CJR: Does Your Agency Have the Innovative Strategies to Deliver on Expectations?

Speaker(s): Chris Chimenti, MSPT
Dan Kevorkian, MSPT

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CJR: Does Your Agency Have the Innovative Strategies to Deliver on Expectations?

Chris Chimenti, MSPT
Dan Kevorkian, MSPT
APTA CSM
San Antonio, TX
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Objectives

• Understand details of the CJR program as described in the 2016 Final Rule published by CMS
• Define important, innovative strategies home health agencies can pursue to create value in this new model of care.
• Recognize the permanent impact this program will have on home health physical therapy practice.
• Learn from the experiences of a home health agency directly impacted by CJR across multiple geographic areas.
Acronyms

• Comprehensive Care for Joint Replacement (CJR)
• Bundled Payment for Care Improvement (BPCI)
  – Began in 2013
  – Voluntary
  – Similar to CJR

Why CJR???

• Demand for TJR
  • ”Prevalence of TKR/THR= 7 million Americans (2014)
  • **2005 - 2030...
    • 1$^O$ THR ↑174%
    • 1$^O$ TKR ↑ 673%
  • Revisions will be needed
  • Current spending $7 billion/year
• 10,000 baby boomers/day through 2031
  – Medicare solvency
• Goals of CJR (and BPCI)
  • Eliminate variation (quality, experience)
  • Reduce fragmentation
  • Reduce cost (variance $16,500 - $33,000)

Do you remember “10+ Therapy”?

CJR Overview

- **CMS Final Rule**
- **Trigger event**
  - MS-DRG 469 & 470 (Major joint replacement)
- **Automatic, mandatory** enrollment
  - First of its kind
- **67 regions** across U.S.
  - ~ 800 hospitals in 33 states
  - ‘Destination’ hospitals
- **Began April 1, 2016**
  - Ends 2020
  - Expected to generate $343 million over 5 year period
- **BPCI takes precedence in overlap**

Hospitals On The Hook

• ‘Target price’
  • 4 separate prices
  • Historical spending (hospital + regional levels)
    • Shifts to 100% regional in years 4 and 5
  • 3-days prior → Hospital admission → 90 days post-discharge
  • ‘Target price’ based upon discount of historical cost
• Annual retrospective reconciliation
  • UNDER target= Incentive payment
  • OVER target= Payment penalty

Annual Balancing Act

Target Price

Actual Spending
What’s Included in the ‘Target Price’?

- DRG and Medicare A/B spending
- ‘Related services’
  - Physician services
  - Inpatient hospitalization
  - Inpatient psychiatric facility
  - IRF/SNF
  - Home health
  - Outpatient services
  - Clinical laboratory
  - DME
  - Part B medications
  - Hospital readmission

Moving Target

- Target prices adjusted annually
- Competition among hospitals in MSA
Progression of Gain/Loss

• ‘Upside’ opportunity in Year 1
  – Capped at 20% throughout program
• ‘Downside’ risk phased in beginning Year 2
  – Progress to 20% in years 4 and 5
• Hospitals may have ‘eased in’
  – Increasing motivation
  – Track post-acute charges
    • Data mining

How Do YOU Get Paid?

• Traditional Medicare reimbursement
• Rates and rules remain constant
Not Just About The $$$

Focus on Quality

Not Just About The $$$

– **Required** measures
  1. Hospital-Level Risk-Standardized **Complication Rate** (RSCR)
     – Acute MI
     – Pneumonia or sepsis within 7 days of admission
     – Surgical site bleeding, pulmonary embolism, or death within 30 days of admission
     – Periprosthetic joint infection, or wound infection within 90 days, mechanical complications
  2. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
     – 32 questions about hospital experience

– **Voluntary** measures
  • Patient reported **outcomes** (PRO)
    – Function

**Where can HH PT demonstrate value?**
Not Just About The $$$

- Quality matters!
- Required measures
  - Hospital Level Risk-Standardized Complication Rate (RSCR)
    - Acute MI
      - Pneumonia or sepsis within 7 days of admission
      - Surgical site bleeding, pulmonary embolism, or death within 30 days of admission
      - Periprosthetic joint infection, or wound infection within 90 days
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- Voluntary measures
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THR/TKR Cost Distribution

- Acute 61%
- Post-Acute 39%

Trivia Question

• What are the two most significant cost-saving opportunities related to post-acute charges?

BPCI cost-reduction levers
1. Hospital LOS
2. Implant cost
3. Lower cost sites of service
4. Discharge to home
5. Readmission rate


![THR/TKR Post-Acute Cost](image)

High Cost of Hospital Readmission

• Hip and knee arthroplasty patients (n= 2,026)
• Average daily cost of a 30-day readmission varied $13,000-21,000.


Long Road...

Importance of Home Health Innovation

- Must meet the new needs of bundled payment challenges
  - Improve quality delivery
  - Decrease costs
  - Prevent avoidable complications
  - Address patient issues immediately

Home Health’s Unique Position

- Home Health is the lowest cost “inpatient” provider
- High level of flexibility allows for truly customized care plans
- However, if your agency is still seeing ortho patients for 3wk4 or 2wk8 you will be left behind
Home Health Cost

• Prior to bundled payment, cost was not a factor in establishing care plan
• Agencies were focused on maximizing revenue through OASIS scoring and therapy utilization
• Must move to a value based plan of care
  – What is the greatest value I can get for the least amount of cost
  – Controlling Therapy Utilization

Home Health Cost

• Therapy Utilization
  – CJR hospitals will be looking to partner with HH agencies who are willing to control utilization and balance with quality delivery
  – HHRG Therapy Thresholds- To Meet or not to Meet?
  – Provide value over volume
    • Evidenced based practice vs. “Cookie-Cutter” therapy
True Value of Home Health for Joint Replacement Patients

• Take a step back and think about the true value of home health for joint replacement patients
  – Immediate therapy assessment within 24 hours
  – Heavily front loaded visits to address concerns and mobility issues
  – Short Term while patient remains homebound
  – Responsiveness to emergent needs
  – Preparing patients for transfer to outpatient therapy as soon as possible

Historical BPCI Model 2 Successes

• CJR is set-up virtually identically to BPCI Model 2 90 day risk period for DRGs 469 / 470
• Lewin Group – Early studies of BPCI episodes from Q4 2010-Q4 2013 show positive impact in cost with approx 10-15% savings in Model 2 Lower Extremity Joint Replacement (LEJR)
• Trends in LEJR include :
  – Decreased Inpatient PAC utilization
  – Increased Home Health Utilization

BPCI Changes Noted – Lewin Group

How Can YOU Stand Out?
#1 – Pre-Surgical Visits

- Assess, educate, & communicate
  - Home environment
  - DME needs
  - Social supports
  - Risk Assessment & Predictor Tool (RAPT)*
    - Surgeon & NN
  - Pre-surgical class
- 2006 OIG Advisory Opinion
  - Payment
    - Medicare B
    - Negotiated payment with anchor hospital

#2- PT Only Admissions

- Autonomous Practitioner
- SN, OT, HHA PRN
  - “Waiting on the nurse”

![Vision 2020](image)

American Physical Therapy Association

#3- Evidence-Based Care

- Established care pathways
  - Best practice
  - Standardization of care
    - Avoid specific # visits
- PT Now Clinical Summary
  - THA, TKA
- PubMed Email Alerts
#4- Falls Prevention

- DME
- Education
- Balance/strength
- Medical complications

#5- Patient Education Materials

- Self-management
- Limits phone calls
- Patient satisfaction
#6- Timely Care

- Admission within 24 hours
- 7 days/week
- Optimize safety
- Identify complications
- Facilitate progress
- Patient satisfaction

#7- Front-Loading

- Highest acuity
- Set plan in motion
#8- Medication Reconciliation

- Every visit
- Education
- Prevent errors
  - Hospital readmission

#9- DVT Monitoring

- Homan’s sign
  - 56% sensitivity (identify true positive)
  - 39% specificity (identify true negative)*

- **Wells’ Criteria**
  - 10 criteria
  - 88% sensitivity
  - 72% specificity**


#10- DVT Monitoring v2

![Risk Assessment Tool for Estimating the Risk of Acute VTE](image)

VTE Risk Factors
- Previous VTE
- Thrombophilia
- Current cancer
- Age > 60 years

Reset

Probability of symptomatic VTE from the time of hospital admission to 90 days post hospital discharge in patients admitted with acute medical illness.

0.5%

#11- Constipation Protocol

- Opioid-Induced Constipation (OID)
#11- Constipation Protocol

- Opioid-Induced Constipation (OID)

  Senokot-S daily; Miralex twice a day

  If no BM x 3 days, give Magnesium Citrate ½ bottle

  If no + result, then give the other ½ bottle the next day

  Contact physician

#12- Vital Sign Assessment

- BP, PR, RR, O2 sat, Temp, Pain
- Lung sounds
#13- Surgical Wound Management

- State practice act
- Close monitoring
  - S&S infection
  - Dehiscence

#14- Communication!

- Nurse Navigator
  - Collaboration = Quality
#15- Manage Complications

- **Prompt, priority action**
- **DVT, pain, infection, cardiopulmonary....**

#16- Prevent Readmission

- **25% hospital readmissions are potentially avoidable**

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#17- Patient Satisfaction

- Hospitals/surgeons like happy patients!
- Word of mouth advertising

#18- Engage Your Staff

- **Why** do I have to do things differently?
- **Why** is CJR important to me?
- Educate
  - Focus
    - Hospital readmission
    - Efficient return to function
#19- Telehealth

- CMS allowing payment for telehealth
  - Billed through hospital outpatient
  - Rural or urban areas
- Flexibility with follow-up appointments
- Early detection of complications

#20- Discharge Planning

- Begins day 1
- Outpatient
  - Timely scheduling
  - Transportation plan
  - Copays
BPCI → CJR

- BPCI program allowed physician group practices to control their own bundles
- CJR shifts the risk and control to the episode initiating hospitals
- Visibility into surgeon practices
  - Paying attention now

Hospitals are slow to react

- CJR began in April of 2016, however only upside risk was in place until December 31st
  - This means that hospitals are not at risk to lose money....
- ......That is until January 1st of this year
- Hospitals have started to take on risk, however don’t expect immediate reactions
- Medicare claims data lags by at least 6 months, so expect opportunities to partner through this year.
- Moral of the story: Don’t get discouraged by constantly running into closed doors. You may just be ahead of the curve!
What is a Episode Initiator Looking For in a Partner?

• Success in BPCI happens when clinical decision making drives the care
• Quality Hospitals are not looking for the “cheapest” provider
• Hospitals are looking for partners with:
  – Exceptional Communication
  – Programming to avoid readmissions
  – Ability to manage urgent issues
  – Fiscally responsible providers

Episode Initiators Don’t Know what they Don’t Know

• Hospitals are aware of inpatient practices, but lack the knowledge of post-acute providers
• In earliest conversations, most time was spent educating Episode Initiators on Home Health Billing and practices
• Erroneous assumptions by Eis included believing:
  – # of Days impacts total cost
  – HH agencies added nursing for additional revenue
  – Home health aide and social work increase cost
  – LUPAs were best practices
Success = Clinical AND Financial

- If clinical outcomes suffer, no-one shares in savings programs
- Must be a good partner in achieving clinical outcomes
- Have a plan when things start to go downhill
  - Are you asking the right questions during patient visits?
  - Are you getting the most out of each visit?
    - Ensuring progress as expected
    - Avoiding complications and early identification of issues
    - Immediate reporting to physician/care managers

Surgeons want to hear from us

- Hospitals will have access financial and performance data on surgeons and begin work to create efficiencies
- Surgeons must be engaged in this process if successful changes are to be implemented
- Do your surgeons understand the implications?
How to Earn Partnerships?

• Share previous outcomes and successes
  – Ensure that you are currently driving quality in HHCAPS and other measures
  – Understand your Readmission rates and what practices you have established to reduce

How to Earn Partnerships?

• Show the value your company can add to a bundle
  – Have a plan to assist in getting patients home vs. SNF/IRF
  – Immediate service – 24 hour admissions
  – Simply cutting visits does not breed success
    • Readmissions are costly – what are you doing to avoid these and other complications
  – Leverage HH as lowest cost provider
How to Earn Partnerships?

• Have ability to share ongoing outcomes
  – Prepare to report data on HHRG rates, therapy visit numbers, key quality metrics (readmissions, clinical outcomes)

• Proactive transparency

Are you ready to be a Collaborator?

• CJR models allow for post acute partners to take risk (CJR collaborators)
• Other providers (physicians, post-acute providers) must provide direct services to patients or play a significant role in CJR care redesign activities to participate in gainsharing

• Gainsharing payments to collaborators:
  – must come from gainsharing payments from Medicare, or from internal cost savings  AND
  – Payments cannot exceed 50% of Medicare reimbursement for services collaborator provided to patient

• CJR collaborators cannot pay more than 50% of the total downside payments owed by the hospital to Medicare
CJR available waivers

CJR allows for certain exceptions to current laws that would otherwise be seen as a violation of anti-kickback statutes called Beneficiary Incentives. These are known as CJR Waivers which include:

- Post-discharge home visits from non-MD staff allowed (outside of home health)
- Telehealth services allowed and billed through hospital/Physician outpatient services
- Patients not required to spend 3 days in-hospital going to a SNF (applies in years 2-5 of the program)
  - Patients can only go to SNFs rated 3-star or higher on Medicare’s Nursing Home Compare system
- Patient Engagement Waivers

Pitfalls

- Over promising / Under delivering
  - Avoid discussions regarding specific numbers of visits
    - Remember, we are required to develop individualized care plans which are reasonable and necessary
    - We can establish “best practices” and “protocols”, but care must be individualized

- Communication
  - Episode initiators want to be kept in the loop for things outside the “norm”
    - Ensure process and expectations for communications are established
Pitfalls

• Ensure HH staff are educated
  – Don’t assume that clinicians, clinical supervisors are aware of agreements we have made
  – Ensure that an appropriate amount of time is spent in training on:
    • What is the CJR program
    • How to identify CJR patients at an agency level
    • Expectations for Clinicians including protocols, best practices and communication processes
    • Early identification of complications and actions to avoid readmissions

Lessons Learned

• There is not 1 answer to controlling cost and improving quality
• Home Health is a valuable tool for success in BPCI/CJR programs
• Leverage home health benefits with your specific ability to meet the needs of your partner
• Focus on clinical quality – 1 readmission is more costly than a SNF utilization
Conclusions

• Value based purchasing is the wave of the future
  – Uncertainty with new administration
  – Expect to see additional alternative payment models
    • CABG/MI bundled program is coming...

Thank You....

Chris Chimenti, MSPT
585-295-6473
cchimenti@hcrhealth.com

Dan Kevorkian, MSPT
615-403-4384
dkevorkian@accentcare.com