

What We Have Learned From Participating in the Comprehensive Care for Joint Replacement (CJR) Program : Optimizing Post-Acute Care



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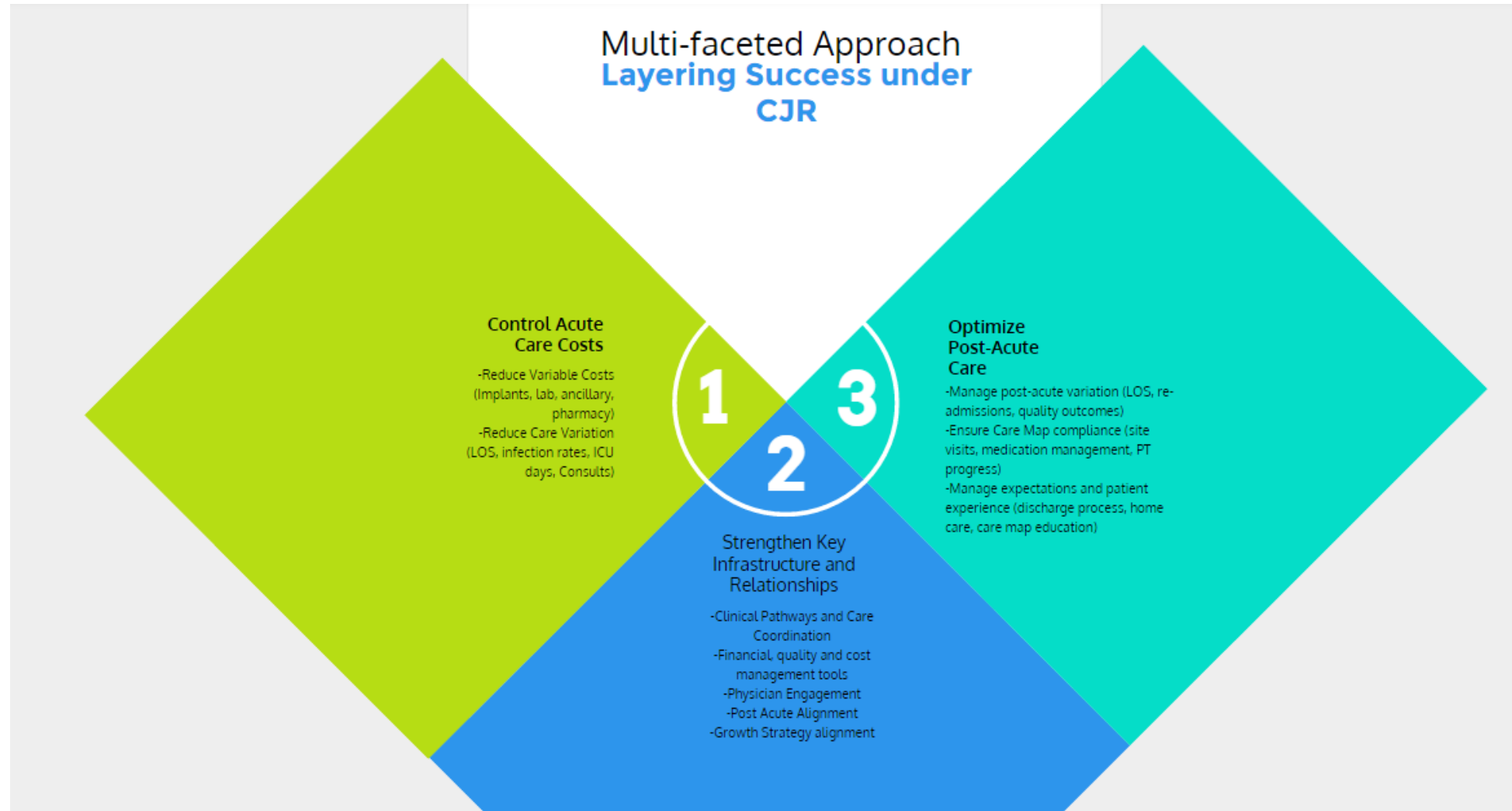


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Visiting Nurse Association Health Group



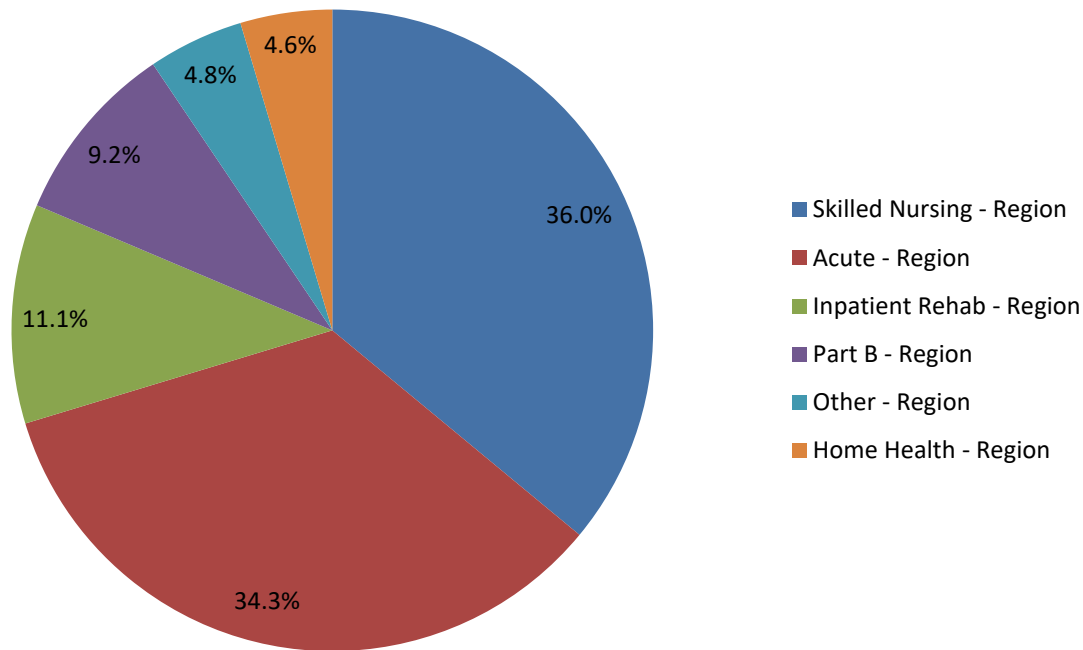
Multi-faceted Approach and Close Coordination of Each Component is Required to Succeed in CJR



Prioritization of Post-Acute Focus

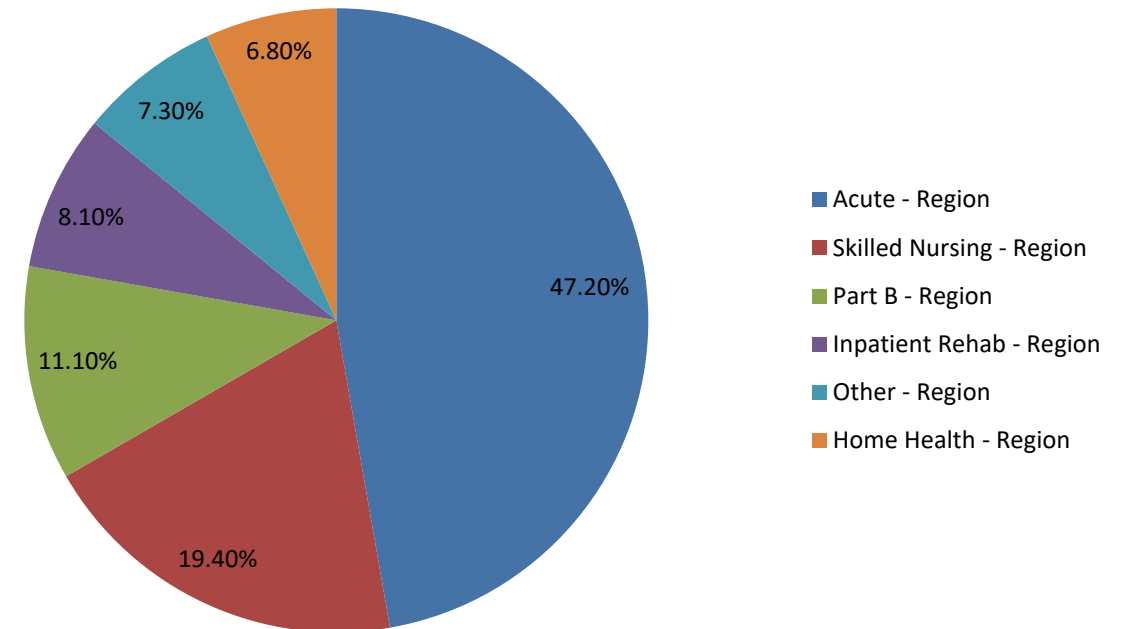
In the Historic Period, Pre-CJR (CY2012) DRG 469-70 w/and w/o FX

- 66% of the overall Episode Cost was attributed to **Post Acute Care**
- 36% of total Episode Cost was attributed **Skilled Nursing**
- 5% to **Home Health**



In the Most Recent Period, PY2-CJR (CY2017) DRG 469-470 w/and w/o FX

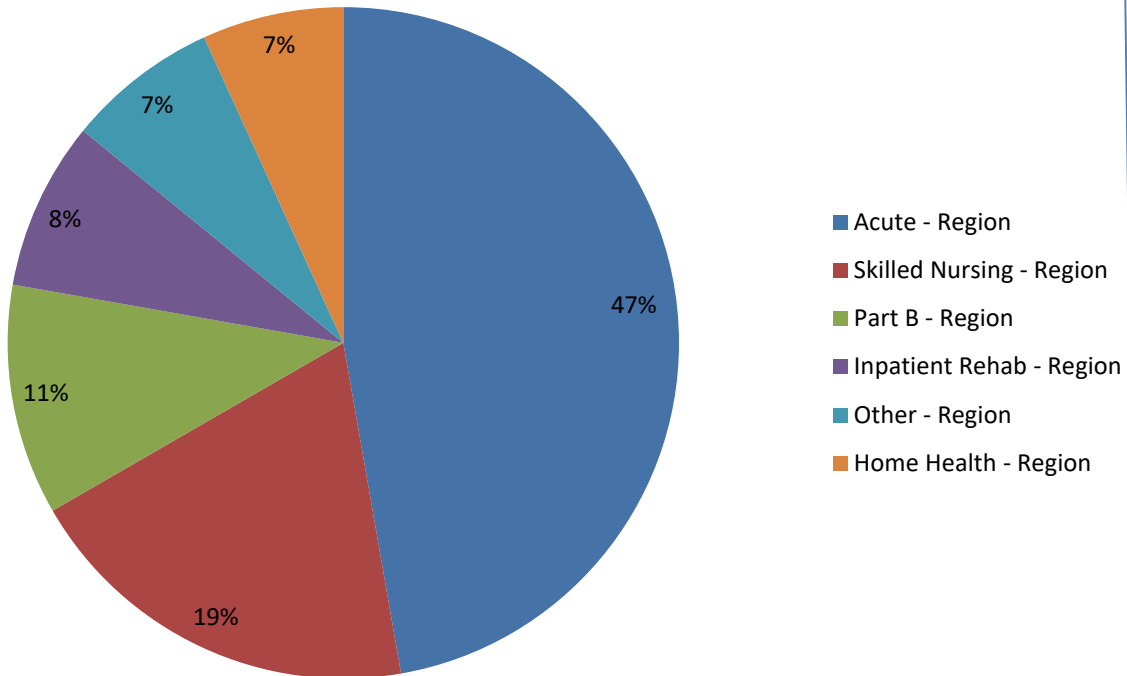
- 53% of the overall Episode Cost was attributed to **Post Acute Care**
- 19% of total Episode Cost was attributed **Skilled Nursing**
- 7% to **Home Health**



Post-Acute Approach

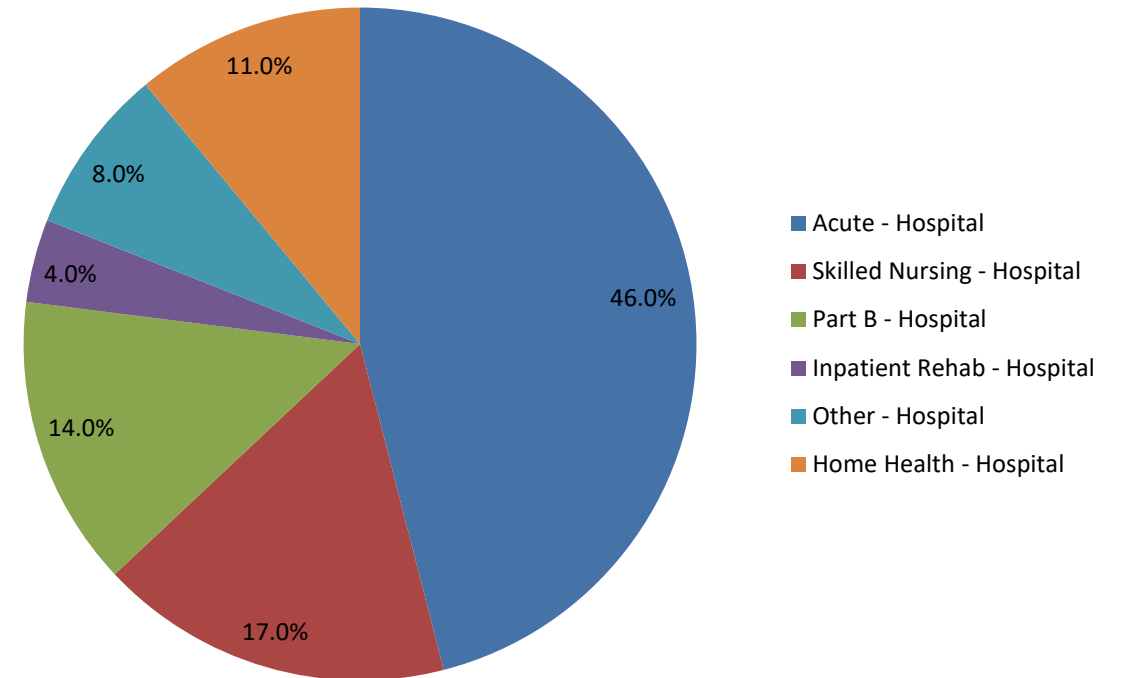
Region FY 2017: DRG 469-470 (w & w/o FX)

Acute - Region	47%
Skilled Nursing - Region	19%
Part B - Region	11%
Inpatient Rehab - Region	8%
Other - Region	7%
Home Health - Region	7%
Total Episode Payment Region	100%



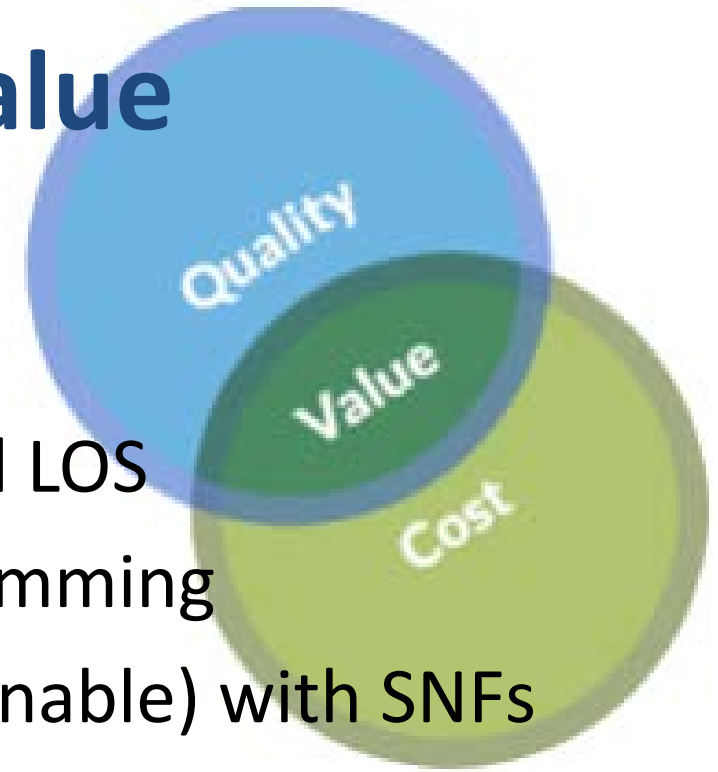
CentraState FY 2017: DRG 469-470 (w & w/o FX)

Acute - Hospital	46.0%
Skilled Nursing - Hospital	17.0%
Part B - Hospital	14.0%
Inpatient Rehab - Hospital	4.0%
Other - Hospital	8.0%
Home Health - Hospital	11.0%
Total Episode Payment-Hospital	100.0%



Step 1: Skilled Nursing Value

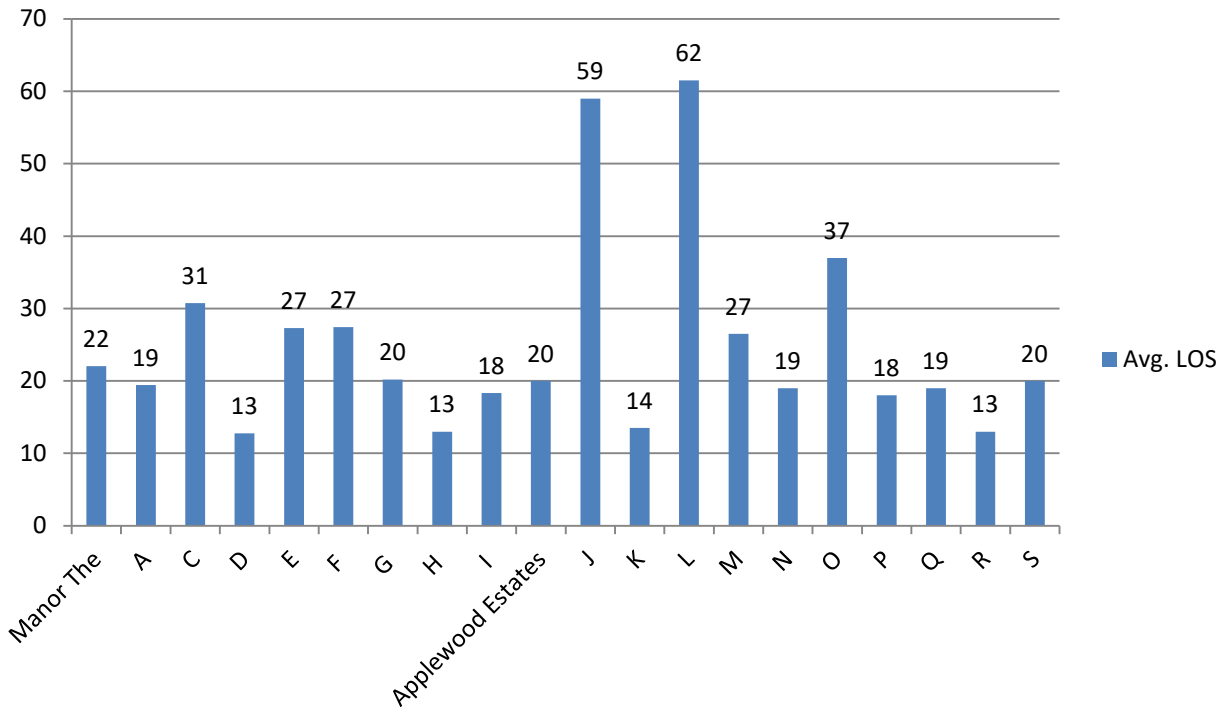
- Communication and Close Coordination of Care
- Risk-stratified Best Practice Care Maps for optimal LOS
- Readmission and Complication Prevention Programming
- Transparency and Data sharing (meaningful, actionable) with SNFs
- Supporting SNFs in Securing Value
- Developing Partnerships with engaged and aligned SNFs
 - Ultimately emerging into an Preferred Provider Post-Acute Network
- Utilizing 2-Day Waiver, where appropriate with Eligible Facilities



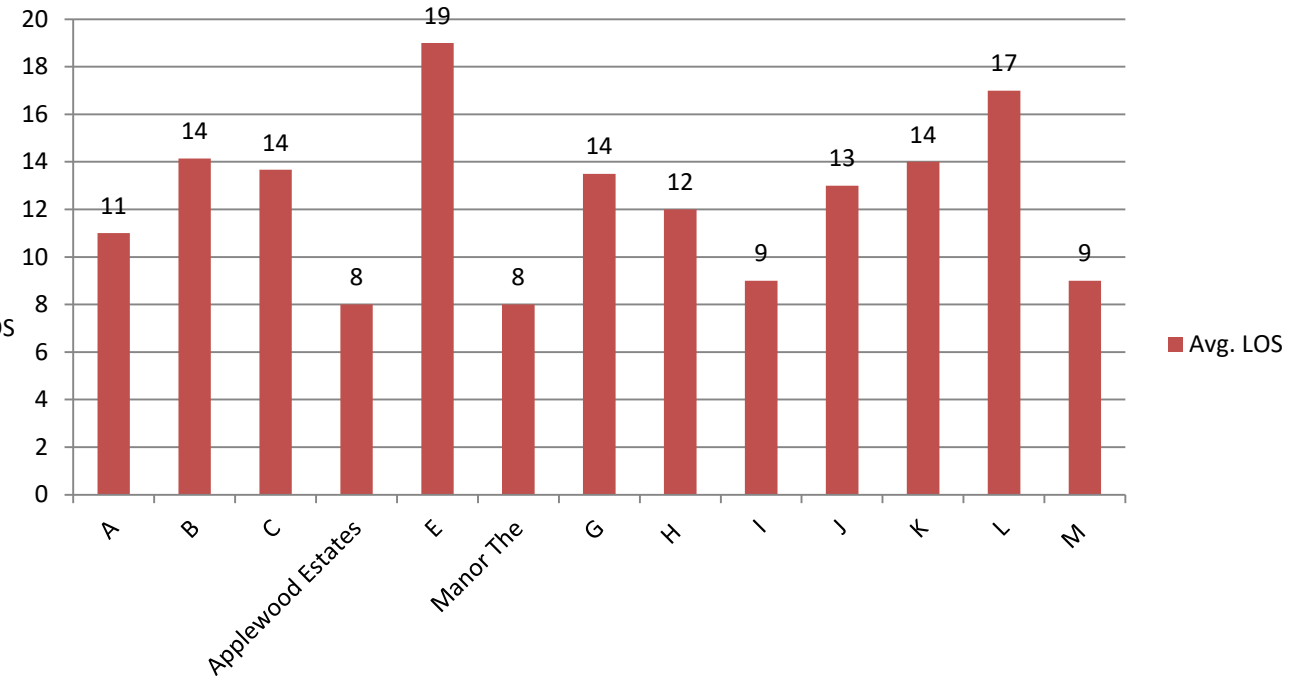
Impact: SNF Value and Partnerships

- PRE CJR (FY 2012) DRG 469-70 w and w/o Fx
- Average SNF LOS:25 Days; Average Post Acute Cost Per Episode:\$31,000
- POST CJR PRE CJR (FY 2017) DRG 469-70 w and w/o Fx
- Average SNF LOS: 12 Days; Average Post Acute Cost Per Episode: \$18,000

Avg. LOS

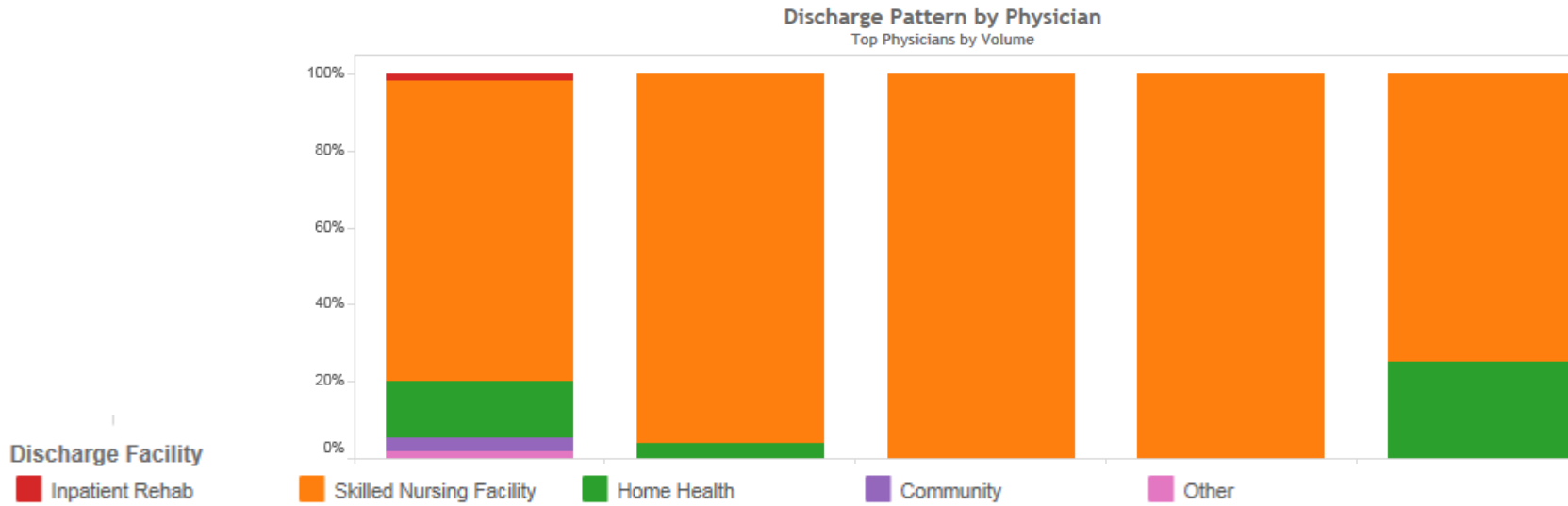


Avg. LOS

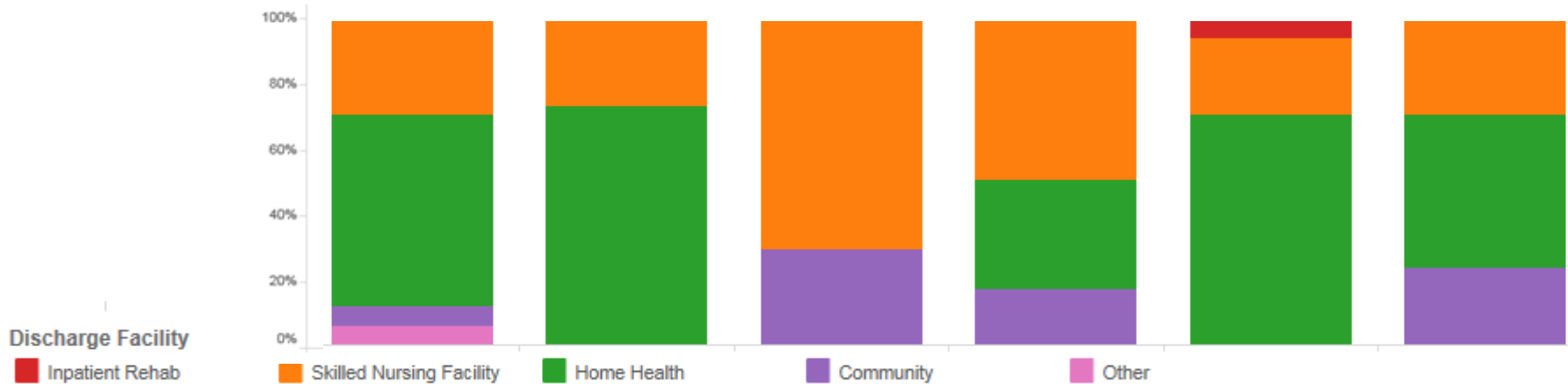


Step 2: Home Health Value and Partnership

PRE-CJR Discharge Pattern by Top Volume Orthopedic Surgeons



2017, 2 Years of CJR: Discharge Pattern by Top Volume Orthopedic Surgeons



Home Health Post-Acute Responsibilities

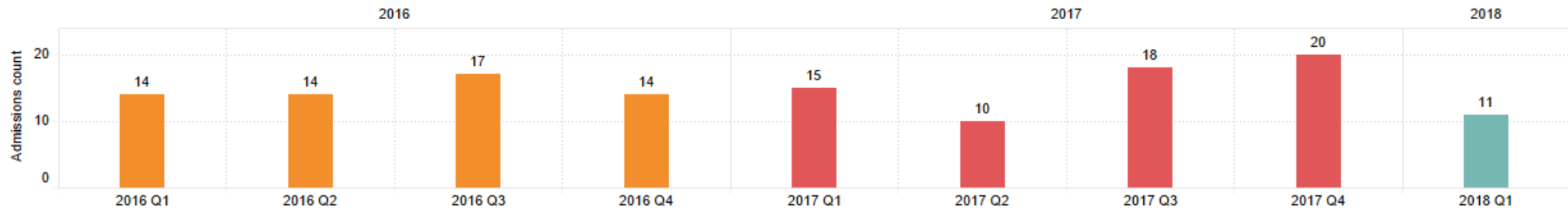
- Home Health is the middle man for CJR patients
- Best option for the majority of Lower Major Joint Replacement patients
- Home Health Responsibilities:
 - Ensure patient is stable
 - Monitor for high risk vulnerability – DVT, PE, wound issues, infection, medication interactions
 - Create patient centric treatment plan to restore function
 - Transition patient as soon as safe to next cite of care
- Home Health Goals:
 - Use best available evidence to create custom treatment pathways
 - Keep patient safe at home – minimize the risk of readmission
 - Improve impairment level deficits to progress functional return

CentraState and VNAHG CJR Hospital Admission Data

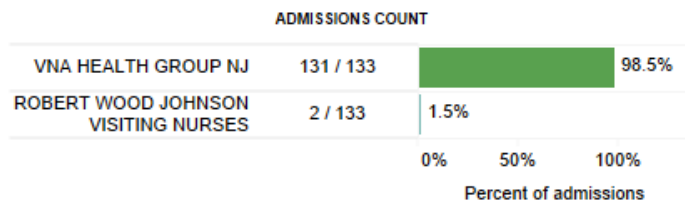
ADMISSIONS BY YEAR



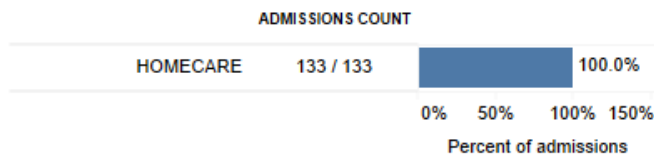
ADMISSIONS BY MONTH



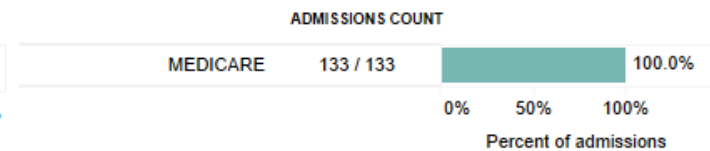
ADMISSIONS BY COMPANY / JV



ADMISSIONS BY SERVICE LINE

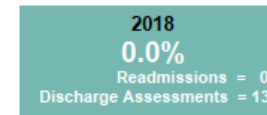
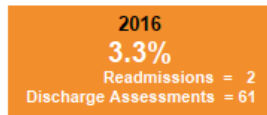


ADMISSIONS BY PAYOR TYPE

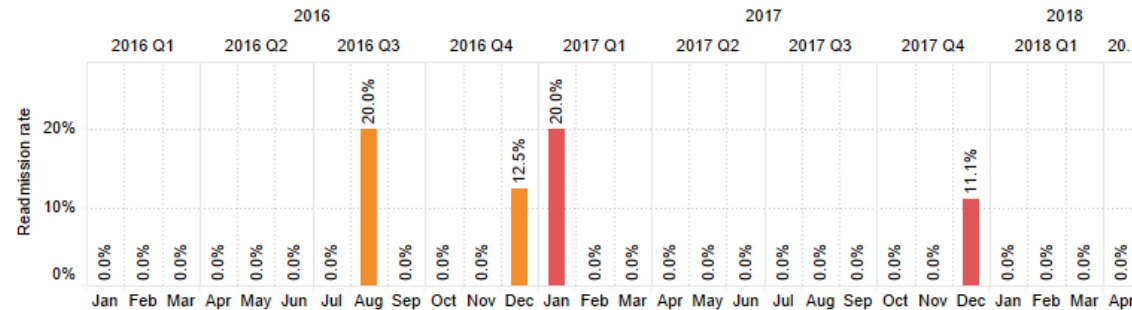


CentraState and VNAHG Hospital Re-admission Data

30-DAY READMISSION RATE BY YEAR



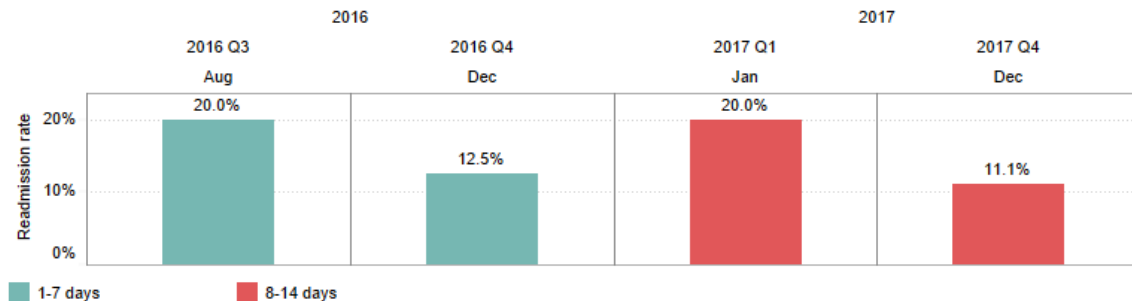
30-DAY REAMISSIION RATE BY MONTH



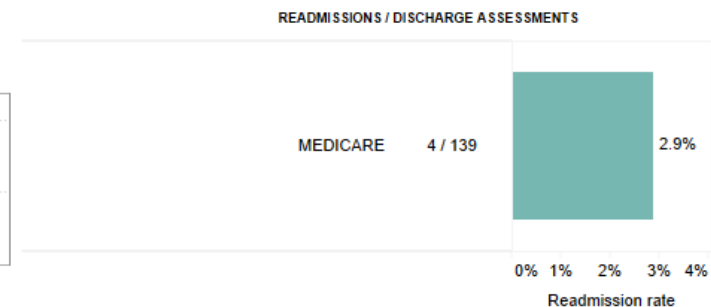
30-DAY READMISSION RATE BY COMPANY / JV



30-DAY READMISSION RATE BY WEEK FROM PREVIOUS HOSPITAL DISCHARGES



30-DAY READMISSION RATE BY PAYOR TYPE



Coordination of Care

- Pre-operative Education
 - Educational video and Home Health Booklet provided to support transition to home health after surgery
- Acute Care
 - On-site Nurse Liaisons meet with patient prior to hospital DC to arrange services and scan in notes to continue care
 - Care paths are activated in EMR at time of intake, triggered by MD identification
 - Worked with Acute PT to develop simple hand-off communication form to relay essential information about patient functional level
 - H – how far is the patient ambulating
 - O – Outcome measure used
 - M – Measurements of ROM, strength, function
 - E – Equipment used or extra information relevant to care hand-off

Coordination of Care Cont.

- Home Health
 - Worked with MDs and CJR Steering Committee to develop and refine Care Paths
 - Redesigned – based on internal data and conversations with Steering Committee
 - Meet Monthly early in CJR program, currently quarterly to share data on outcomes, re-admissions, patient satisfaction, and discuss challenges and opportunities to further refine the program
- Outpatient
 - Created alert in our EMR to notify therapists to reconnect patients with hospital outpatient services



QUESTIONS?