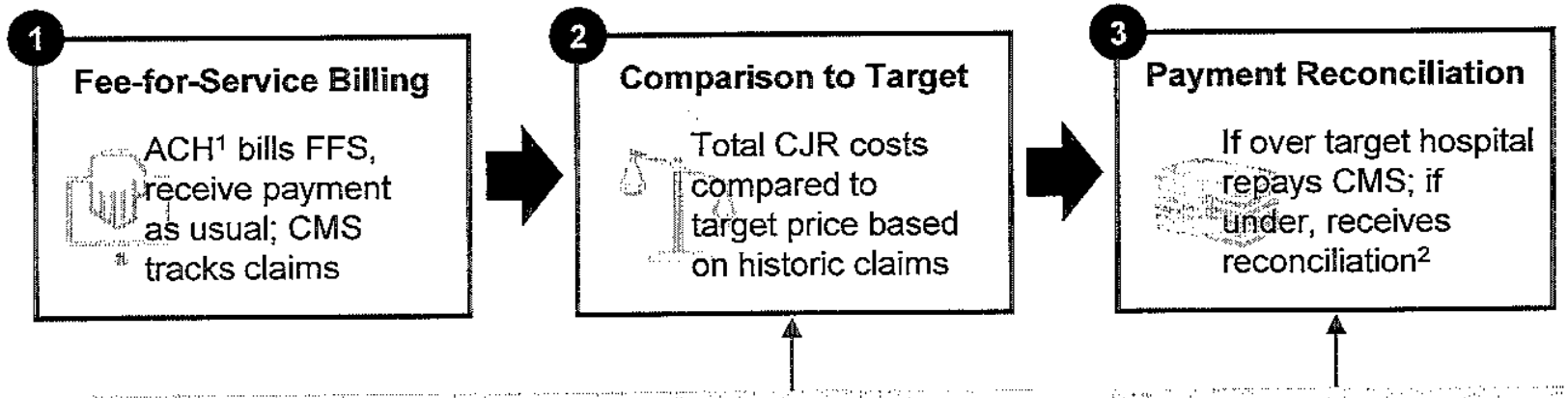
Hospitals will receive updated target prices twice per year (January and October) to account rate updates across various payment systems

Source: CMS, Financial Leadership Council analysis.

No Immediate Change in Billing

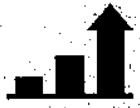
CMS Will Use Retrospective Reconciliation to Adjust Hospital Payments

Hospital Payment Process Under Comprehensive Care for Joint Replacement



Incorporates Blend of Regional and Facility Historic Claims Data

- Target price based on 3 years of historic claims, updated bi-annually for relevancy
- ACH and regional claims determine target price
- In 2018 and 2019 only regional data will be used



Phases in Downside Financial Risk

- Only upside risk in year 1, partial downside risk in years 2-3, full downside risk in years 4-5

1) Acute Care Hospital.
2) ACH must also meet certain quality standards.

Source: Centers for Medicare and Medicaid Services, "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services," www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals; Post-Acute Care Collaborative interviews and analysis.

Comprehensive Care for Joint Replacement Model

Several Key Changes in the Final Rule to Know

CJR Final Rule Highlights

- **Mandatory** for hospitals in **67 markets**, not for physicians, PACs or BPCI
- **90 day episode** covering **hips & knees** (DRGs 469 and 470) with risk adjustment for hip fracture
- Pricing based on **mix of hospital and regional benchmarks**, shifting to 100% regional by 2019
- **No downside until Year 2 (2017)**
- **Composite quality scoring methodology** determines discount level applied
- **Phase in risk and reward**: Maximum upside "stop gain" and downside "stop loss" amounts modified from proposal
- Benchmarks set annually in advance, reimbursed on FFS basis with **reconciliation at EOY**

CJR by the Numbers

5
Years the program will cover, 2016-2020

788
Expected number of participant hospitals

23%
Percent of national LEXJR[1] episodes in the program

$343m
Estimate of episodic savings over 5 years

1) Lower extremity joint replacement.

Source: CMS, Financial Leadership Council analysis.

Central Elements of CJR Bundles

	Definition	Why It's Important
 Episode of Care	All care related to MS-DRG 469 or 470 discharges during anchor hospitalization and 90 days post-discharge (all Medicare Part A and B)	The program holds hospitals accountable for financial responsibility for spending across the entire episode of care
 Target Price	CMS spending goal for an episode of care; a target that is 3% lower (discounted) than historical/regional spending performance	This is the benchmark that your episodic spending will be judged against
 Reconciliation Process	Process used to determine difference between hospital performance (actual episode spend) and target price	This is the process CMS uses to determine if it will make a reconciliation payment to you, or if you will receive a repayment
 Quality	Specific measures that CMS has defined as important indicators of quality for CJR episodes of care	Quality performance determines the discount required and whether your organization is eligible to receive a reconciliation payment

Source: CMS, Financial Leadership Council analysis.

CJR Program Waivers

Key Elements Waived to Help Test Delivery Model Changes

Skilled Nursing Facility Three-Day Rule

Starting in performance year 2, CMS will waive the SNF 3-day rule if a patient is discharged to a SNF with at least a three star quality rating in 7 of the last 12 months (ratings available at Nursing Home Compare website)

Waiver of "Incident To" Direct Supervision Requirement for post discharge home visits

Non-physician and clinical staff permitted to provide home visits - for beneficiaries that don't qualify for home health services - under general supervision (meaning physician doesn't have to be present) for CJR related discharges. Up to 9 visits may be billed under during the episode under G9490[1]

Telehealth Services

CMS waives the geographic site requirement for telehealth, allowing CJR patients to receive telehealth services no matter where they are located, even if they are not considered rural status. Remote visits (in-home) billed under new G-codes G9482 – G9489[2]

1) G9490 will have the same RVUs as HCPCS code G9187
2) Work and MP RVUs crosswalk to 99202-99205 and 99212-99215

Source: CMS, Financial Leadership Council analysis.

Literature Review

EARLY RESULTS

Literature Review

EARLY RESULTS OF A TOTAL JOINT BUNDLED PAYMENT PROGRAM: THE BCPI INITIATIVE

Cleveland Clinic (Froimson, 2013)

- The first community hospital to go live for risk during first phase (out of 450 hospitals).

	Historic	Current	Calculated Change
Discharge to home	22%	68%	↑ 46%
Discharge to SNF	78%	32%	↓ 46%
SNF LOS	11.2 days	7 days	↓ 4.2 days

Preoperative Checklist for Joint Replacement Risk

Identifying and Managing Patient Risk for Readmission and Increased LOS[1]

The checklist below, developed by Dr. Mark Froimson of Trinity Health, is an example of a comprehensive checklist that considers more than patient medical status during evaluation for surgery. The checklist includes both medical and social determinants of outcome. Flagging patients with these conditions can help providers better prepare patients for surgery and reduce risk for readmission and increased length of stay.

	Condition	if yes...	Intervention
☐	Diabetes (Hgb A1c > 7.9)		Delay and refer
☐	Smoker		Refer to smoking cessation
☐	Obesity (BMI > 40)		Refer for counseling or metabolic consult
☐	Anemia (Hgb< 12 in females; Hgb<13 in males)		Delay and refer for work up or blood management
☐	Staph Colonization (if in a healthcare facility, or a healthcare worker, or history of MRSA)		Screen and decolonize
☐	Narcotic dependence		Manage upfront, offer pain consult
☐	Anticoagulation or VTE[1] history		Evaluate and counsel
☐	Lack of supportive home environment		Social work intervention
☐	Psychiatric diagnosis		Depression , anxiety consult

1) Venous thromboembolism.

Source: Froimson, M, "Perioperative Management Strategies to Improve Outcomes and Reduce Cost during an Episode of Care," The Journal of Arthroplasty, 30 no. 3, (2015): 346-348..

Assessing Readmission Risk in Joint Replacement

NYU Langone Medical Center Hospital for Joint Diseases' Readmission Risk Assessment Tool

The following Readmission Risk Assessment Tool (RRAT) was created by researchers at NYU Langone Medical Center as part of their study on the management of modifiable risk factors prior to total joint replacement. The tool includes 8 common risk factors found in patients undergoing these surgeries, suggested interventions for each risk factor, and a numerical value denoting each factor's relative severity, with 3 being the most severe.

Risk Factor	Risk Stratification Score	Suggested Intervention
Infection (Staphylococcus Aureus colonization)	3	Every patient is screened for Staphylococcus Aureus colonization. If positive; • Treat with nasal mupirocin or povidone-iodine, chlorhexidine gluconate (CHG) wipes, and appropriate antibiotic coverage If requirements are not met, hard stop until alternate protocol is implemented
Smoking (tobacco use)	1	Enroll in smoking cessation program 4-8 weeks prior to surgery (all users)
Obesity Body Mass Index (BMI) greater than 40	3	Enroll in a nutritional counseling program, long-term weight loss program, and undergo bariatric consult
BMI of 35-39.9	2	Enroll in nutritional counseling with consideration of acute weight loss program
BMI of 30-34.9	1	Enroll in nutritional counseling program
Cardiovascular Disease Qualifying patients: • 60 years or older • History of coronary artery disease, cerebrovascular accident, peripheral vascular disease or venous thromboembolic disease • Present at least two cardiac risk factors, including: renal insuffiency (CrCl<60 mL/min), diabetes, chronic obstructive pulmonary disease, hypertension, recent smoker (less than 30 days), cancer, heart failure	1	*Patients meeting this criteria at the NYU Langone Medical Center Hospital for Joint Diseases are enrolled in a trial to help identify an effective pre-operative protocol to minimize cardiovascular events. Organizations implementing a similar risk screening tool should refer patients to the appropriate intervention to manage cardiovascular risk within their organization.*
Venous Thromboembolic Disease (VTED) History of pulmonary embolus or deep venous thrombosis	2	Inferior vena cava (IVC) filter or aggressive VTED management
Has VTED risk factors, including: cerebrovascular accident, chronic obstructive pulmonary disease, BMI>40, coronary artery disease, peripheral vascular disease, activated protein C resistance	1	
Neurocognitive, psychological and behavioral problems (including drug and alcohol dependency) Alcohol abuse or chronic active narcotic dependency	2	
Neurocognitive deficits such as traumatic brain injury (TMI), active psychiatric illness, dementia, etc.	1	
Score of 7 or more for depressing using PHQ-9 (Patient Health Questionnaire)	1	
Physical Deconditioning Non-ambulatory or needs assistance with transfers status	2	
Co-morbidities affecting physical function and ambulation	1	
Diabetes Fasting blood glucose > 180mg/dl	3	Refer to diabetic management clinic; must be corrected before surgery
Hemoglobin A1c>8	2	Referred to diabetic management clinic (endocrinologist)
Well controlled Diabetes Mellitus	1	

Source: Boraiah S, et al., "Management of Modifiable Risk Factors Prior to Primary Hip and Knee Arthroplasty: A Readmission Risk Assessment Tool," *J Bone Joint Surg Am*, *97* no. 23 (2015): 1921-1928.

Literature Review

READMISSION CAUSES

Literature Review

THIRTY-DAY READMISSION RATES AS A MEASURE OF QUALITY: CAUSES OF READMISSION AFTER ORTHOPEDIC SURGERIES AND ACCURACY OF ADMINISTRATIVE DATA

Journal of Healthcare Management (McCormack, 2013)

- Assessed medical records of all post-procedure patients readmitted within 30 days from 2007 to 2009.
- "Unplanned" readmission = any complication, surgical or nonsurgical.
- Three main causes of readmissions were:
  - 60% = Surgical site infections (most costly)
  - ~20% = Wound complications (pain, bleeding, etc.)
  - 18.2% = Medical issue/ nonsurgical complication (DVT, PE, CHF, etc.)
- Risk of readmission is increased by 55% when care is of relatively low quality.

Literature Review

INCIDENCE OF AND RISK FACTORS FOR 30-DAY READMISSION FOLLOWING ELECTIVE PRIMARY TOTAL JOINT ARTHROPLASTY

The Journal of Arthroplasty (Pugely, 2013)

- 2011 data from American College of Surgeons – National Surgical Quality Improvement Program (ACS-NSQIP)
  - 8,105 THA patients with overall readmission rate = **4.2%.**
  - 11,814 TKA patients with overall readmission rate = **4.6%.**
- Causes:
  - wound infections
  - sepsis
  - thromboembolic
  - cardiac
  - respiratory

Literature Review

- THA predictors:
  - obesity (P = 0.008)
  - steroid use (P = 0.037)
  - bleeding disorder (P = 0.002)
  - dependent functional status (P = 0.022)
  - high ASA class (P < 0.001)
- TKA predictors:
  - age (P = 0.002)
  - male gender (P = 0.03)
  - cancer history (P = 0.008)
  - elevated BUN (P = 0.002)
  - bleeding disorder (P < 0.001)
  - high ASA class (P < 0.001)

Literature Review

FACTORS AFFECTING READMISSION RATES FOLLOWING PRIMARY TOTAL HIP ARTHROPLASTY

The Journal of Bone & Joint Surgery (Mednick, 2014)

- 2011 data from American College of Surgeons – National Surgical Quality Improvement Program (ACS-NSQIP)
- 9,411 patients with CPT 27130 Primary Total Hip Arthroplasty
- **3.65%** thirty-day readmission rate
- Risk factors:
  - Diabetes ($P < 0.001$)
  - COPD ($P < 0.001$)
  - Bleeding disorders ($P < 0.001$)
  - Preoperative Blood Transfusion ($P = 0.035$)
  - Corticosteroid Use ($P < 0.001$)
  - Dyspnea ($P = 0.001$)
  - Previous Cardiac Surgery ($P = 0.002$)
  - Hypertension ($P < 0.001$)

Literature Review

- PREOPERATIVE
  Independently associated risk factors
  - Higher likelihood of readmission:
    - BMI > 40
      - odds ratio, 1.941 [95% CI, 1.019 to 3.696]; P = 0.044
    - Preoperative Corticosteroid Use
      - odds ratio, 2.928 [95% CI, 1.731 to 4.953]; P < 0.001
  - Lower likelihood of readmission:
    - High Preoperative Albumin
      - odds ratio, 0.688 [95% CI, 0.477 to 0.992]; P = 0.045
- POSTOPERATIVE
  Independently associated with a higher likelihood of readmission
  - Surgical Site Infection
  - Pulmonary Embolism
  - Deep Venous Thrombosis
  - Sepsis

Literature Review

READMISSION RATES

Literature Review

DISCHARGE DESTINATION AFTER REVISION TOTAL JOINT ARTHROPLASTY: AN ANALYSIS OF POSTDISCHARGE OUTCOMES AND PLACEMENT RISK FACTORS

Journal of Arthroplasty (Keswani, 2016)

- 2011 to 2013 American College of Surgeon's National Surgical Quality Improvement Program (ASC-NSQIP)
- 9973 Revision Total Joint Arthroplasty (RJR) patients

- DISCHARGE DISPOSITION:
  - 66% to home
  - 23% to SNF
  - 11% to IRF

- 30-DAY READMISSION RATES:
  - 6.1% from home
  - 9.3% from "nonhome" (SNF or IRF)

- CONCLUSION:
  - 1.3 times more likely to be readmitted from SNF vs home
  - 1.51 times more likely to be readmitted from IRF vs home

Literature Review

DOES DISCHARGE DISPOSITION AFTER PRIMARY TOTAL JOINT ARTHOPLASTY AFFECT READMISSION RATES?

Journal of Arthroplasty (Bini, 2010)

- **90-day** readmission rates for 9150 patients following THA or TKA (2001-2004)
- If discharged to SNF (versus home), then had higher odds of hospital readmission.

		90-day Readmit Rate
3432 THAs		2.9%
LOS 3.61		
	2840 DC to home	2.4%
	592 DC to SNF	5.2%
5718 TKAs		3.5%
LOS 3.63		
	4863 DC to home	3.3%
	855 DC to SNF	4.4%

Literature Review

- If discharged to home, then a surgical complication was the most common cause.
- If discharged to SNF, then a medical complication was the most common cause.
- Patients discharged to SNF are sicker and therefore predisposed to complications.
- This study was consistent with other articles that found that the majority of patients discharged to SNF were older, female, and with a higher ASA score.

Fig. 1a ASA classification	
ASA I	Normal healthy patients
ASA II	Patients with mild systemic disease
ASA III	Patients with severe systemic disease that is limiting but not incapacitating
ASA IV	Patients with incapacitating disease which is a constant threat to life
ASA V	Moribund patients not expected to live more than 24 hours
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes

Literature Review

THIRTY-DAY READMISSION RATE AND DISCHARGE STATUS FOLLOWING TOTAL HIP ARTHROPLASTY USING THE SUPERCAPSULAR PERCUTANEOUSLY-ASSISTED TOTAL HIP SURGICAL TECHNIQUE (SuperPATH)

International Orthopaedics (Gofton, 2015)

- 479 SuperPATH THA cases reviewed - multicenter, retrospective
- "Reduced 30-day all-cause readmission rates (**2.3%** vs **4.2%**) and more were routinely discharged home (91.5% vs. 27.3%)"
- "Allows for same day ambulation and no standard postoperative patient restrictions." (mean hospital length of stay of 1.6 days)
  - Implication → Further minimizes discharges to SNF
- 91.5% discharged to home, 4.1% discharged to SNF

Literature Review

- "Has the potential to significantly reduce post-discharge costs."
- Decreased 30-day readmissions plus fewer patients discharged to post-acute care facilities suggested a combined cost reduction of 66.2%.
  - Implication → Increased competition amongst SNFs for fewer patients
- "Higher patient turnover potentially allows for more procedures to be performed."
  - Implication → Will Medicare save or spend more?

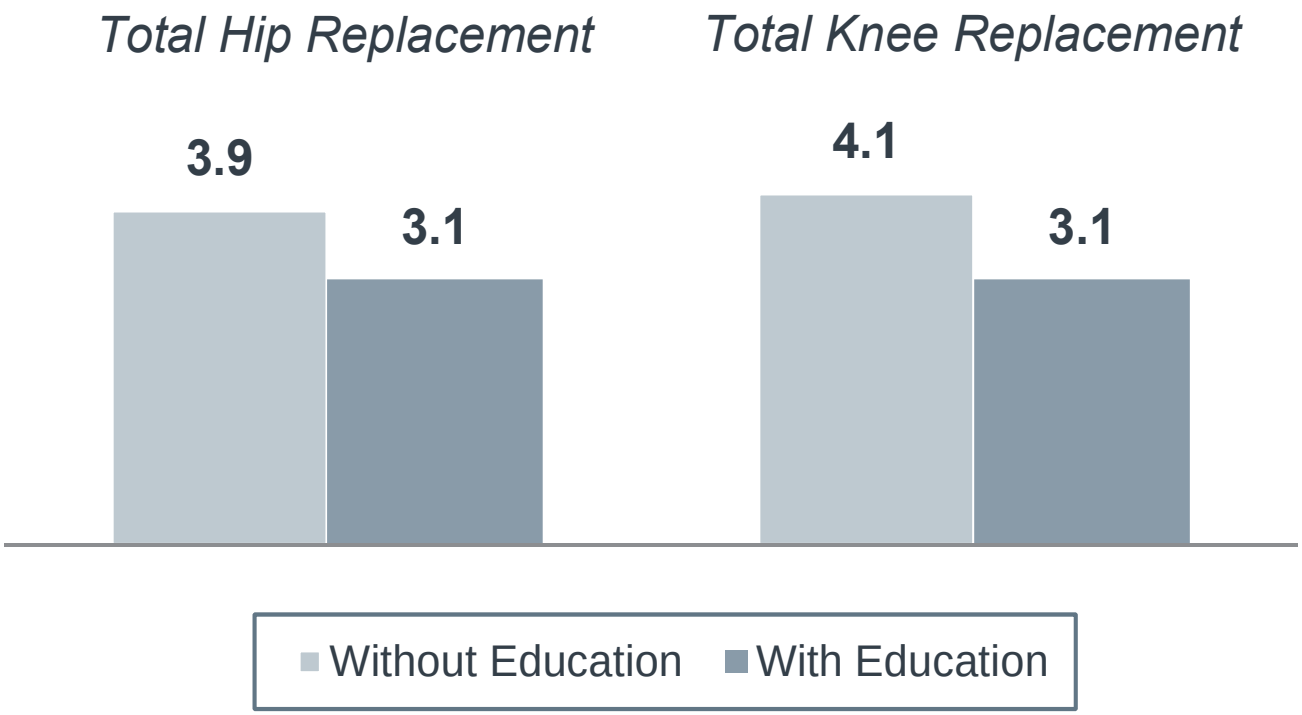
Literature Review

PREDICTING READMISSIONS

Impact of Pre-surgical Education on Length of Stay (Days)

2010

n=177 total hip replacement patients; n=143 total knee replacement patients



Source: Mancuso, et al., "Randomized Trials to Modify Patients' Preoperative Expectations of Hip and Knee Arthroplasties," *Clinical Orthopaedics and Related Research*, 466(2), 2008: 424-431; Yoon et al., "Patient Education Before Hip or Knee Arthroplasty Lowers Length of Stay," *The Journal of Arthroplasty*, 25 (4), 2010: 547-551; Service Line Strategy Advisor research and analysis.

Predicting Location after Arthroplasty Nomogram (PLAN)

Cleveland Clinic's Joint Replacement Discharge Prediction Tool

Patient Information to Collect

- Patient Age: ____ Patient BMI: _____
- Procedure: ☐ Primary TKR ☐ Primary THR ☐ Revision of TKR ☐ Revision of THR ☐ Bilateral TKR
- Active Comorbidities
  - Heart Disease: ☐ No ☐ Yes, Active Monitoring ☐ Yes, but No Active Monitoring
  - Diabetes: ☐ No ☐ Yes
  - Hypertension: ☐ No ☐ Yes
  - COPD: ☐ No ☐ Yes
  - Joint Infection ☐ No ☐ Yes
  - Arthritis, multiple joints: ☐ No ☐ Yes

- Pre-op ambulation: (select one of the following)
  - ☐ Independent Community Distances
  - ☐ Impaired Community Distances
  - ☐ Impaired Home Distances
  - ☐ Minimal or Wheelchair Bound

- Projected post-op weight bearing (select one)
  - ☐ Full or weight-bearing as tolerated
  - ☐ 50%-75%
  - ☐ 25%
  - ☐ Touch-down weight bearing or non-weight bearing

- Number of entry steps: _____
- Bathroom location: ☐ 1st floor ☐ 2nd floor Bedroom location: ☐ 1st floor ☐ 2nd floor
- Caregiver support: ☐ Inconsistent/none ☐ Occasional available (2-4 days/week) ☐ Consistent/live-in (5-7 days/week)
- Home location: ☐ Up to 150 miles away ☐ Over 150 miles away

Literature Review

PREDICTING PATIENT DISCHARGE DISPOSITION AFTER TOTAL JOINT ARTHOPLASTLY IN THE UNITED STATES

Journal of Arthroplasty (Barsoum, 2010)

- 517 patient charts
- Created the nomogram
- 1993 LOS 8.0 days for lower extremity TJA
- Decreased by about 50%
- 2005 LOS:
  - 3.8 days for TKA
  - 4.7 days for Revision TKA
  - 4.2 for THA
  - 6.1 for Revision THA
- Year 2030 projected growth increases:
  - 673% TKA
  - 174% THA

Literature Review

- TJA Revision burden to double by 2015 (knees) and 2026 (hips), which is approximately 10% per year
- Preoperatively predicting a patient's discharge disposition is valuable to the hospital, clinicians, patients, and families in preparing for postoperative care.
- A study found that the main concern of the patient was the notion of feeling safe. The absence of a caregiver was found to be a significant factor (P=0.002). Little attention is given to psychological and social factors. It is not uncommon for patients to feel reluctant about directly home after arthroplasty.
- The ability to preoperatively counsel a patient and give them the expectation that they will likely be physically ready to go home may help alleviate patient reluctance and improve readiness for discharge and overall satisfaction.
- Hence . . . The "PLAN" & The Nomogram
- rcalc.ccf.org (free calculator)

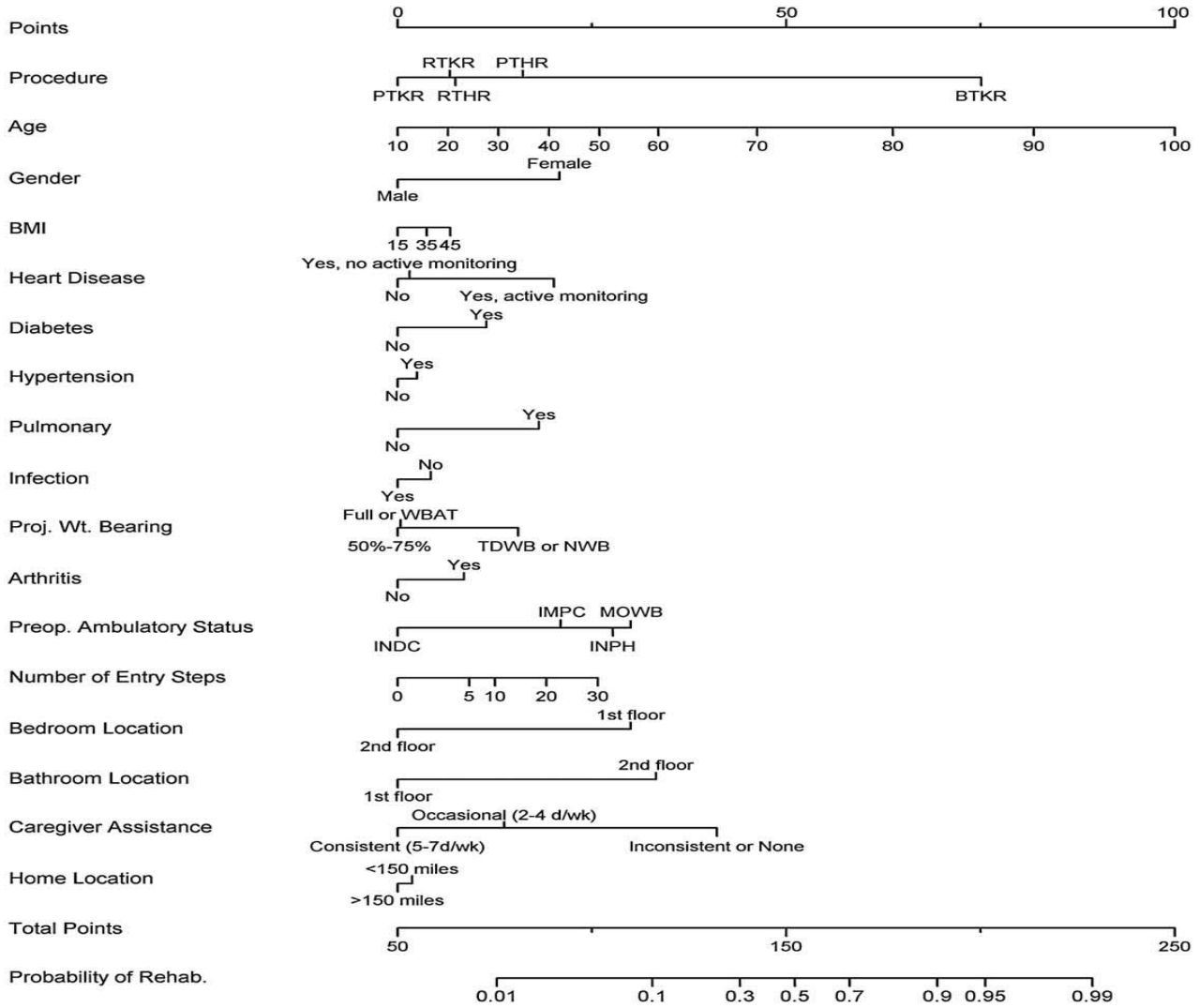


Fig. 2. Predicting Location after Arthroplasty Nomogram. Instruction for physician: locate the patient's procedure on the Procedure axis. Draw a line straight upward to the Points axis to determine how many points toward not being discharged directly home the patient receives for his or her procedure. Repeat this process for the remaining axes, each time drawing straight upward to the Points axis. Sum the points achieved for each predictor and location on the Total Points axis. Draw a line straight down to find the patient's probability of not being discharged directly home. PTKR indicates primary total knee replacement; RTKR, revision total knee replacement; PTHR, primary total hip replacement; RTHR, revision total hip replacement; BTKR, bilateral knee replacement; WBAT, weight bearing as tolerated; TDWB, touch-down weight bearing; NWB, non–weight bearing; INDC, independent community distances; IMPC, impaired community distances; IMPH, impaired home distances; MOWB, minimal or wheelchair bound.

Literature Review

DOES “6-CLICKS” DAY 1 POSTOPERATIVE MOBILITY SCORE PREDICT DISCHARGE AFTER TOTAL HIP AND KNEE ARTHROPLASTIES?

Journal of Arthroplasty (Menendez, 2016)

- 2014
- 744 patients undergoing primary THA or TKA

- Activity Measure for Post-Acute Care (AM-PAC) “6-Clicks” Mobility Score

– Versus –

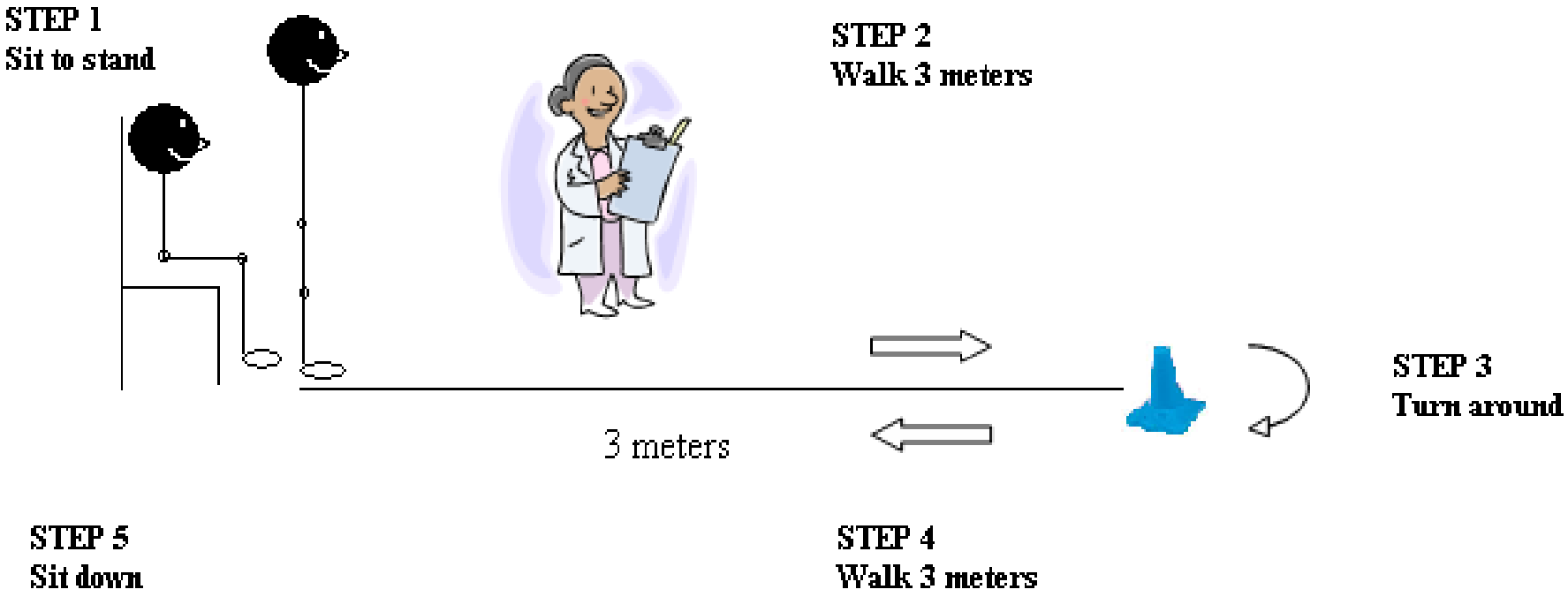
- Base Model (Age, Sex, Charlson Comorbidity Index, Procedure Type)

- Score collected by Physical Therapists within 24 hours of surgery

Literature Review

- Determined the utility in predicting:
  - 1) Discharge disposition after TJA
  - 2) Accuracy in estimating prolonged hospital stay
  - 3) Readmissions
  - 4) Emergency department visits
- RESULTS: AM-PAC “6-Clicks” superior to the base model
  - 1) 22% better
  - 2) 32% better
  - 3) No significant difference
  - 4) 27% better
- CONCLUSION:
  - AM-PAC “6-Clicks” is a valid, simple tool for predicting disposition after TJA.
- www.AM-PAC.com
- www.PAC-Metrix.com

The TUG


STEP 1
Sit to stand
STEP 2
Walk 3 meters
3 meters
STEP 3
Turn around
STEP 5
Sit down
STEP 4
Walk 3 meters

Timed Up and Go (TUG) Test

Purpose

Use this tool prior to joint replacement surgery to identify patients with a high risk of falling post-surgery. Patients' performance can be used to inform discharge location.

Overview

This tool walks through how to administer a Timed Up and Go (TUG) Test with joint replacement patients. The tool provides performance benchmarks to help caregivers evaluate patients' risk of falling.

Notes and Considerations

- The TUG test was originally developed to assess mobility of the elderly; however, it is also commonly used to test other populations, including joint replacement patients.
- Although the TUG test does not explicitly recommend a discharge location, caregivers can use patients' performance on the test to help determine the ideal discharge location.

Equipment:

- Armchair
- Tape measure
- Tape
- Watch

Setup:

- Have the patient sit correctly (hips all of the way to the back of the seat) in a chair with arm rests. The chair should be stable and positioned such that it will not move when the patient moves from sit to stand.
- Place a piece of tape or other marker on the floor 3 meters away from the chair so that it is easily seen by the patient.

Instructions:

- On the word "GO" the patient should stand up, walk to the line on the floor, turn around, walk back to the chair, and sit down.
- The examiner should start timing on the word "GO" and stop timing when the patient is seated again correctly in the chair with his or her back resting on the back of the chair.

Notes:

- The patient should wear his or her regular footwear.
- The patient should walk at his or her regular pace.
- The patient may use any gait aid normally used during ambulation but may not be assisted by another person.
- The patient is allowed to use the arm rests during the sit – stand and stand – sit movements.
- There is no time limit. The patient may stop and rest (but not sit down) if needed.
- The patient should be given a practice trial that is not timed before testing.

Interpreting Results:

- Results correlate with gait speed, balance, functional level, and the ability to go out. Results can change over time.
- Normal, healthy elderly usually complete the task in ten seconds or less. Very frail or weak elderly with poor mobility may take 2 minutes or more.

Normative Reference Values by Age		
Age Group	**Time (in seconds)**	**95% Confidence Interval**
60-69 years	8.1	7.1-9.0
70-79 years	9.2	8.2-10.2
80-99 years	11.3	10.0-12.7

Cut-off Values Predictive of Falls	
Group	**Time (in seconds)**
Community dwelling frail older adults	>14 associated with high fall risk
Frail older adults	> 30 predictive of requiring assistive device for ambulation and being dependent in activities of daily living

Risk Assessment and Prediction Tool (RAPT)

Six question tool identifies patients most suitable for home discharge

Calculating RAPT Score:

- Answer each question and enter score in the far right column, then enter total score in the bottom row.

Question	Scoring	Enter Score Here
What is your age group?	50-65 years: 2 66-75 years: 1	
What is your gender?	Male: 2 Female: 1	
How far, on average, can you walk? *(A block is 200m.)*	Two blocks or more: 2 1-2 blocks : 1 Housebound (most of the time): 0	
Which gait-aid do you use, more often than not?	None: 2 Single-point stick: 1 Crutches/frame: 0	
Do you use community supports, e.g., home help, meals-on-wheels?	None or one per week: 1 Two or more per week: 0	
Do you live with someone who can care for you after your operation?	Yes: 3 No: 0	
	TOTAL	

Interpreting RAPT Score:

- Score interpretations below are based on Hansen VJ, et al., which does the Risk Assessment and Prediction Tool Predict i Discharge Disposition After Joint Replacement" which validates score in a U setting.
- Predictive accuracy may be low for scores between 7 and 10; consider supplementing with PLAN tool if not already

Score	Time (in seconds)
< 7	Higher-risk patient, patient should consider post-acute rehab or SNF settings
7-10	Intermediate-risk, use additional tools to predict setting and reduce patient risk
>10	Low-risk patient, should prepare for home discharge

Source: Hanson VJ, et al., "Does the Risk Assessment and Prediction Tool Predict Discharge Disposition After Joint Replacement?," Clin Orthop Relat Res., 473, no. 2, (2015) 597–601: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4294888/; Physician Executive Council interviews and analysis.

Some Functional Assessment Tools

Test / Measure
Acute Care Index of Function **(ACIF)**
Activity Measure for Post-Acute Care™ Inpatient Short Form **("6 Clicks")**
Functional Status Score in the ICU **(FSS-ICU)**
Physical Function in the ICU Test (Scored) **(PFIT-s)**
Performance Oriented Mobility Assessment **(POMA)**
Berg Balance Scale **(BBS)**
Timed Up and Go **(TUG)**
Timed Walking Tests **(6MWT & 2MWT)**
Gait Speed
Function in Sitting Test **(FIST)**
Resources for functional tests & measures
Smartphone/Tablet apps with functional tests & measures

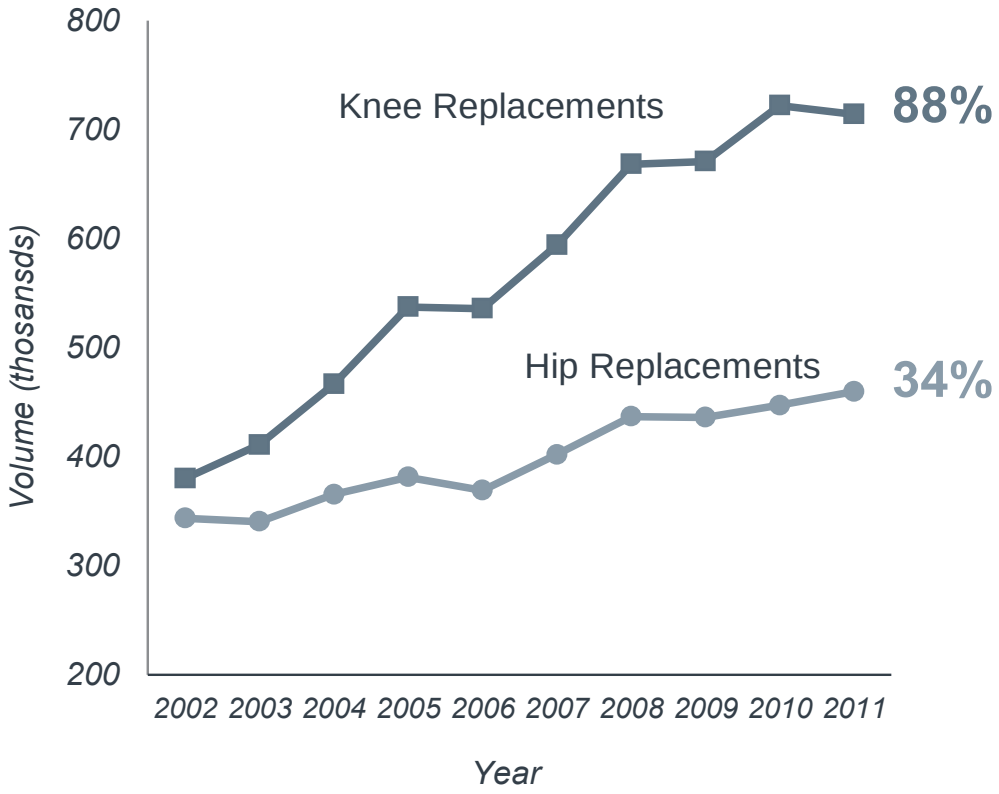
Literature Review

COSTS

Increasing Threat to Joint Replacement Profitability

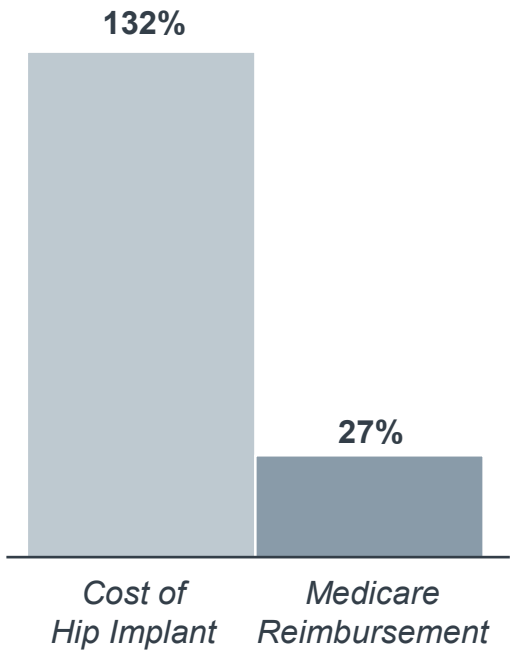
Need to Contain Costs for High-Volume Procedures

Orthopedic Procedures Growing Rapidly



Procedure Costs Outpace Medicare Reimbursement Rates

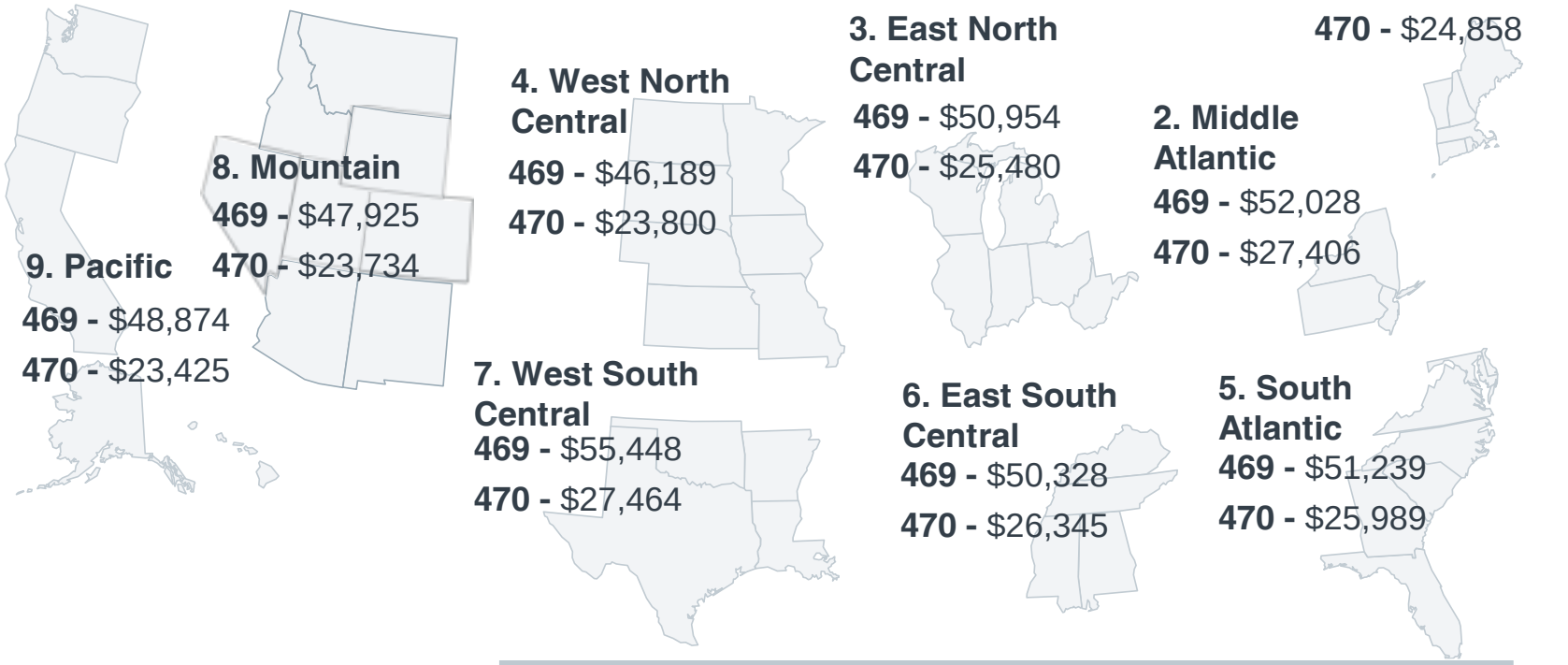
Growth Rates, 1991-2008



Source: HCUP Nationwide Inpatient Sample (NIS); Wilson NA, et al., "Hip and Knee Implants: Current Trends and Policy Considerations," *Health Affairs (Millwood)*, 27 (2008): 1587–1598; Physician Executive Council interviews and analysis.

Census Divisions Determine Regional Boundaries

Average Regional Historical Episodes[1] CY 2012 – CY 2014



1. New England
469 - $47,928
470 - $24,858

2. Middle Atlantic
469 - $52,028
470 - $27,406

3. East North Central
469 - $50,954
470 - $25,480

4. West North Central
469 - $46,189
470 - $23,800

5. South Atlantic
469 - $51,239
470 - $25,989

6. East South Central
469 - $50,328
470 - $26,345

7. West South Central
469 - $55,448
470 - $27,464

8. Mountain
469 - $47,925
470 - $23,734

9. Pacific
469 - $48,874
470 - $23,425

Assigning MSA splitters based on population
CMS will assign facilities within MSA to a census divisions based on distribution of population within a given MSA

1) Displayed figures do not reflect removal of special payment provisions outside of IPPS (VBP, HAC, Readmissions, DSH, IME etc.), nor include risk adjustment for hip fractures
http://innovation.cms.gov/initiatives/ccjr/

Source: CMS, Financial Leadership Council analysis.

Device Costs Vary Greatly

$1.8K - $12.1K

Range of device costs for unilateral knee replacements at 61 California hospitals

Source: Robinson J, et al., "Variability in Costs Associated with Total Hip and Knee Replacement Implants," *Journal of Bone and Joint Surgery*, (94)18, 2012; Service Line Strategy Advisor research and analysis.

Bundled Payment Expands Hospital Responsibility for Costs, Patient Care

Portion of Spending Under Hospital Responsibility Under Fee-for-Service and Bundled Payment

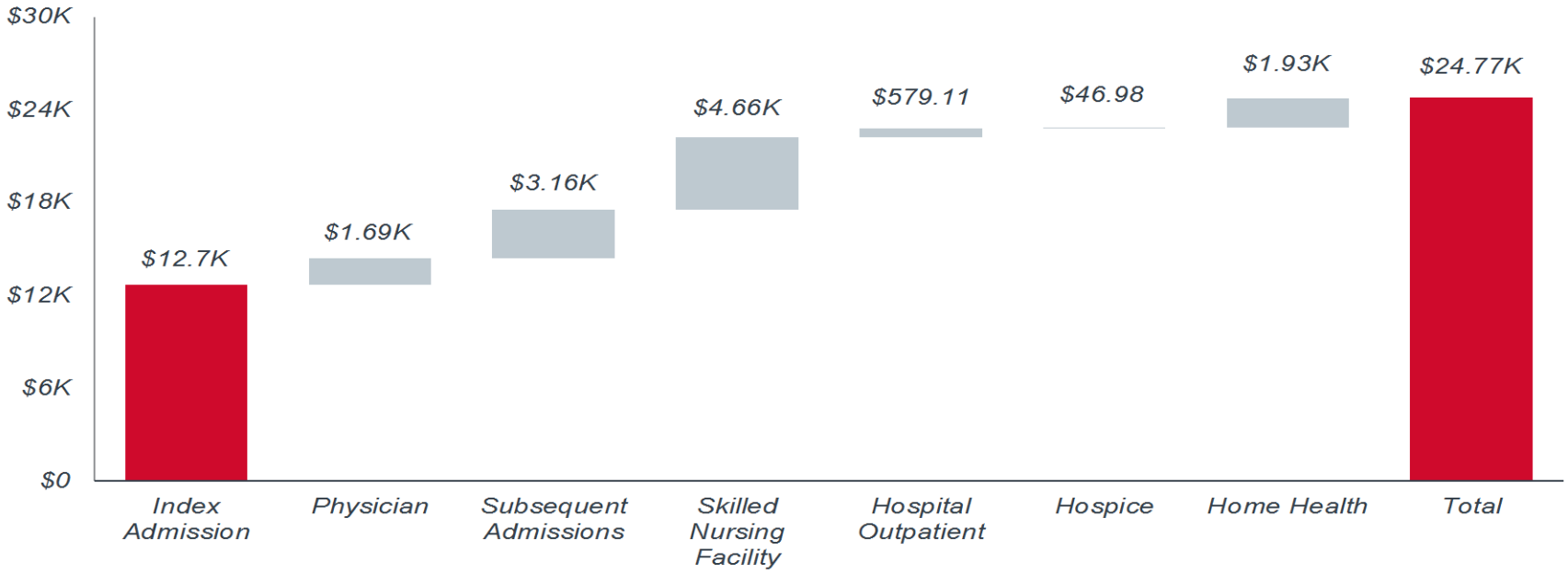
Hospital responsibility for spending under fee-for service → **Hospital responsibility for spending under bundled payment**

$12.7K National median cost of index admission, 2013

$24.7K National median cost of 90-day care episode, 2013

Episode Costs for Major Joint Replacement of the Lower Extremity

2013, 90-Day Episode Including Index Admission

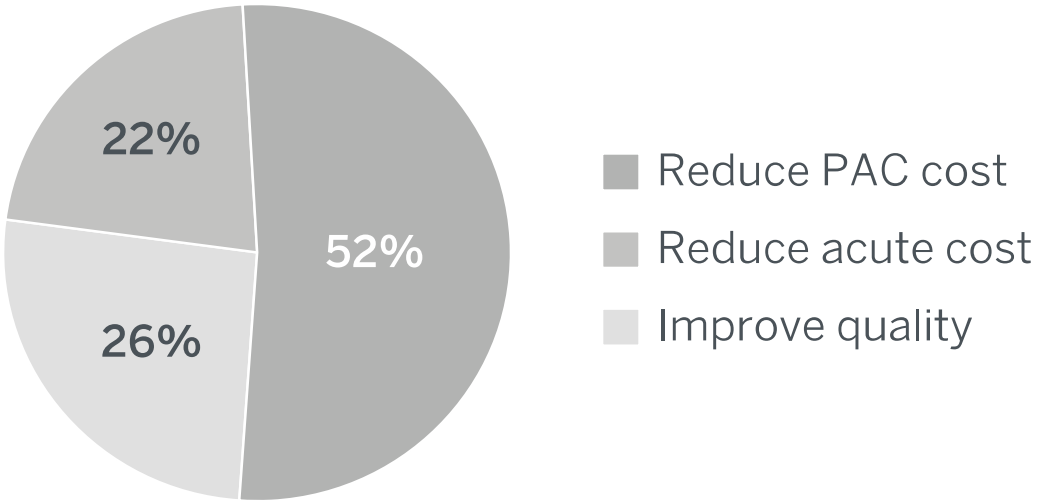


Source: Episodic Cost Profiler, The Advisory Board Company, http://www.advisory.com/Research/Health-Care-Advisory-Board/Tools/2013/Episodic-Cost-Profiler; Service Line Strategy Advisor research and analysis.

Hospitals' Top Priority for CJR[2] Success

Advisory Board Member Poll

n=266



Literature Review

MEASURING THE HOSPITAL LENGTH OF STAY/READMISSION COST TRADE-OFF UNDER A BUNDLED PAYMENT MECHANISM

5th Biennial Conference of the American Society of Health Economists (Carey, 2014)

- "The cost of an additional day of stay was offset by expected cost savings from an avoided readmission in the range of 15% to 65% of the cost of the additional day."

Literature Review

COST ANALYSIS OF TOTAL JOINT ARTHROPLASTY READMISSIONS IN A BUNDLED PAYMENY CARE IMPROVEMENT INITIATIVE

Journal of Arthroplasty (Clair, 2016)

- 2013 January through December
- 664 Primary TJA patients
- 90-Day Readmission Window

- SURGICAL COMPLICATIONS:
  - 54% of THA readmissions
  - 44% of TKA readmissions

- Average cost:
  - THA $36,038 (range $6,375 - $60,137)
  - TKA $38,953 (range $4,790 - $104,794) ($27,979 without outlier)

Literature Review

- MEDICAL COMPLICATIONS:
  - 46% of THA readmissions
  - 56% of TKA readmissions

- Average cost:
  - THA $22,775 (range $5,678 - $82,940)
  - TKA $24,183 (range 3,306 - $186,069) ($11,682 if eliminated outlier)

Literature Review

COST BURDEN OF 30-DAY READMISSIONS FOLLOWING MEDICARE TOTAL HIP AND KNEE ARTHROPLASTY

The Journal of Arthroplasty (Bosco, 2014)

- 2,572 patients from 2009 to 2012 with THA, TKA, rTHA, rTKA
  - $17,103 = estimated cost of each readmission of THA (= 4.3% cost burden)
  - $13,008 = estimated cost of each readmission of TKA (= 2.8% cost burden)
  - Readmission rate = **2.4%** for both.
- FORMULAS:
  - Cost Burden = 30-Day Readmission Cost/Total Medicare A Payment
  - Readmission Cost Ratio (RACR) = Cost Burden/Readmission Rate

Literature Review

- THA RACR = 1.8.
  This means each 1.0% increase in readmission rate,
  results in 1.8% increase to cost burden.

- TKA RACR = 1.2.
  This means each 1.0% increase in readmission rate,
  results in 1.2% increase to cost burden.

- Using Gofton numbers* 4.2% → 2.3% RR = $32,496 saved per 100 cases THA

Literature Review

BUNDLED PAYMENTS IN TOTAL JOINT ARTHROPLASTY: TARGETING OPPORTUNITIES FOR QUALITY IMPROVEMENT AND COST REDUCTION

Clinical Orthopaedics and Related Research (Bozic, 2014)

- 250 Medicare beneficiaries followed
- Mean cost = $25,568 for primary TJA, $50,648 for revision TJA.
- Readmission rate = **10%**
  (**5%** for primary, **33%** for revisions with major comorbidities)
- 36% of the cost was attributable to post-discharge payments.
  - Over 80% of these costs were attributable to discharging patients to post-acute care facilities (70%) and readmissions (11.2%).

Literature Review

- ETHICS:
  - “Bundled payments also have the potential to create incentives to withhold care. Therefore, bundled payments require quality monitoring to assure that providers do not skimp on care.”
  - “Bundled payment methodologies could encourage hospitals and physicians to avoid providing care for more complex patients with multiple comorbid diseases, leaving this vulnerable population with limited access to care. Strategies tested in other bundled payment models such as outlier payments, required reinsurance, and gain/loss caps can help to mitigate the incentive to ‘cherry pick’ only healthy patients” (Sood).

Literature Review

ETHICS

Influence But D n't Restrict Patient PAC Choice

Hospitals May Provide Beneficiaries Incentives to Aid Recovery

Hospitals Cannot Restrict Patient Choice

Providers are not allowed to provide patients with a restricted provider list, must offer all PAC options

Hospitals Can Recommend PAC Providers and Sharing Arrangement Partners

"Participant hospitals may recommend preferred providers and suppliers, consistent with applicable statutes and regulations…"

Beneficiary Considerations

- *Hospital must*; notify patients that they are a CJR participant
- Explain participation will not impact care
- Notify that freedom of choice is unaffected
- Inform patients of partners they have financial arrangements with

Patient Engagement Incentives

- CMS Finalizes proposal allowing hospitals to provide " n-kind" patient engagement incentives
- Incentives must be related to care and provide preventive care or advance clinical goals
- Hospitals can lend technology/equipment worth up to $1,000, must retain ownership of items >$100 value

Source: CMS, Financial Leadership Council analysis.

Literature Review

WHAT FINANCIAL INCENTIVES WILL BE CREATED BY MEDICARE BUNDLED PAYMENTS FOR TOTAL HIP ARTHROPLASTY?

Journal of Arthroplasty (Clement, 2016)

- 553 Medicare patients (age 65+)
- Primary Unilateral THA
- Financial data collected over a 2-year period
- Only looked at costs of hospitalization and readmissions (not postacute care)
- RESULTS - Increased costs were associated with:

		Regression coefficient
Advanced Age	(P < 0.001)	$155/yr
Elevated BMI	(P = 0.005)	$107/BMI point
Due to Fracture	(P < 0.001)	$2,775
Higher ASA Score	(P < 0.001)	$2,137/ASA grade
MCC's (Medicare modifier for major complications)	(P < 0.001)	$4,892/complication

Literature Review

CONCLUSION:

- Bundled payments should be adjusted upward by the aforementioned amounts (regression coefficients above).
- Furthermore, these figures likely underestimate costs in many bundling models which incorporate larger proportions of postdischarge care.
- Failure to adjust for factors affecting costs may create barriers to care for specific patient populations.

Literature Review

MOVING FORWARD

Waivers Offered Under Comprehensive Care for Joint Replacement

3-DAY STAY WAIVER[5]

Overview	*Limits*
Waives the requirement of a 3-day inpatient stay for subsequent SNF stay coverage	Available only for SNFs with 3-star rating or higher; CMS will keep an updated list of eligible SNFs

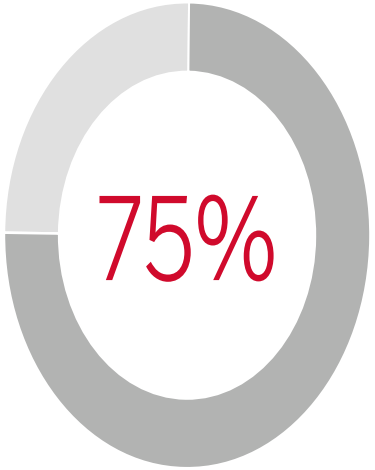
TELEHEALTH GEOGRAPHIC AND ORIGINATING SITE WAIVER

Overview	*Limits*
Allows providers to bill for telehealth regardless of patient's geographic location or care setting	Only for services on CMS's approved list; for those in an HH[6] episode, cannot be visits covered under HH PPS[7]

POST-DISCHARGE HOME VISIT WAIVER

Overview	*Limits*
Permits home visits incident to physician care to be delivered without direct physician supervision	Home health and community-based providers are excluded from offering home visits under this waiver[8]

What happens when the process of exchanging information is flawed?



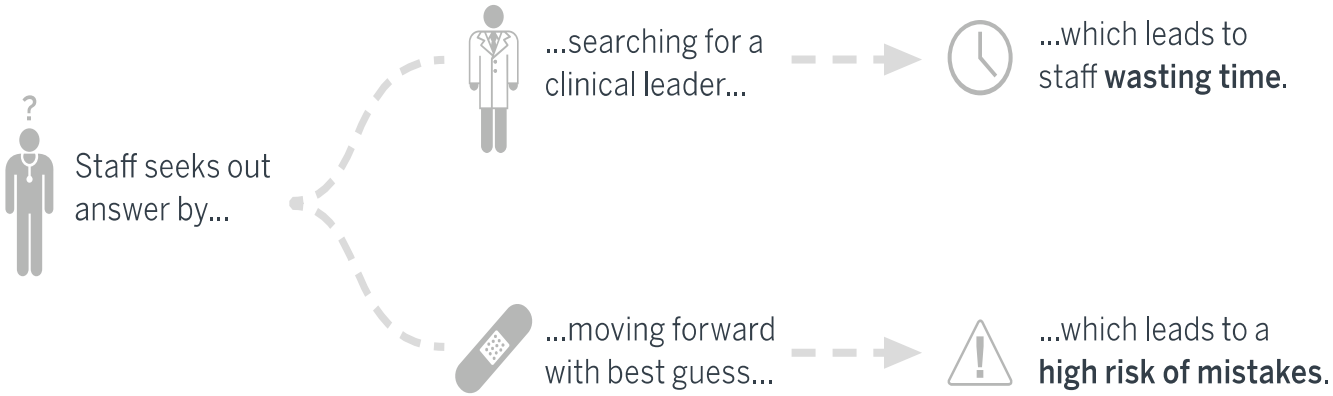
of hospital discharge summaries do not mention pending test results

9.4%

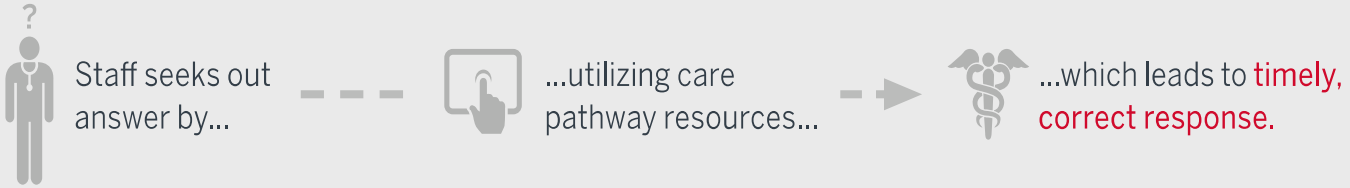
of unreported pending results required change in patient management

Train your discharge planning staff on the types of information to share with PAC providers and consider creating **targeted teams** to oversee the exchange of critical information like patients' lab results. Using "warm" handoffs—transitions where hospital staff and post-acute staff speak directly—can enhance the process.

What happens when frontline staff need clinical questions answered and there is no care pathway?



Instituting proper care pathways help connect frontline staff to clinical expertise.



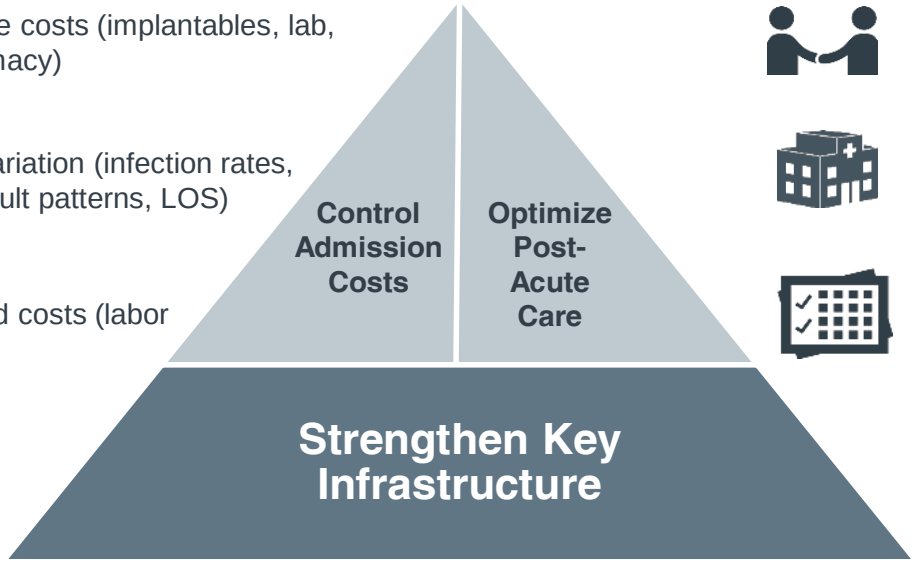
Prioritize Your Cost Savings Opportunities

Strategic and Operational Levers for Winning Under CJR

Reduce variable costs (implantables, lab, ancillary, pharmacy)

Reduce care variation (infection rates, ICU days, consult patterns, LOS)

Reconsider fixed costs (labor mix, overheads)



Improve patient experience (discharge process, care plan education)

Manage post-acute provider variation (readmissions, quality outcomes, LOS)

Ensure care plan compliance (visit completion, medication management, PT progress)

Physician engagement
- Formal structures for physician alignment
- Aligned incentives, gainsharing
- Shared infrastructure (e.g., IT, care coord.)

Post-acute alignment
- Formal relationships with key providers
- Clear care coordination processes
- Transparent quality metrics

Clinical pathways and care coordination
- Clear protocols and care pathways
- Care coordination infrastructure

Quality, financial and cost management tools
- Opportunity identification
- Monitoring and performance management

Growth strategy (exploring expansion to commercial plans, consumer bundles)

Source: Financial Leadership Council analysis.

Sharing in the Risk and Reward

Finalized Collaborator Agreements Worth a Closer Look

Sharing Arrangements

- Participant hospital is responsible for episode spending and bears financial risk
- Hospitals allowed to share in the reward and risk with "collaborators" through sharing arrangements, terms cannot incentivize volumes or restrict services when required
- Potential collaborators:
  - SNFs/HHAs/LTCHs/IRFs
  - Physician Group Practices
  - Physicians
  - Non-physician practitioners
  - Providers and suppliers of outpatient therapy

General Sharing Requirements

- Providers must have detailed "collaborator agreement" to be eligible for reconciliation or repayment must include details such as:
  - Methodology for verifying internal cost savings
  - Full scope of gainsharing and financial terms of the arrangement
  - Description of how outcomes/success will be measured including quality performance
- Collaborators must meet quality requirements set by acute care hospital, contribute to care redesign
- Must furnish a billable service within the CJR episode in the relevant year
- **PGP collaborators** must have one physician/non-physician member who furnished service to CJR beneficiary and clinically involved in CJR at the hospital in the specific calendar year, must participate in CJR care redesign

1) OIG/CMS joint statement issued at: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/2015-CJR-Model-Waivers.pdf

Source: CMS, Financial Leadership Council analysis.

Under CJR, Chances to Partner and Gainshare

Partnership Restrictions

To be formal partners, providers must **furnish billable services** for hospital's CJR episodes

To share financial risk, PAC and hospital partners must have a **Collaborator Agreement before services are rendered**

Hospital can **recommend preferred providers**, but cannot give patients a restricted provider list

Risk-Sharing Restrictions

Hospital may only share funds from **internal savings[1] or portions of final reconciliation or repayment**

Gainsharing payments cannot be based on referrals/patient volumes; must be partly **based on quality metrics set by the hospital**

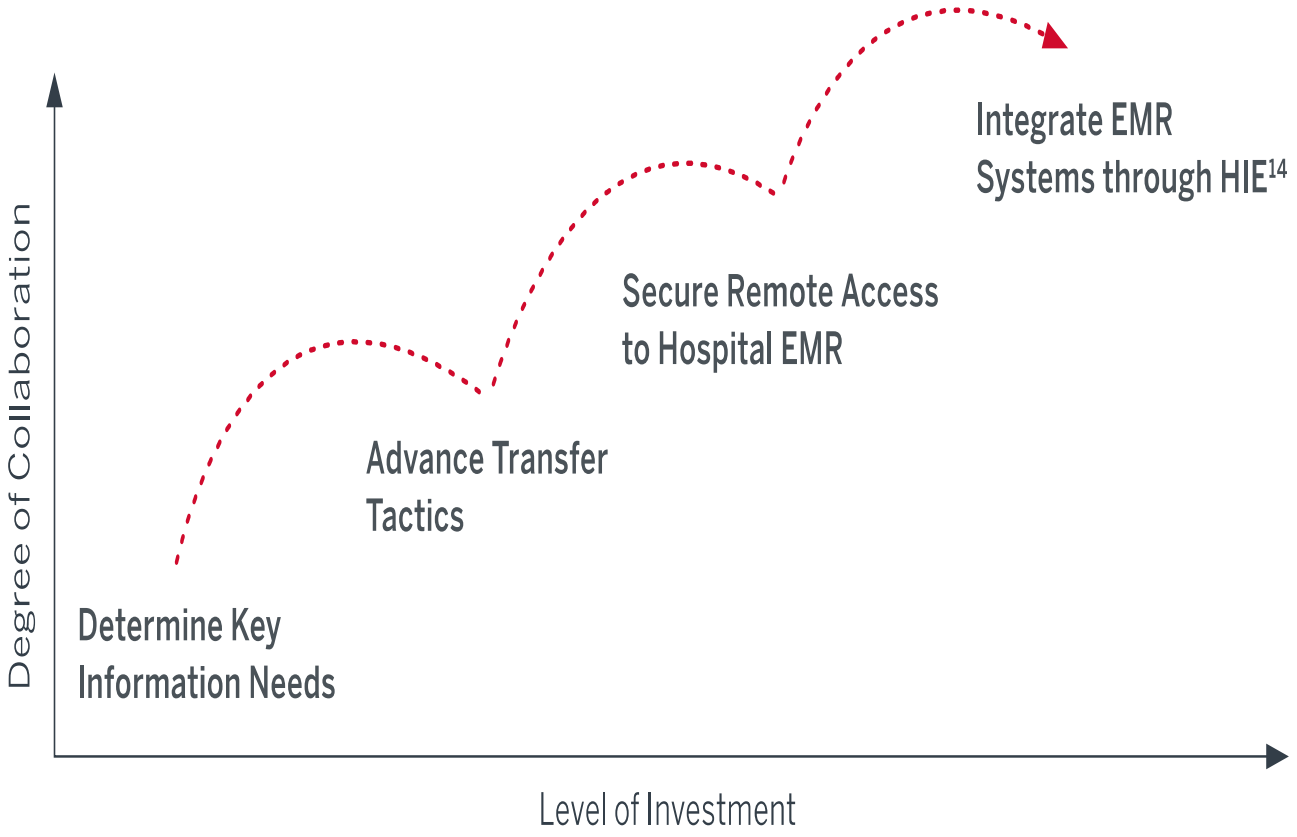
If sharing downside risk, each PAC partner **cannot pay more than 25%** of total repayment required

To share upside or downside risk, hospital and PAC partners must have a formal sharing arrangement that includes certain provisions; these provisions are listed in the Final Rule beginning on page 157

1) Savings the hospital realizes as a result of care redesign under CJR.

Source: Centers for Medicare and Medicaid Services, "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services," www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals; Post-Acute Care Collaborative interviews and analysis.

Clear and complete information exchange doesn't happen overnight. Break down the process into steps to achieve fluid communication with your PAC partners.

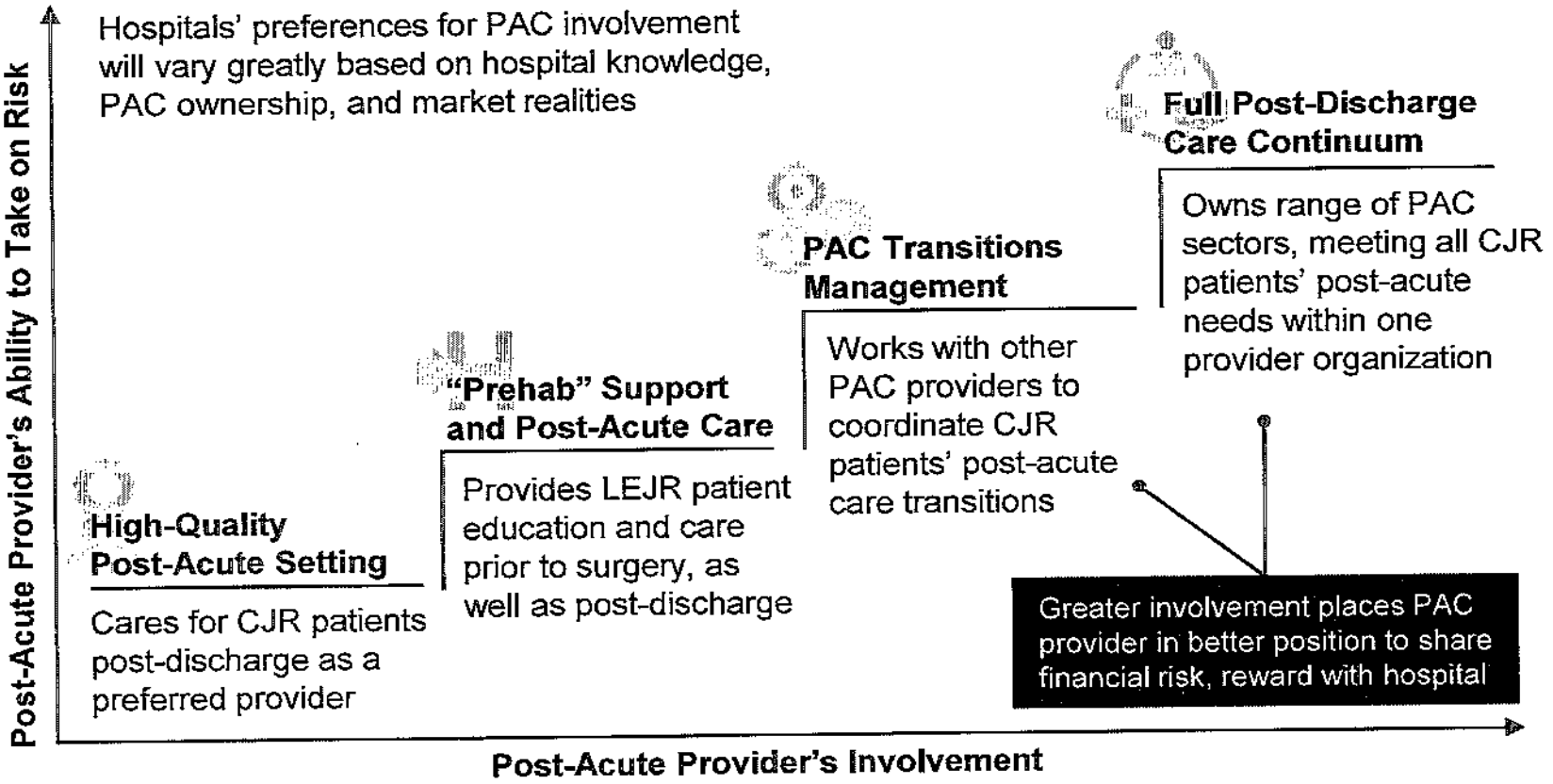


Scaling PAC Involvement to Meet Hospital Need

CJR Partnerships Not One-Size-Fits-All

Range of Options for Support, Partnership

Hospitals' preferences for PAC involvement will vary greatly based on hospital knowledge, PAC ownership, and market realities



Source: Centers for Medicare and Medicaid Services, "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services," www.federalregister.gov/articles/2015/11/24/2015-29436/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals; Post-Acute Care Collaborative interviews and analysis.

Postoperative Care Coordination Increases Mobility

Overview of the Post Discharge Pathway

Standardized Recovery Plan

- Prior to discharge, patients receive a personal recovery plan including physical therapy schedules, ambulation goals, and medication reconciliation
- Confirmation that all at-home equipment (cane, walker, etc.) were ordered and delivered

Anti-coagulation Clinic

- 2-3 days post discharge, patients visit anti-coagulation clinic to ensure anticoagulant levels are appropriate

Patient Follow Up

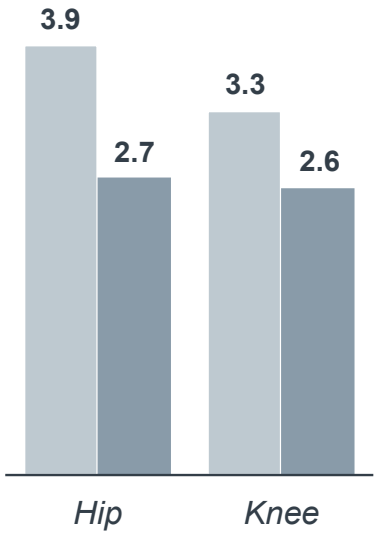
- Follow up nursing call one week post discharge to assess compliance and satisfaction
- Two orthopedic clinic visits (two weeks and then three months postdischarge)
- Optional weekly telemedicine visits for the first month, then monthly until nine months postoperative

Source: UC Irvine Health, Orange, CA; Physician Executive Council interviews and analysis.

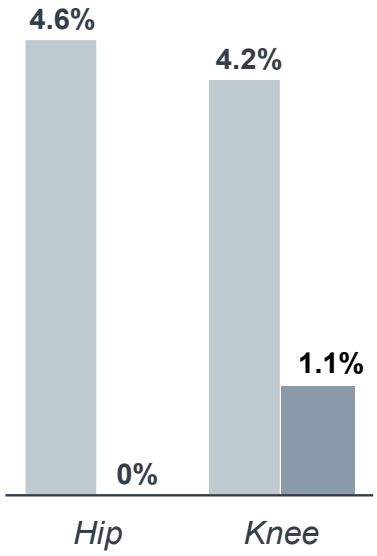
Joint Replacement Home Improves Quality

Early Results from UC Irvine Health

Average Length of Stay



30-Day Readmissions Rate



National Average UC Irvine Health

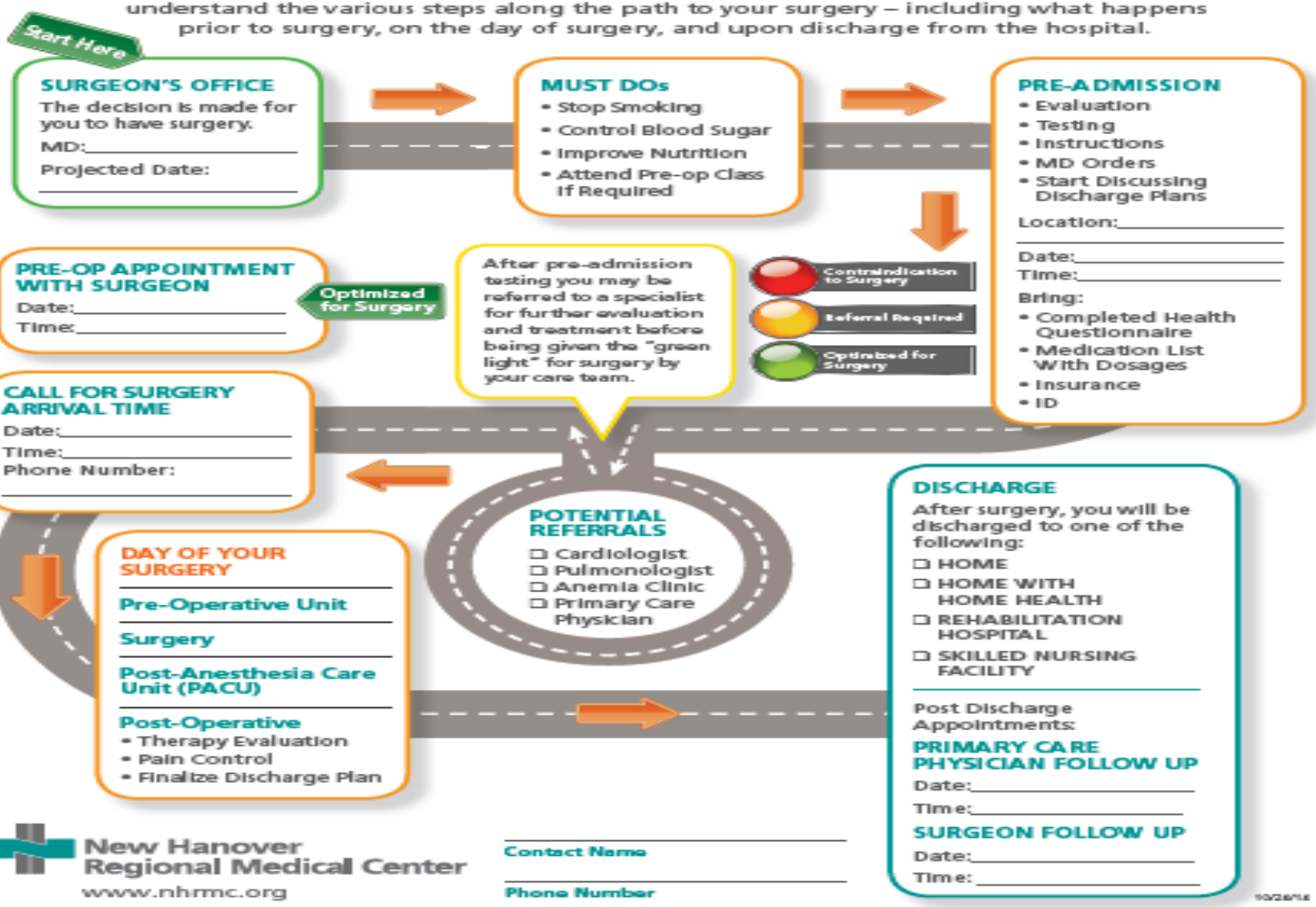
Other Quality Outcomes

0%	Major complications
0%	Intraoperative blood transfusions
9.8%	Postoperative transfusions (Hip)
4.2%	Postoperative transfusions (Knee)

Sources: Garson L, et al., "Implementation of Total Joint Replacement-Focused Perioperative Surgical Home: A Management Case Report," *Anesthesia & Analgesia,* 118, no. 5 (2014): 1081-1089; Steiner C, et al., HCUP Projections: Mobility/Orthopedic Procedures 2003 to 2012. 2012. Accessed: http://www.hcup-us.ahrq.gov/reports/projections/2012-03.pdf; UC Irvine Health, Orange, CA; Physician Executive Council interviews and analysis.

Road Map to Surgery & Recovery

The following "road map" has been developed by your NHRMC care team to help you understand the various steps along the path to your surgery – including what happens prior to surgery, on the day of surgery, and upon discharge from the hospital.



Summary

What are the effects of bundled payments on readmission rates?

The ABC'S:

A for effort → A for outcomes (= Reduce Cost & Increase Quality)

Be up to date, informed, & conscientious

Coordinate, **C**ommunicate, plan (pre- & post-operatively), & reduce variation

SNF's have higher competition, higher patient turnover, & are held accountable for readmissions


EVERYBODY
SUCKS
2016
The US is doomed.

Conclusion

We don’t always have good options.

The path we are on is unsustainable.

Medicare may eventually go broke.

Cost saving measures need to be implemented.

Spending less is difficult, but can be done while maintaining quality.

There will be a lot of learning for all of us to do along the way.


OH, I'M NOT FLYING ANYWHERE. I'M JUST HERE FOR THE PAT DOWN.
Geezer Planet
www.yesemails.com

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