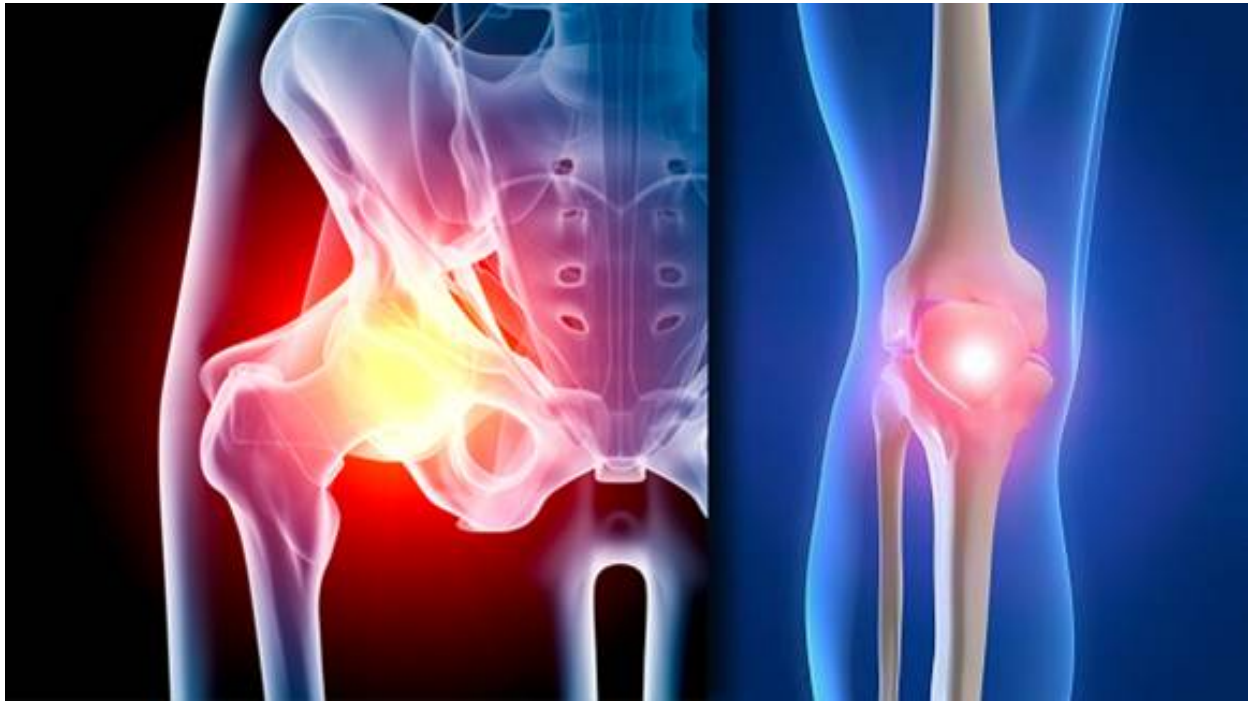
What We Have Learned From Participating in the Comprehensive Care for Joint Replacement (CJR) Program :

Optimizing Post-Acute Care



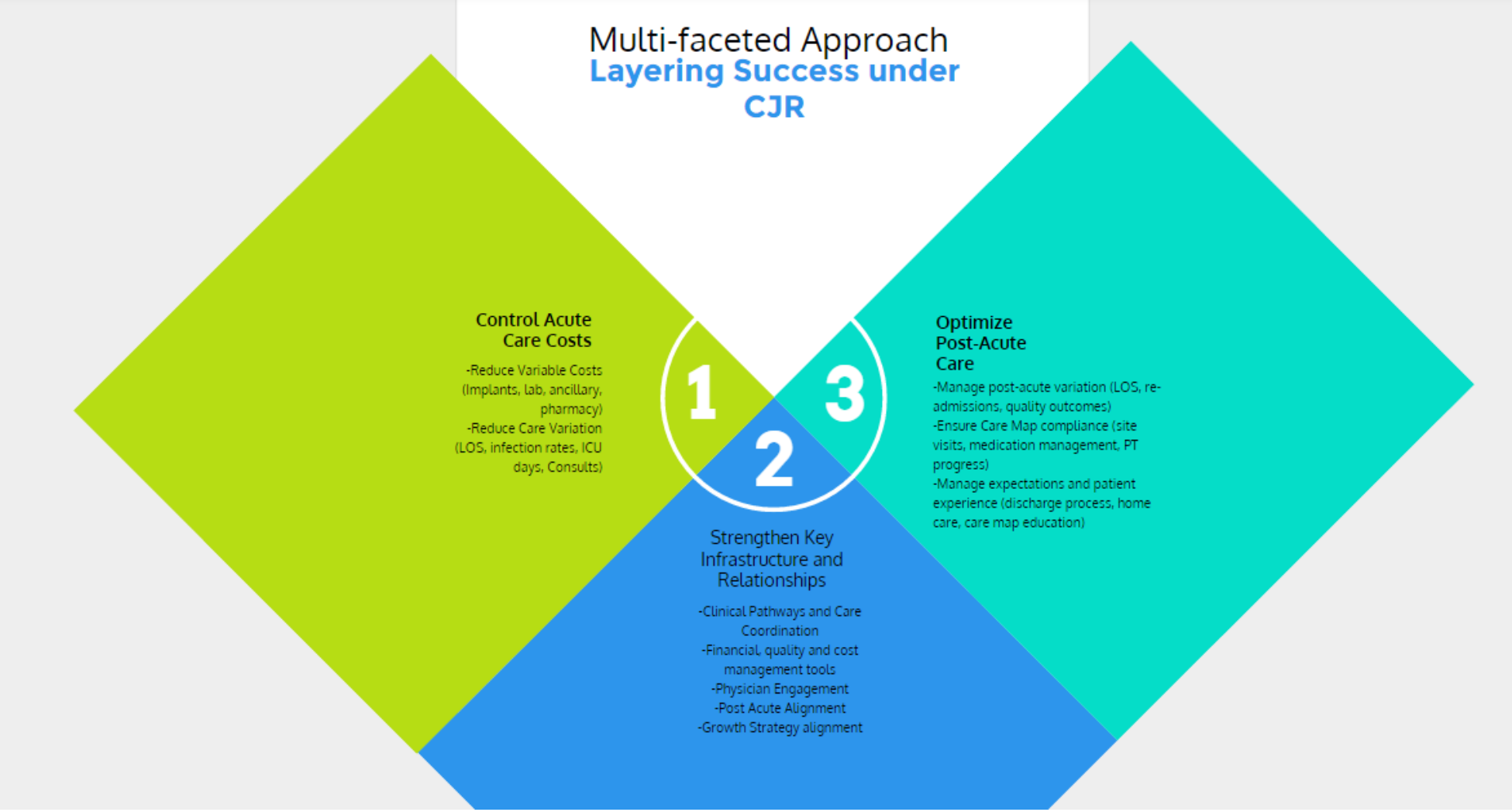
Dr. Cheryl Lyn Hayne, PhD, MSc, MPH
Director of Managed Care & Chair of CJR Committee
CentraState HealthCare System

CentraState Healthcare System®
Freehold, NJ

Jeffrey Sommer, PT, DPT, OCS
Orthopedic Manager and Educator
Visiting Nurse Association Health Group

vna HealthGroup

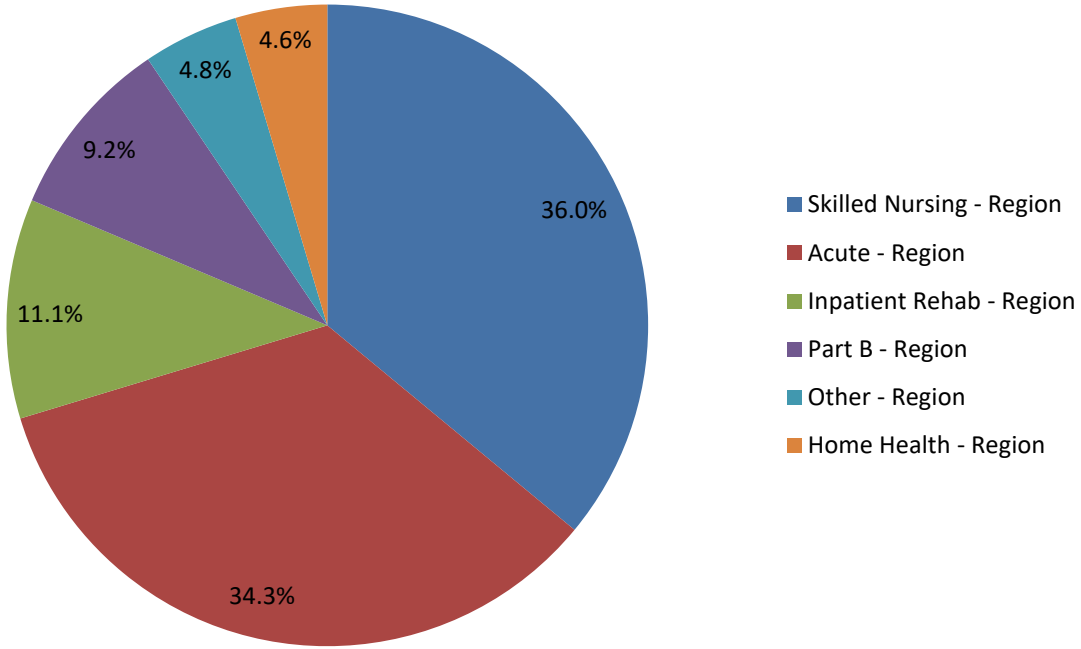
Multi-faceted Approach and Close Coordination of Each Component is Required to Succeed in CJR



Prioritization of Post-Acute Focus

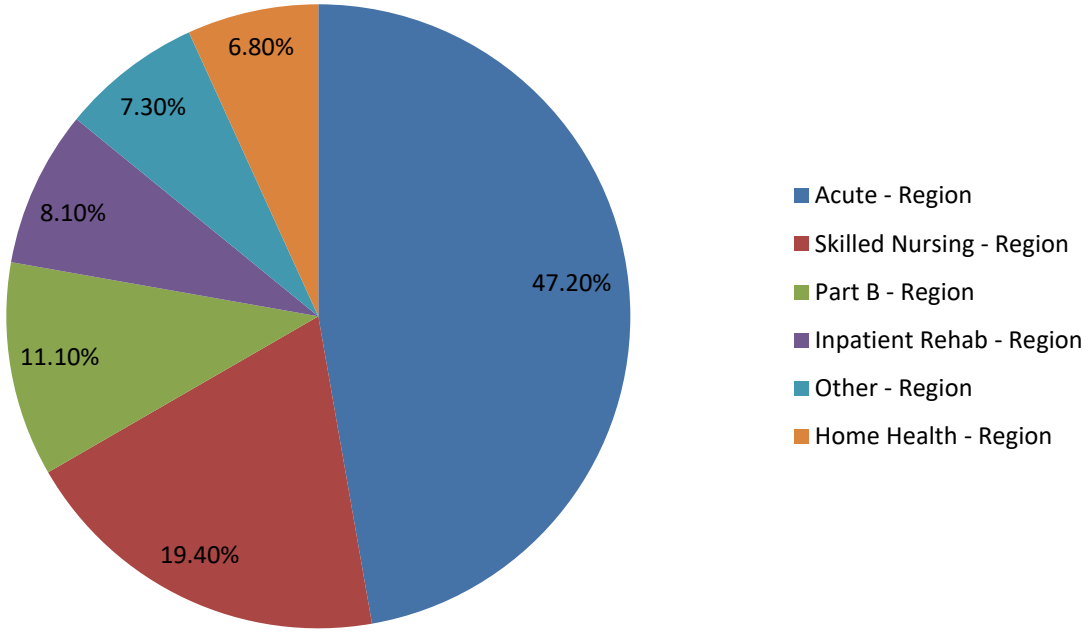
In the Historic Period, Pre-CJR (CY2012) DRG 469-70 w/and w/o FX

- **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

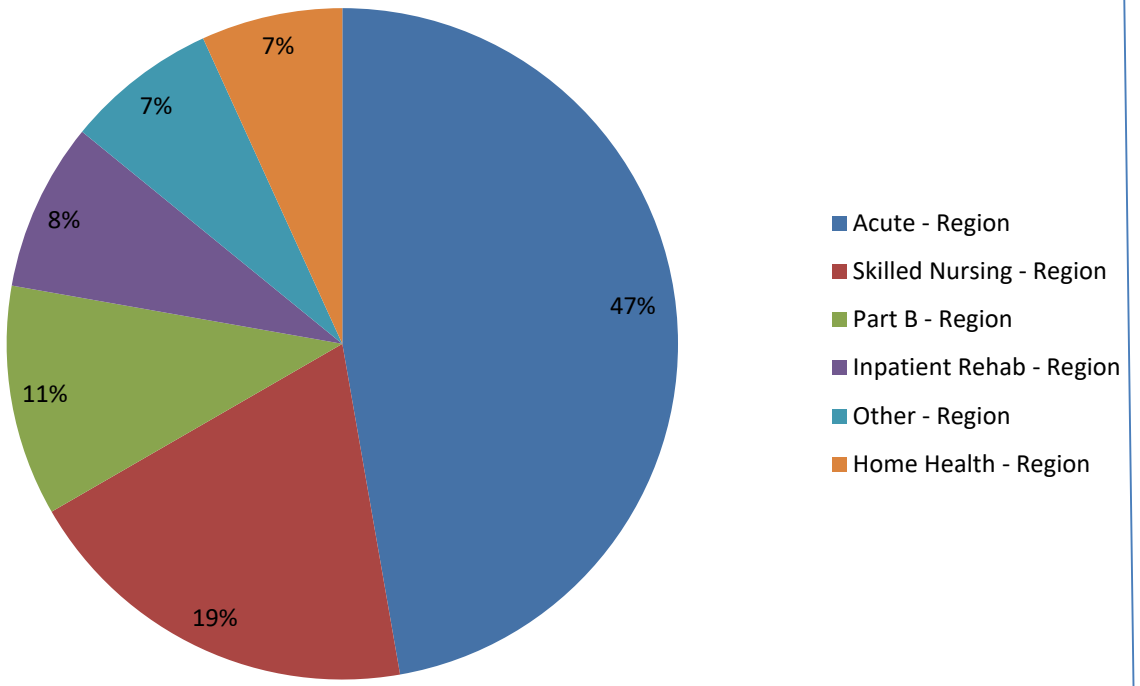
- **53%** of the overall Episode Cost was attributed to **Post Acute Care**
- **19%** of total Episode Cost was attributed **Skilled Nursing**
- **7%** to **Home Health**



Post-Acute Approach

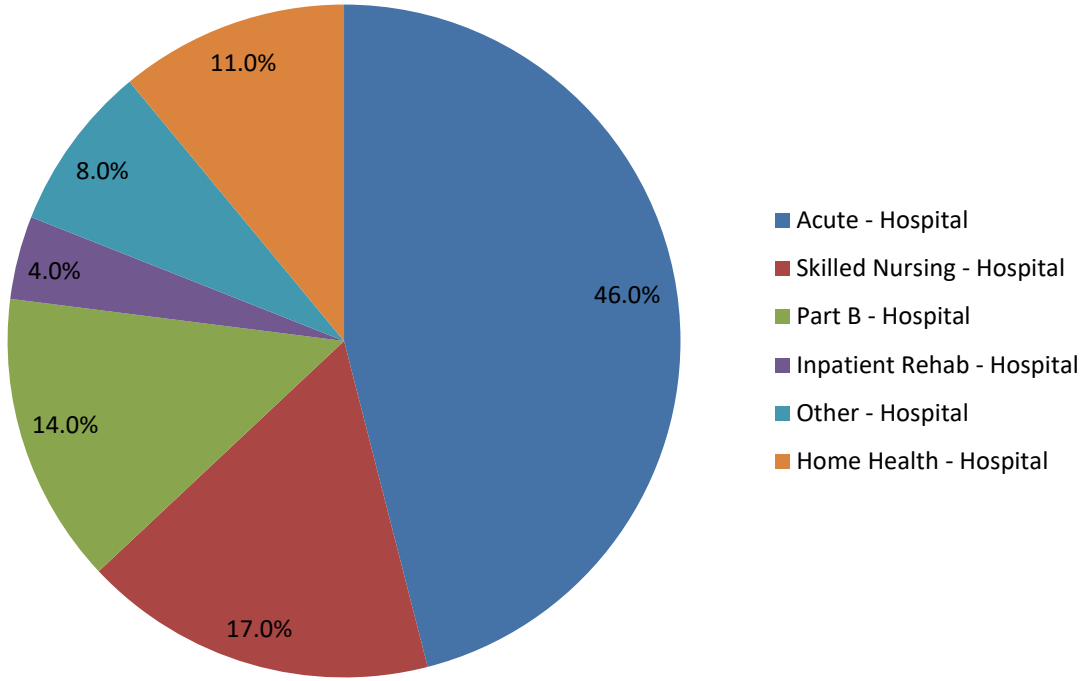
Region FY 2017: DRG 469-470 (w & w/o FX)

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%

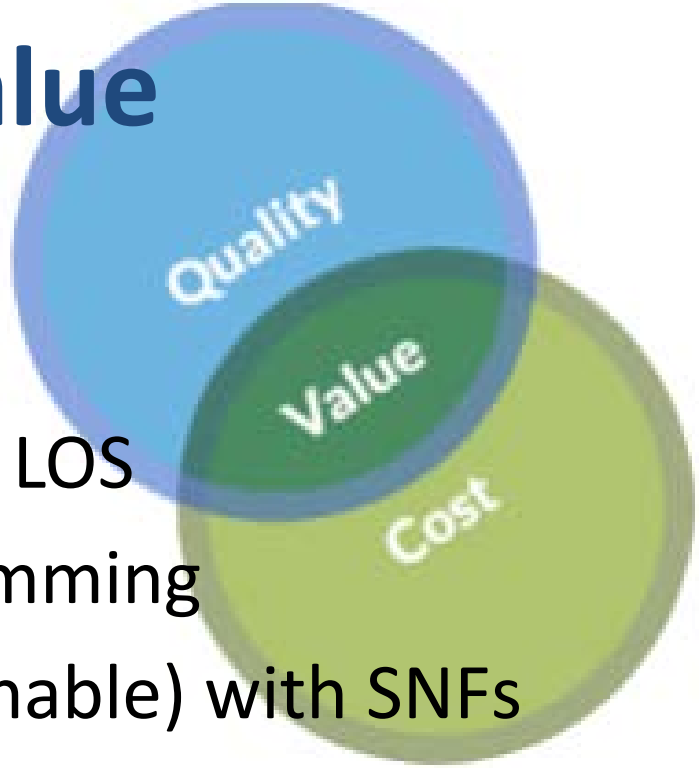


CentraState FY 2017: DRG 469-470 (w & w/o FX)

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%



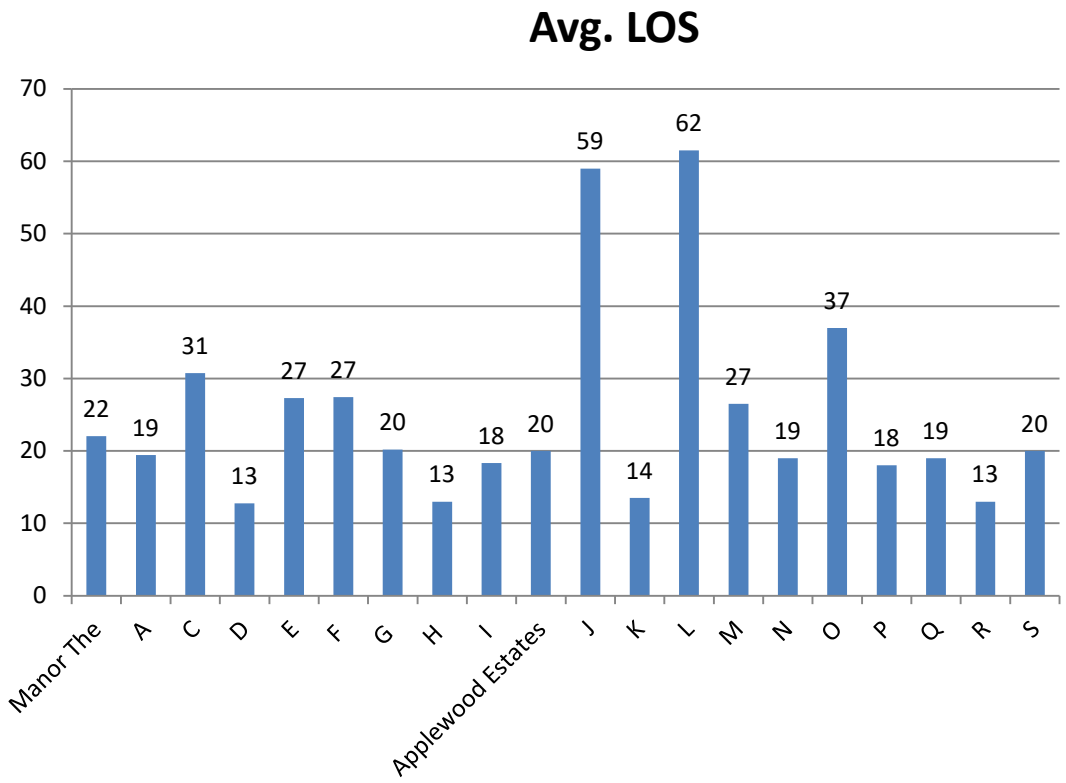
Step 1: Skilled Nursing Value

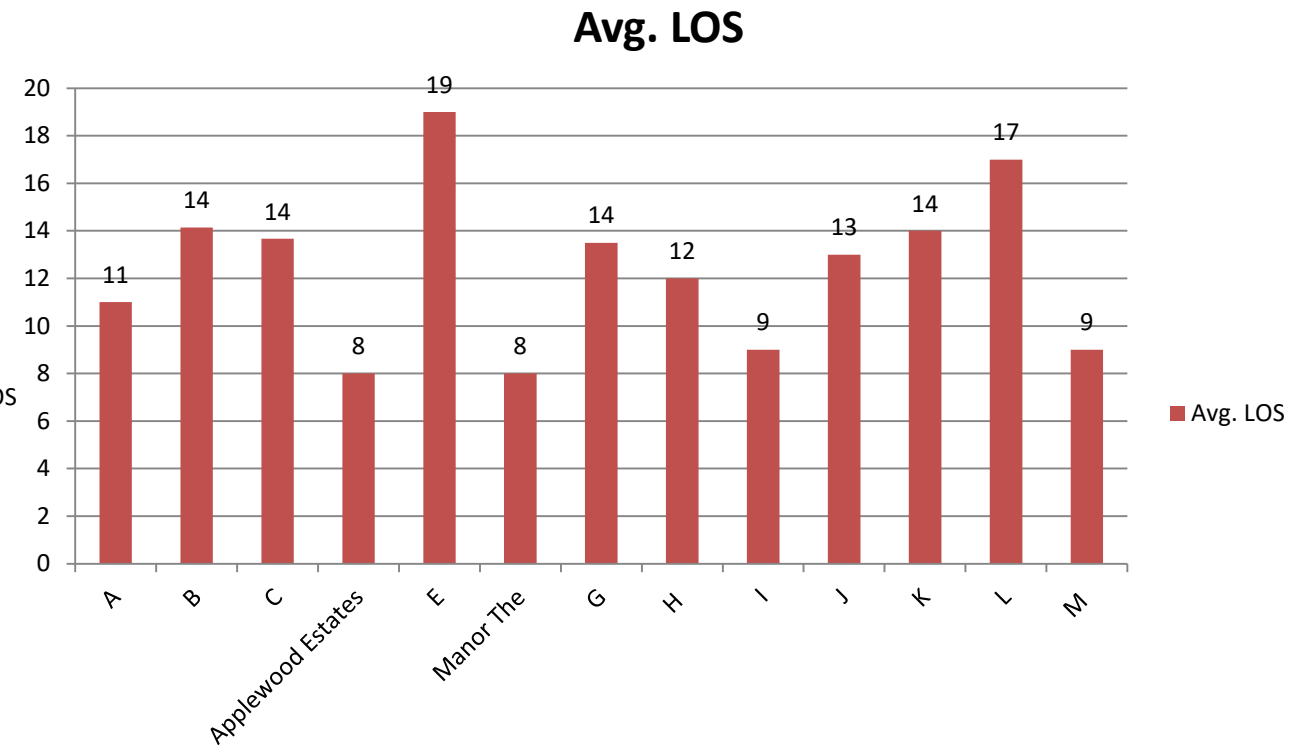


- Communication and Close Coordination of Care
- Risk-stratified Best Practice Care Maps for optimal LOS
- Readmission and Complication Prevention Programming
- Transparency and Data sharing (meaningful, actionable) with SNFs
- Supporting SNFs in Securing Value
- Developing Partnerships with engaged 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

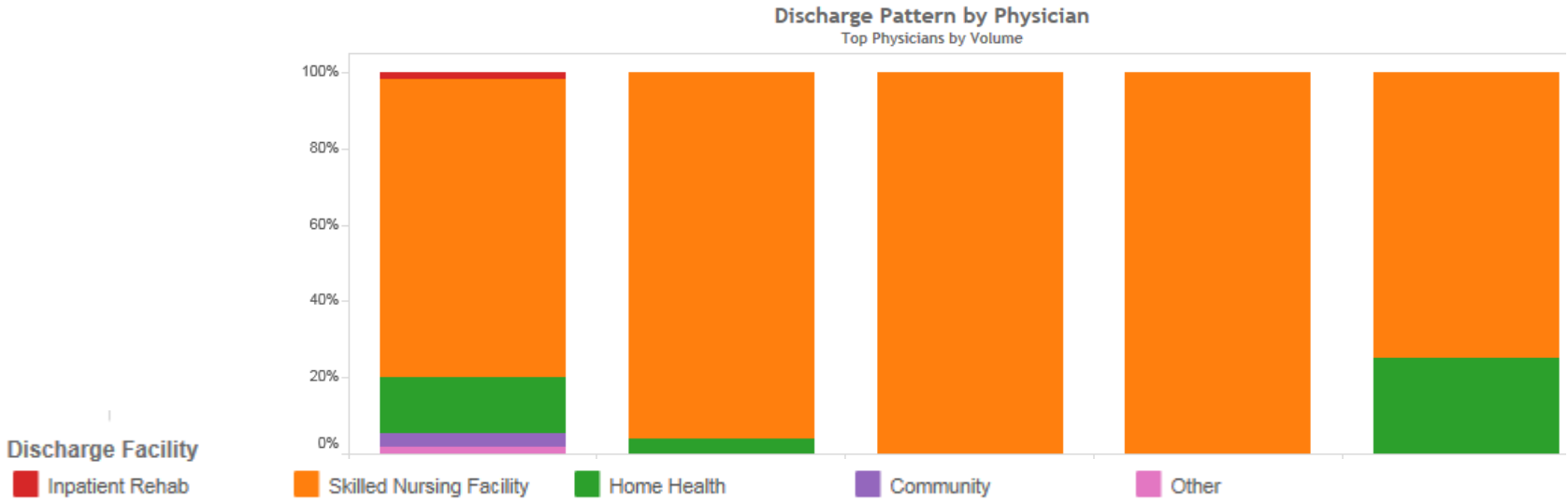
- PRE CJR (FY 2012) DRG 469-70 w and w/o Fx
- Average SNF LOS:25 Days; Average Post Acute Cost Per Episode:$31,000
- POST CJR PRE CJR (FY 2017) DRG 469-70 w and w/o Fx
- Average SNF LOS: 12 Days; Average Post Acute Cost Per Episode: $18,000



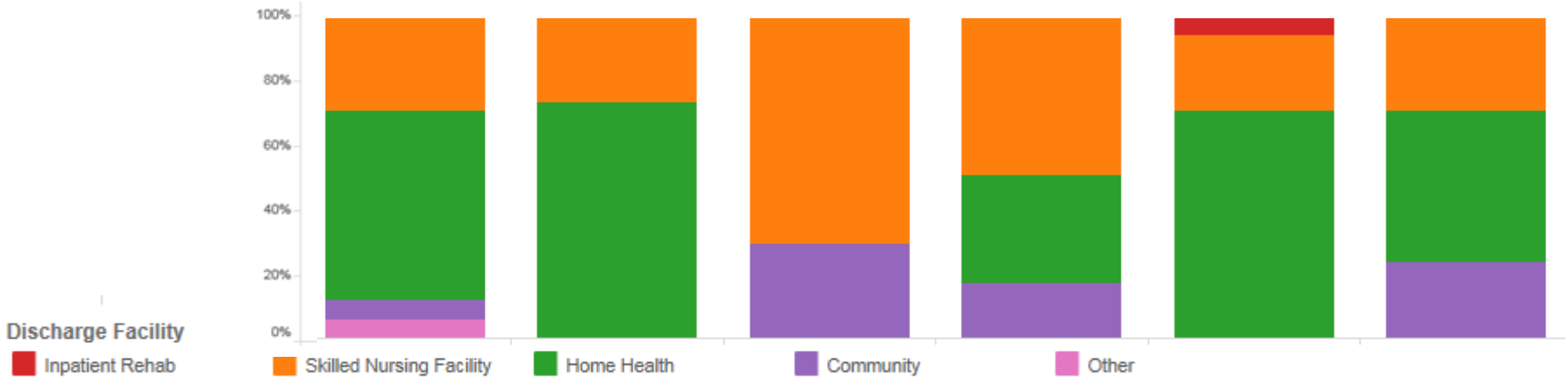


Step 2: Home Health Value and Partnership

PRE-CJR Discharge Pattern by Top Volume Orthopedic Surgeons



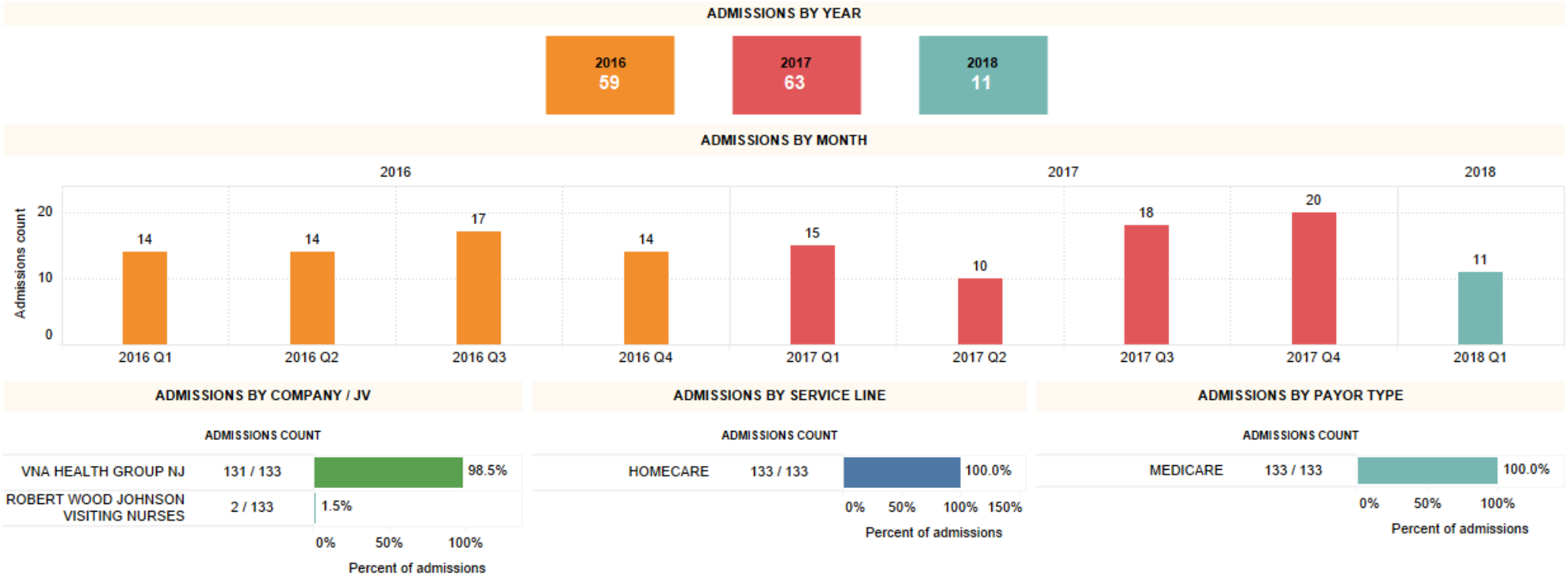
2017, 2 Years of CJR: Discharge Pattern by Top Volume Orthopedic Surgeons



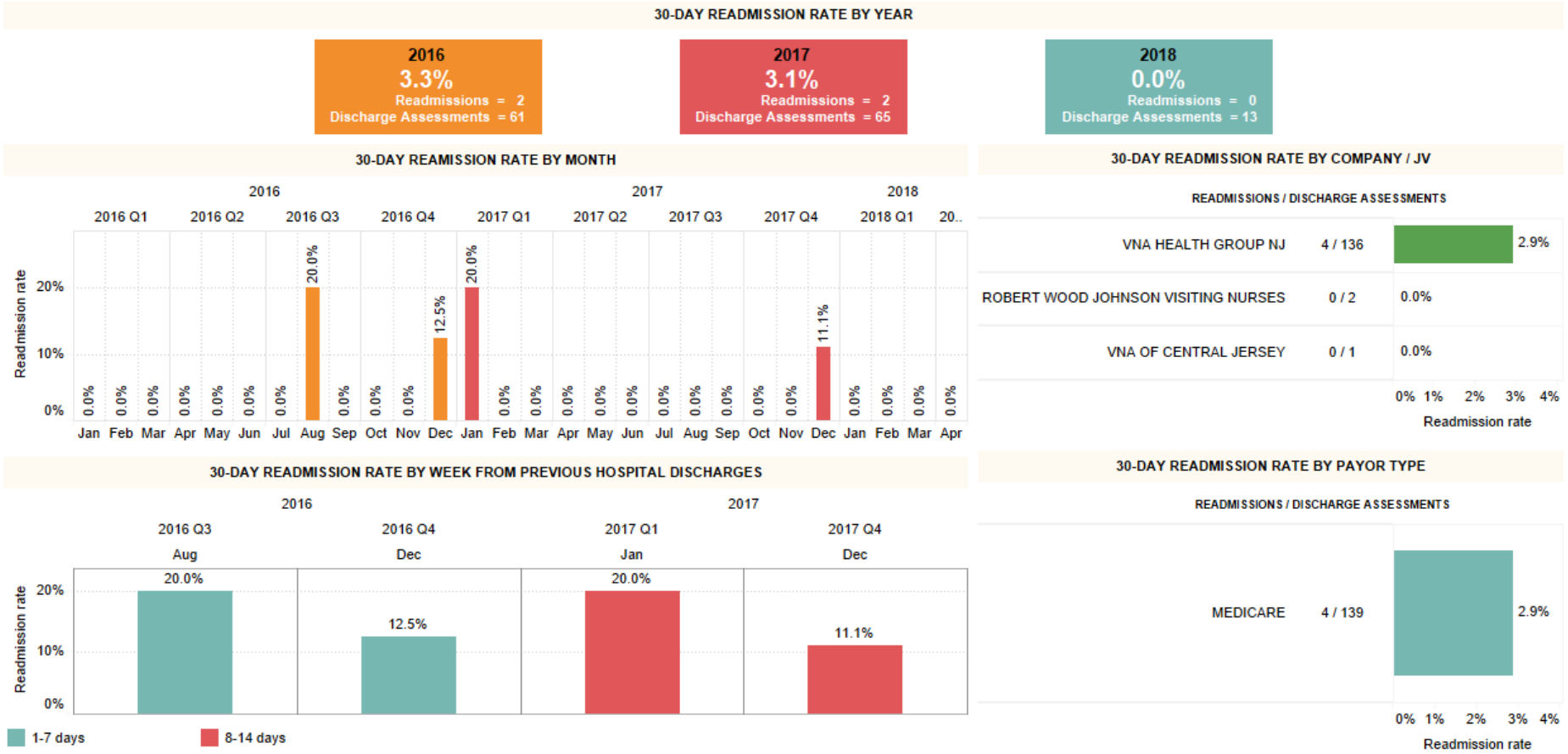
Home Health Post-Acute Responsibilities

- 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



CentraState and VNAHG Hospital Re-admission Data



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?