Episode Payment Models (EPM) – CJR and Beyond

Understanding Reimbursement Changes

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PACAH

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AGENDA

- What is Bundled Payment?
- Payment Reform
- Care Redesign
- Care Coordination for Joint Replacement
- Now What
- Keys to Success
- Opportunities
- Next Steps

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What is Bundled Payment?

A single payment to providers for defined services over a defined period of time. Might also be called episode –based payment; episodic payment; case rate; packaged pricing;

- A number of models implemented over past 3+ years
  - CMS Bundled Payment for Care Improvement
    - Model 1, Model 2, Model 3, Model 4
    - Variable length episodes of care
    - Voluntary Program
- Accountable Care Organizations
- Episode Payment Models – CJR, others

Most bundled payment models are “restrospective”. This makes it possible to build bundled payment on a fee-for-service base, “truing up” when the episode is over.

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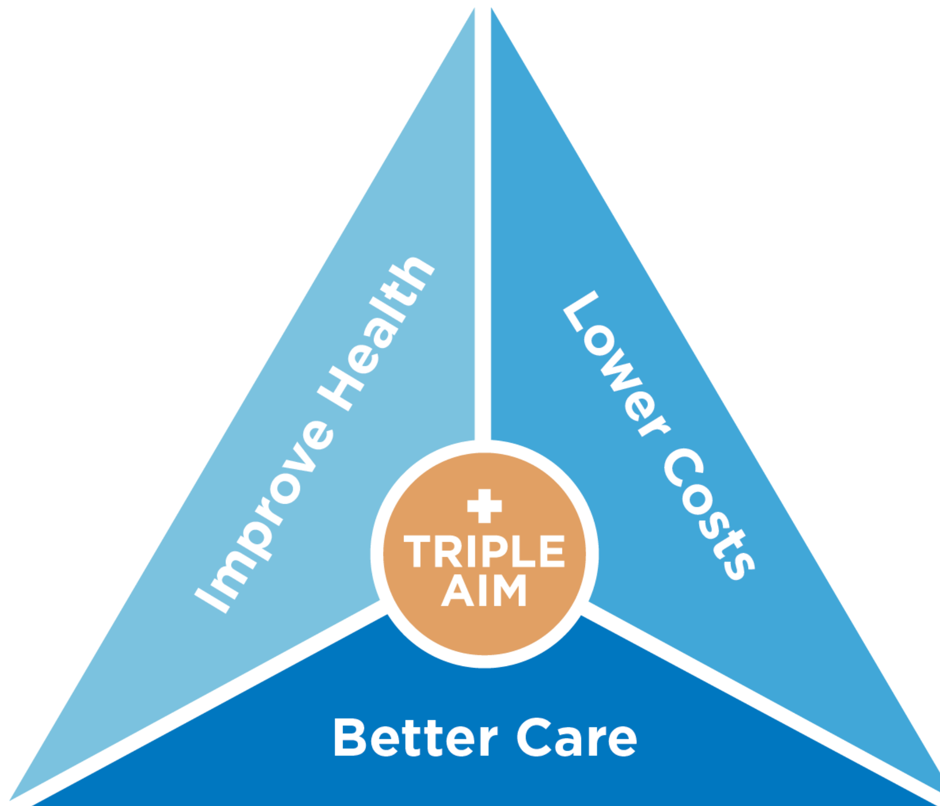
Where is this coming from?

Triple Aim :

Better Care, Smarter Spending, Healthier People



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Triple Aim : Better Care, Smarter Spending, Healthier People

"Whether you happen to be a patient, a provider, a business, a health plan or a taxpayer, it's in our common interest to build a health care delivery system that's better, smarter and healthier – a system that delivers better care; a system that spends health care dollars more wisely; and a system that makes our communities healthier."

"Today, for the first time, we are setting clear goals – and establishing a clear timeline – for moving from volume to value in Medicare payments."

- Sylvia Mathews Burwell, HHS Secretary
- *January, 2015*

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Payment Reform: Linking Payment to Quality

In January, 2015, CMS announced targets to increase the number of payments that are linked to quality outcomes by 2018.

- *"Our first goal is for 30% of all Medicare provider payments to be in **alternative payment models** that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018."*
- *"Our second goal is for **virtually all medicare fee-for-service payments to be tied to quality and value**; at least 85% in 2016 and 90% in 2018."*

- HHS Secretary Burwell

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Goals of Bundled Payments

- Promote quality and financial accountability of care
- Reduce Medicare expenditures while preserving or enhancing the quality of care
- Alignment of financial and other incentives for all health care providers and suppliers during an episode
- Improve coordination and transitions of care
- Advance the mission of Center for Medicare and Medicaid Innovation (CMMI) and the Secretary's goal of increasingly paying for value rather than volume

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What is different with Bundled Payments?

- Target rates established for specific diagnoses
- Single entity hold “responsibility” for the entire period of the bundle (episode)
- All providers are paid under prevailing payment models but all costs aggregated via claims data
- Designed to improve value, bundled payments include clear quality metrics focused on desired clinical outcomes that providers must achieve to maximize their payment
- Providers are incented to think and act differently in the way care is planned and delivered
- Beneficiaries directly benefit from improved care coordination and **care redesign** activities that reduce readmissions and complications rates, as well as an improved care experience during the inpatient hospitalization and post-discharge period.

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How is care delivery different?

- Episode owners are responsible for costs of all care provided, regardless of provider and setting
- Requires much more coordination and collaboration
- Keys to success:
  - **Control Cost**
    - Manage LOS
    - Reduce re-hospitalization
  - **Maintain Quality**
  - **Demonstrate meaningful value**

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What is Care Redesign?

•Virtually every payer for therapy services has been actively exploring and/or implementing alternative payment models for years

•Despite the many models from different payers, there are common themes to what they are looking for:

- Be **patient centered**
- **Collaborate** across providers and settings
- Demonstrate meaningful **value**

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Care Redesign – What does it mean?

- Remember that goal of improved coordination and transitions of care? Combine that with the goal of reducing expenditures….
- Patients are likely to transition through care settings faster
- A single care setting will not necessarily need to meet patients' every rehab need
- Care likely will need to focus on certain specific skills or abilities to enable the next transition
- Be aware of the patients' episode goals, and
- Identify your part in that episode

- Focus efforts at removing the barriers preventing transition to the next care setting

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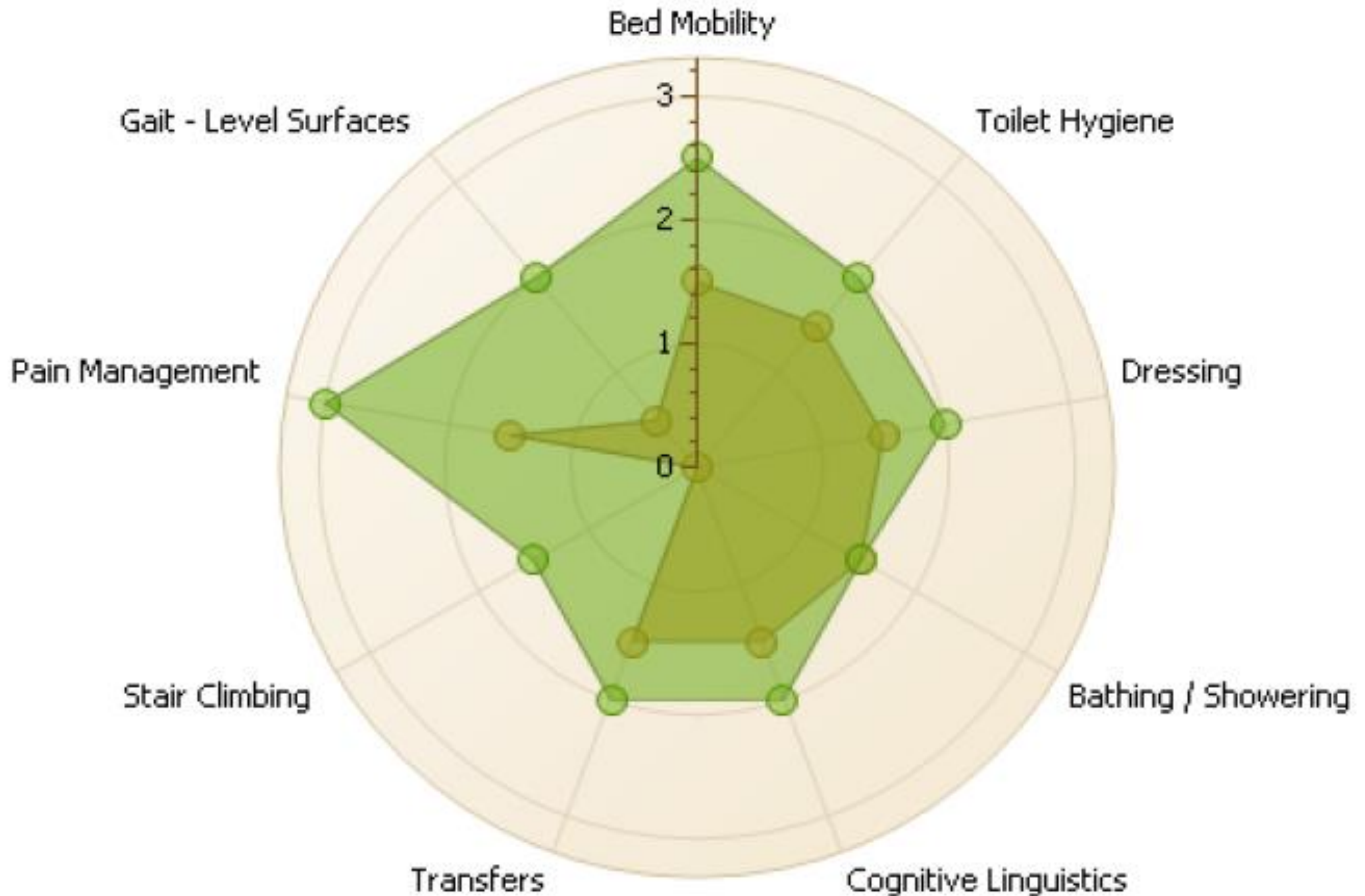
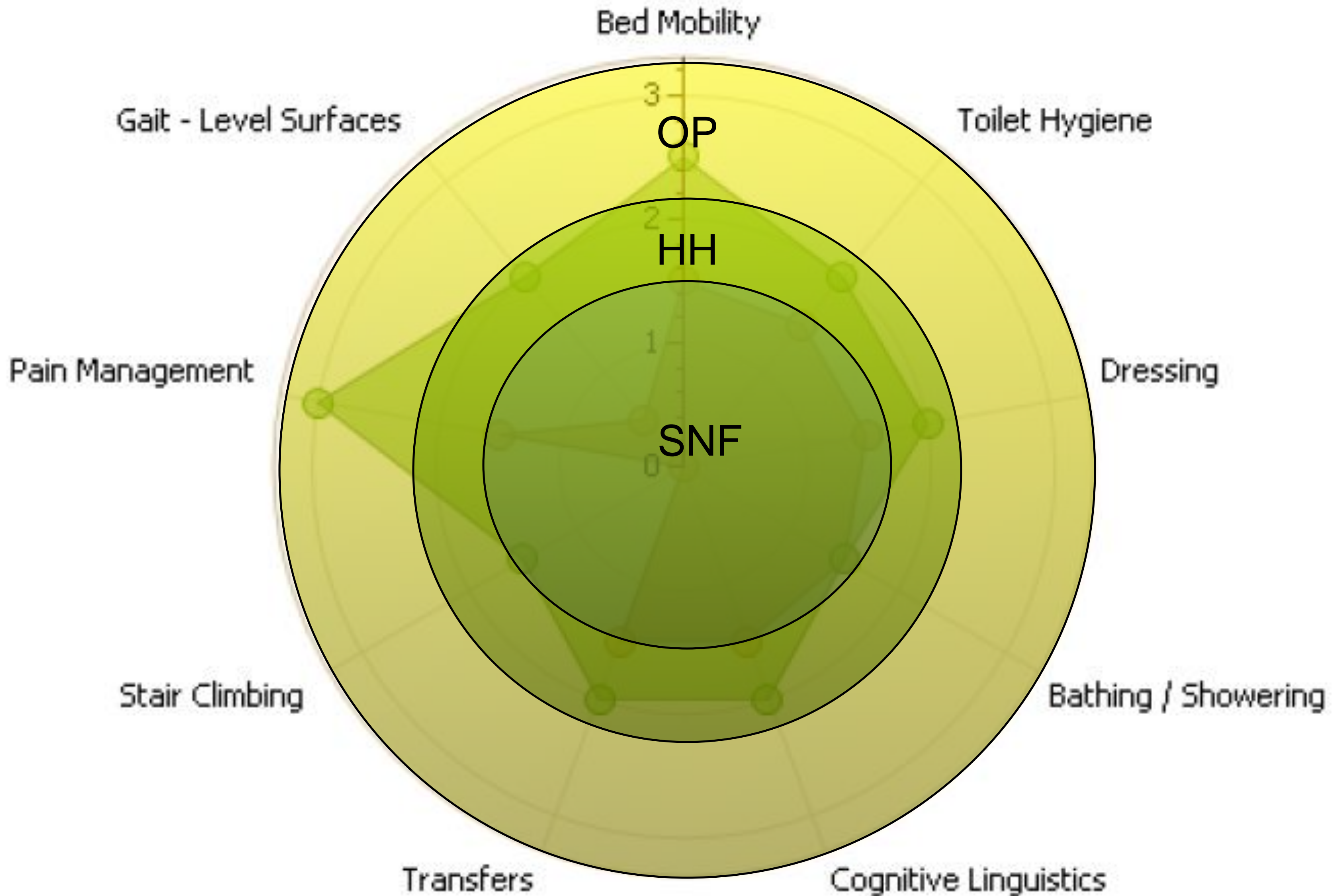
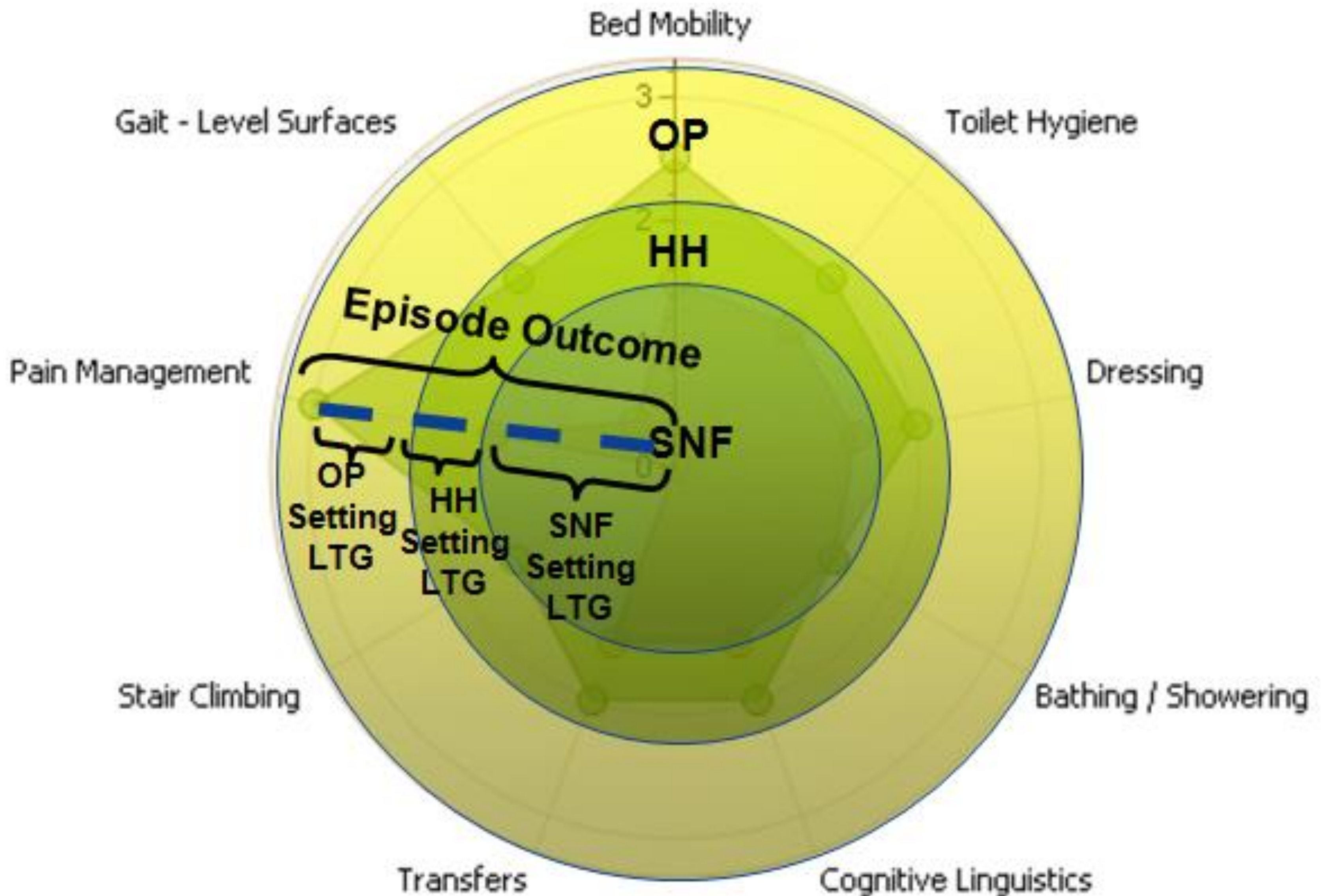
Care Redesign – What does it mean?



Care Redesign – What does it mean?



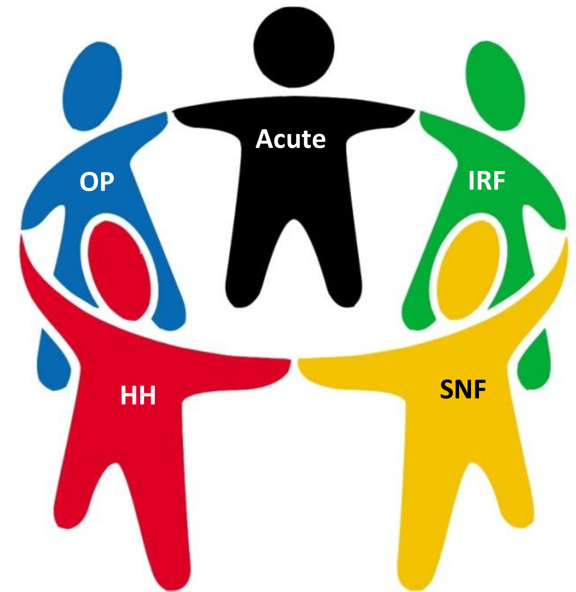
Care Redesign – What does it mean?



Care Redesign – What does it mean?

CMS believes that the CJR model will incentivize hospitals and PAC providers to:

Focus on the **patient's** experience throughout the episode of care by **collaborating** and coordinating the services that are delivered so that they can demonstrate **value** by providing that care in the most **efficient** setting while still achieving the patient's goals.



Comprehensive Care for Joint Replacement (CJR)

- Retrospective bundled payment model for
- Projected to save $343 million over 5 year period
- There are 430,000 TJRs in DRG 469 and 470 per year costing Medicare $7 billion per year
- Implementation began April 1, 2016
- With few exceptions, participation is mandatory. Unlike all other existing bundled payment models
- Applies to all acute care hospitals furnishing the services in 67 selected MSAs (approximately 800 hospitals in 33 states)
- Goals
  - Aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries – hip and knee replacements
  - Tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and PAC providers to work together to improve quality and coordination of care from the initial hospitalization through recovery

CJR – Summary of Key Provisions

- Involves two DRG groups:
  - 469 major joint replacement or reattachment of lower extremity with major complications or co-morbidities (MCC)
  - 470 major joint replacement or reattachment of lower extremity without MCC
- Episode initiated with admission to hospitals for lower extremity joint replacement (LEJR) procedure assigned to DRG 469 or 470
- Episode ends 90 days after discharge from the acute care hospital and includes the acute hospital claim costs
- Episode includes LEJR procedure, inpatient stay and all related care covered under Medicare Parts A and B within 90 days after discharge including hospital care, post-acute care and physician services.

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Services included in the Bundle

- The following categories of items and services are included in the episodes:
  - Physician services
  - Inpatient hospital services (including hospital readmissions)
  - Inpatient psychiatric facility (IPF) services
  - Long-term care hospital (LTCH) services
  - Inpatient rehabilitation facility (IRF) services
  - Skilled nursing facility (SNF) services
  - Home health agency (HHA) services
  - Hospital outpatient services
  - Outpatient therapy services
  - Clinical laboratory services
  - Durable medical equipment (DME)
  - Part B drugs
  - Hospice services

CJR – Summary of Key Provisions

- Participant hospitals in selected markets would be episode initiators and bear financial risk
- Risk bearers cannot be non-Medicare providers (companies such as Remedy Partners, naviHealth, Signature Medical and others)
- Retrospective annual reconciliation against a target price. Upside opportunity for years 1-5; downside risk only for performance years 2-5.
- CJR hospitals will receive separate episode target prices for DRG 469 and 470 reflecting difference in spending and will use risk stratification methodology to set different target prices for patients with hip fracture within each DGR due to significantly higher spending associated with these more complicated cases.

CJR – Summary of Key Provisions

- Target prices will reflect a blend of historical hospital specific and regional spending with regional component increasing over time
- The target price will include up to 3% discount to Medicare representing their upfront savings and the pool from which incentive dollars to top-performing hospitals will be paid.
- Payment eligibility dependent on performance on three hospital-based quality measures
    1. Complication measure - hospital level complication rate (RSCR) following elective primary THA and/or TKA
    2. Patient experience survey measure – HCAHPS survey
    3. Voluntary data submission – patient reported outcomes (PRO)

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CJR – Summary of Key Provisions

- Following completion of a CJR model year, participant hospitals that achieve actual episode spending below the target price and achieve minimum composite quality scores will be eligible to earn a reconciliation payment for the difference up to a cap:
  - Up to 5% of the target price in years 1 & 2, 10% in year 3 and 20% in years 4 & 5

- Hospitals with episode spending that exceeds the target price will be financially responsible for the difference to Medicare up to specified repayment limits:
  - No repayment responsibility in performance year 1
  - 5% in performance year 2
  - 10% in performance year 3
  - 20% in performance years 4 & 5

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Quality Measures

The CJR program will implement quality performance standards that must be met for the hospitals to receive reconciliation payments.

Quality Measure	Weight in Composite Quality Score - Proposed	Weight in Composite Quality Score - Final
Hospital level 30-day, all-cause readmission following elective primary THA and/or TKA	20%	N/A
Hospital-level complication rate (RSCR) following elective primary THA and/or TKA	40%	50%
HCAHPS survey	30%	40%
Voluntary THA/TKS data submission on patient reported outcome experience	10%	10%

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Quality Measures

The hospital’s composite quality score is a summary score reflecting performance and improvement on two measures

Performance Percentile	THA/TKA Complications measure quality performance score (points) (1 additional pt available for improvement)	HCHAPS Survey measure quality performance score (points) (0.8 additional point available for improvement)
≥ 90th	10.0	8.00
≥ 80th and <90th	9.25	7.40
≥ 70th and < 80th	8.5	6.80
≥ 60th and < 70th	7.73	6.2
≥ 50th and < 60th	7.00	5.60
≥ 40th and < 50th	6.25	5.00
≥30th and <40th	5.5	4.40
< 30th	0.00	0.00

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Quality Measures

Composite scoring methodology determines

1. Hospital eligibility for reconciliation payments
2. Amount of quality incentive payment that may be made to hospital

For Performance Year One:

Composite quality score	Quality Category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount % for reconciliation payment	Effective discount % for repayment amount
< 4.0	Below Acceptable	No	No	3.0	NA
≥ 4.0 and <6.0	Acceptable	Yes	No	3.0	NA
≥ 6.0 and ≤13.2	Good	Yes	Yes	2.0	NA
> 13.2	Excellent	Yes	Yes	1.5	NA

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Quality Measures

For Performance Years 2 and 3:

Composite quality score	Quality Category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount % for reconciliation payment	Effective discount % for repayment amount
< 4.0	Below Acceptable	No	No	3.0	2.0
≥ 4.0 and <6.0	Acceptable	Yes	No	3.0	2.0
≥ 6.0 and ≤13.2	Good	Yes	Yes	2.0	1.0
> 13.2	Excellent	Yes	Yes	1.5	0.5

For Performance Years 4 and 5:

Composite quality score	Quality Category	Eligible for reconciliation payment	Eligible for quality incentive payment	Effective discount % for reconciliation payment	Effective discount % for repayment amount
< 4.0	Below Acceptable	No	No	3.0	3.0
≥ 4.0 and <6.0	Acceptable	Yes	No	3.0	3.0
≥ 6.0 and ≤13.2	Good	Yes	Yes	2.0	2.0
> 13.2	Excellent	Yes	Yes	1.5	1.5

CJR – Summary of Key Provisions

- Beneficiary protections
  - Retain the right to obtain care from any qualified Medicare provider
  - Beneficiaries are automatically included in the model and cannot opt out. Also cannot opt out of data sharing.
  - Hospitals must provide written information
- Beneficiary exclusions
  - Medicare Advantage members
  - ESRD
  - Medicare is secondary payer

CJR – Summary of Key Provisions

- Waivers related to SNFs and physicians will be available
  - Beginning Jan, 2017, the 3-day stay waived for SNF admission providing the SNF is 3-star or higher at the time of hospital discharge and for 7 of prior 12 months; Applies only to CJR patients.
  - Telehealth waivers;
  - Home visit supervision waivers
- Gainsharing agreements with PAC providers are allowed, within limits

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Why Is This Important?

1

Mandatory Program
This is the first mandatory CMMI demonstration requiring participating from all hospitals located in 67 MSAs

2

Hospitals Bear Financial Risk
Hospitals must bear risk for hospital care and 90 days post-discharge for MS-DGRs 469 and 470

3

CMS Aggressively Pursuing Shift to Value-Based Payments
Hospitals not in one of the selected MSAs should still continue preparing to take on more financial risk

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How Does it Work? How will Participants and Providers Be Paid?

Set Target Price

Price is set based on 3 years of historical data on episode payments for MS-DRG 469 and 470. **CMS then applies a discount**, which is generally 2 percent.

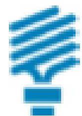
Upfront FFS Payments

Medicare will pay all Part A and Part B providers who serve patients identified as participating in the initiative using the **current FFS payment systems**.

Payment Reconciliation

After the patient's episode ends, **actual expenditures will be compared to the target price.**

- If expenditures exceed the target price, the hospital will pay difference to Medicare.
- If expenditures are less than target price, and quality threshold is met, Medicare will pay difference to hospital.



Note: BPCI Model 2 and Model 3 Joint Replacement episodes entered into Phase 2 on or before July 1, 2015 take precedence over CCJR episodes

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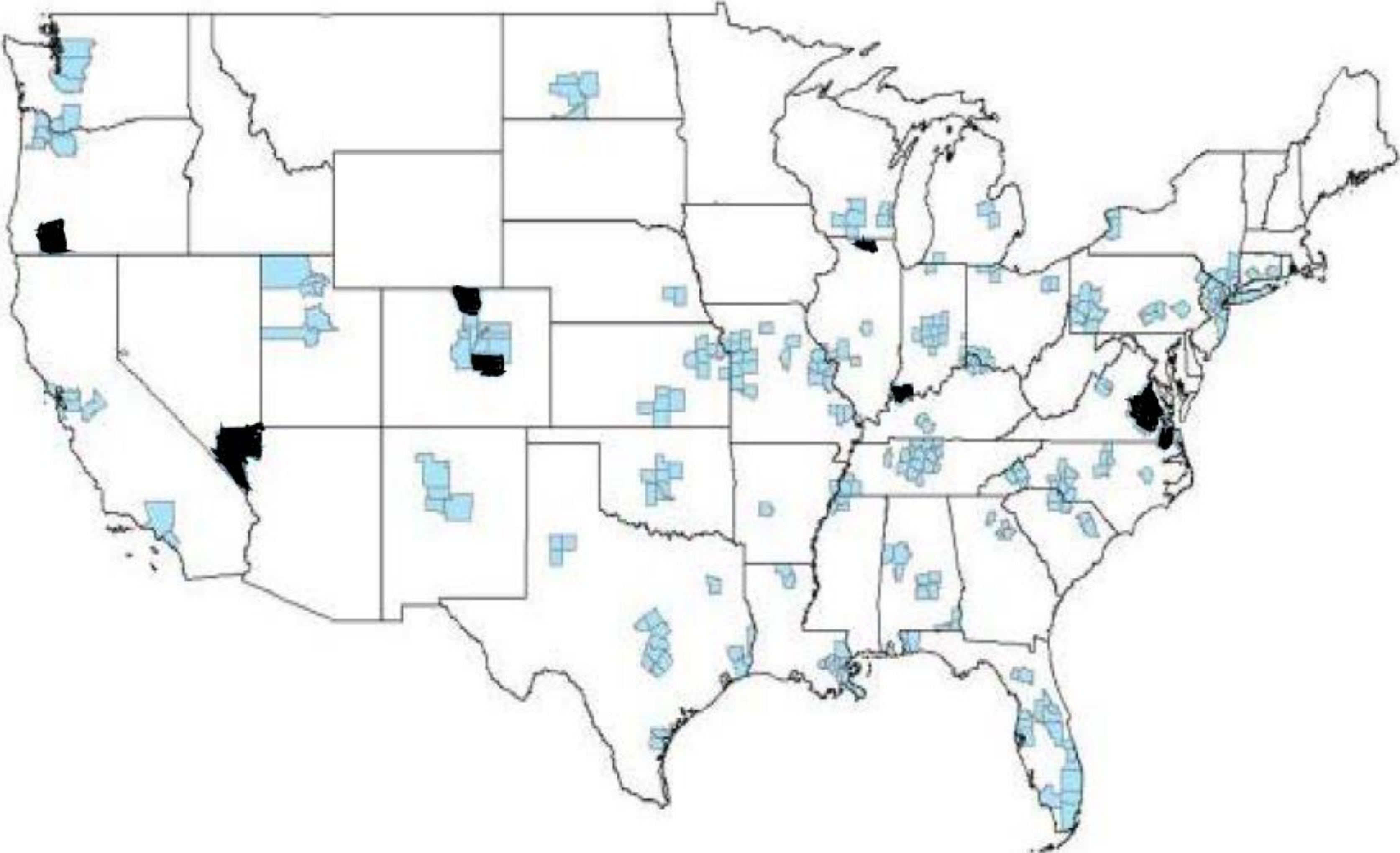
Where is This Going to Happen?
Revised from 75 MSAs to 67



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67 MSAs

MSA	MSA Title	Counties
10420	Akron, OH	Portage County, Summit County
10740	Albuquerque, NM	Bernalillo County, Sandoval County, Torrance County, Valencia County
11700	Asheville, NC	Buncombe County, Haywood County, Henderson County, Madison County
12020	Athens-Clarke County, GA	Clarke County, Madison County, Oconee County, Oglethorpe County
25420	Harrisburg-Carlisle, PA	Cumberland County, Dauphin County, Perry County
35620	New York-Newark-Jersey City, NY-NJ-PA	Dutchess County, Bergen County, Bronx County, Essex County, Hudson County, Hunterdon County, Kings County, Middlesex County, Monmouth County, Morris County, Nassau County, New York County, Ocean County, Orange County, Passaic County, Pike County, Putnam County, Queens County, Richmond County, Rockland County, Somerset County, Suffolk County, Sussex County, Union County, Westchester County
38300	Pittsburgh, PA	Allegheny County, Armstrong County, Beaver County, Butler County, Fayette County, Washington County, Westmoreland County
39740	Reading, PA	Berks County

Episode Costs – Average Medicare Payment per CJR Episode

Physician, $1,675

Durable Medical Equipment (DME), $122

Outpatient, $604

Hospital Readmissions, $1,155

Home Health Agency (HHA), $2,123

Inpatient Rehabilitiation Facility (IRF), $1,568

Skilled Nursing Facility (SNF), $5,034

Long-term Acute Care Hospital (LTACH), $91

Initial Hospital Stay, $13,193

Post-discharge spending

Total Medicare Payment per Episode = $25,565

Source: Avalere analysis of the 2012, 2013 and 2014 Medicare Standard Analytical Files. Includes episodes initiating between Jan 1, 2012 and Sept 30, 2014. Physician and DME payments estimated using 5% national sample, all other payments reflect averages derived from 100% of Medicare claims nationally. Avalere analysis excludes all physician and outpatient spending from the post-discharge period.

Now What? What Does it all Mean?

- The mandate to hospitals is clear – Reduce costs and Maintain or Improve Quality

- **Reduce Costs** – possible strategies
  - Careful selection of PAC providers
  - Actively manage LOS
  - Increased focus on avoidable readmissions
  - Shift in discharge patterns / PAC utilization

- **Maintain/Improve Quality** – possible strategies
  - Actively encourage patient choice
  - Establish quality performance expectations
  - Offer downstream clinical support
  - Manage downstream escalations
  - Care pathways

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Now What? What Does it all Mean?

- A hospital's financial performance will be highly dependent on downstream care
  - **hospitals will care more where their patients go**
- Expect hospitals to establish performance metrics / scorecards
  - Length of Stay
  - Readmission Rates
  - Patient Satisfaction
  - Staffing levels
  - Rehabilitation Services availability
  - Patient Outcome Measures

Now What? What Does it all Mean?

- Some hospitals will pursue risk-sharing agreements
  - To share upside gain or downside risk, hospital and PAC partners must have formal agreements that abide by certain restrictions
    - Providers must furnish billable services
    - Gainsharing payments must be partly based on quality metrics set by hospital
    - A single PAC provider cannot 'pay' more that 25% of total repayment required

- According to Avalere, the launch of CJR marks a shift in how CMS is approaching alternative payment models, and providers everywhere should take note, **even if bundled systems are not yet required in their markets or settings.**

- Industry analysts, including Avalere, report that in the final year of the Obama Administration, they expect CMMI to develop more mandatory models, similar to CJR as they look to accelerate the transition to value-based care.

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What Next?

Exhibit 3.2: Frequency and Total and Average Medicare Episode Payments of Select MS-DRG Families for 30-day Fixed-length Episodes (2007-2009)

MS-DRG Family	Med/ Surg	Number of Episodes	Percent of Episodes	Rank	Total Episode Payment (billions)	Percent of Episode Payment	CV of Total Episode Payment	Average Episode Payment
Major joint replacement or reattachment of lower extremity (469, 470)	Surgical	1,230,640	4.7%	1	$24.2	6.3%	0.42	$19,631
Heart failure & shock (291, 292, 293)	Medical	1,228,240	4.7%	2	$14.7	3.9%	0.80	$12,006
Simple pneumonia & pleurisy (193, 194, 195)	Medical	1,029,800	3.9%	3	$10.7	2.8%	0.82	$10,381
Chronic obstructive pulmonary disease (190, 191, 192)	Medical	956,240	3.7%	4	$9.0	2.3%	0.79	$9,382
Intracranial hemorrhage or cerebral infarction (64, 65, 66)	Medical	619,860	2.4%	9	$10.3	2.7%	0.71	$16,681
Hip & femur procedures except major joint (480, 481, 482)	Surgical	403,940	1.5%	15	$9.9	2.6%	0.38	$24,432
Perc cardiovasc proc w drug-eluting stent (247)	Surgical	329,800	1.3%	20	$4.5	1.2%	0.40	$13,568
Coronary bypass w cardiac cath (233, 234)	Surgical	100,260	0.4%	59	$4.0	1.0%	0.42	$39,646
Revision of hip or knee replacement (466,467,468)	Surgical	94,480	0.4%	65	$2.3	0.6%	0.45	$24,121
Cardiac valve & oth maj cardiothoracic proc w/o card cath (219, 220, 221)	Surgical	71,420	0.3%	78	$3.2	0.8%	0.45	$44,926
Coronary bypass w/o cardiac cath (235, 236)	Surgical	66,120	0.3%	86	$2.0	0.5%	0.45	$29,534
Cardiac valve & oth maj cardiothoracic proc w card cath (216, 217, 218)	Surgical	39,800	0.2%	125	$2.3	0.6%	0.39	$58,075
Bilateral or multiple major joint procedures of lower extremity (461,462)	Surgical	33,720	0.1%	137	$1.0	0.3%	0.33	$30,281
Nonspecific cva & precerebral occlusion w/o infarct (67,68)	Medical	32,520	0.1%	140	$0.3	0.1%	0.76	$10,533
Acute ischemic stroke w use of thrombolytic agent (61, 62, 63)	Medical	18,020	0.1%	177	$0.4	0.1%	0.56	$24,599
Coronary bypass w ptca (231, 232)	Surgical	6,260	0.0%	249	$0.3	0.1%	0.37	$50,720

Source: Dobson | DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars. All episodes have been extrapolated to reflect the universe of Medicare beneficiaries. Medicare Episode Payment includes care from all facility-based and ambulatory care settings and excludes beneficiary co-payments. IME, DSH, copay, capital, and other third party have been removed from payments. HH PPS payments do not include payments for Part D drug or DME services that are provided under SNF, IRF, and LTCH PPS payments.

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What Next? New bundles proposed by CMS in August, 2016

- Three new episode payment models (bundles)
  - Acute Myocardial Infarction (AMI)
    - DRGs: PCI 246-251; AMI 280-282
  - Coronary Artery Bypass Graft (CABG)
    - DRGs: 231-236
  - Surgical Hip/Femur Fracture Treatment (SHFFT)
    - DRGs: 480-482
  - A Cardiac Rehabilitation (CR) Incentive payment model
  - As proposed, would begin July, 2017 and end December, 2021

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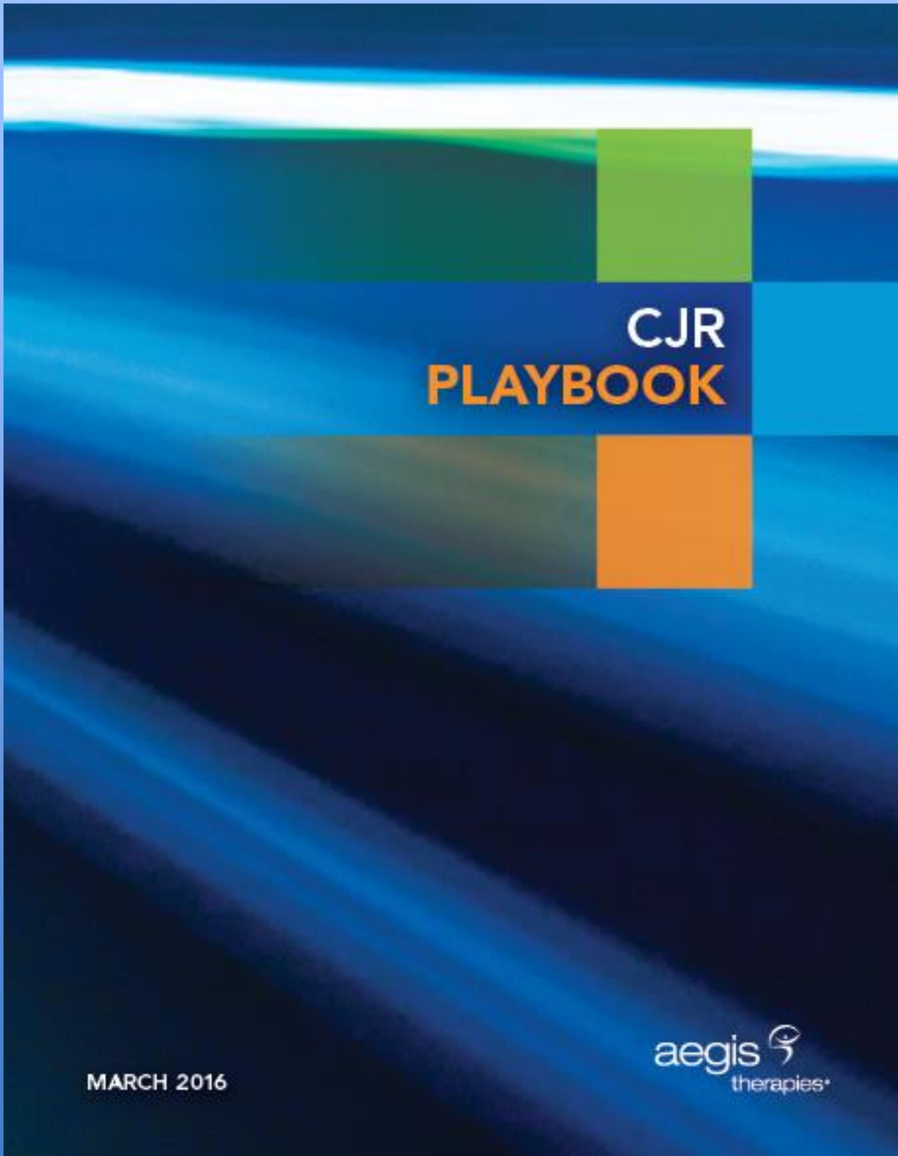
Aegis Support Tools



Aegis Support Tools

HOSPITAL DISCUSSION CHECKLIST

Partner: ___________________________

CJR Hospital Partnership Checklist			
Topic	Check as Completed	Next Steps Needed	Comments
Understanding of CJR background and MSA designation impact			
What are you looking for in a post-acute care (PAC) partner?			
Hospital Metrics			
• # procedures/month for 469			
• # procedures/month for 470			
• Current LOS in acute hospital			
• Discharge locations: % to SNF and % to HHA			
• Which SNFs			
• Which HHAs			
Share SNF metrics on:			
• # admissions for 469			
• # admissions for 470			
• Current LOS			
• Discharge locations			
• Outcomes			
• Rehospitalization rate			
Navigation/communication and tracking over the 90-day continuum of care			
Gain sharing opportunities?			
Is SNF ≥ 3 star (3 star quality rating) for 7/12 prior months (beginning 2nd year)			
What else do they need from us (SNF and/or Aegis)?			

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SNF PREPARATION CHECKLIST

Partner: ___________________________

CJR SNF Partnership Checklist			
Topic	Check as Completed	Next Steps Needed	Comments
Understanding of CJR background and MSA designation impact			
Staff training needs for care redesign and CJR impact on facility and patient care			
• DNS, ADNS, RNAC			
• Charge nurses			
• Admissions staff			
• Social worker(s)			
• Activities staff			
Changes needed for admission patterns?			
Changes needed for therapy staffing			
Facility stats /metrics			
• # admissions for 469			
• # admissions for 470			
• Current LOS			
• Discharge locations			
• Outcomes			
• Rehospitalization rate			
• Education regarding rate and concerns?			
Referral partners (hospitals, HHAs, outpatient clinics, physicians, etc.)			
• Who are they?			
• What conversations have occurred?			
• Next steps needed with these partners?			

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Keys to Success

- Meet with hospitals to understand their approach to EPMs like CJR
  - Some taking a wait and see approach
  - Others already making network selections based on prior history
  - What are your hospitals doing?

- Analyze utilization data
  - Number of target procedures at hospitals
  - Where have hospitals discharged these patients?
  - Has that pattern changed?
  - Your risk or opportunity

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Keys to Success

- Understand market dynamics and your position in the marketplace
  - Identify what you have to offer the hospital

- Know your key metrics
  - Medicare LOS
  - Readmit %
  - 5-star score
  - Average SNF episode cost

- Readmissions will be a major driver of CJR episode costs – requires high focus to manage and reduce

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Identify Opportunities

- Help with Patient Placement
  - Hip fracture patients with THR will have higher target prices.
  - Higher target price makes SNF stay less likely to drive episode overuns
  - Develop and demonstrate high capabilities with these more fragile patients
- Help organize a Post-Acute Network
  - Partner with other PAC providers (other settings) to facilitate smooth, safe and efficient transitions
- Need to avoid downstream ‘system contacts’ (hosp, ER)

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Identify Opportunities

Learn and Understand Hospital 'Pain Points' and Needs

- Need for high quality post-acute partners
  - Hospitals are often unaware of PAC utilization patterns (Advisory Board)
  - "Hospitals don't know where their patients go after they are discharged. Their success under CJR will hinge on being able to track patients and partner with high-performing post-acute care providers." (Avalere report, March 30, 2016)

- Be innovative
  - Offer Prehab services
  - Be active in or even provide the care coordination

- Develop and offer Clinical Pathways
  - From a medical management perspective, joint replacement peri-operative clinical pathways result in better outcomes that are achieved faster and at lesser cost (J Orth Surg, JAMA)

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Traditional Care Pathway

CABG- DRG 106, 107							
Anticipated post-acute phase LOS: 21 days							
Problem/Focus	**Pre-admission indicators. Post op day ______**	**1st 24 hours. Post Op day _____.**	**1st 48 hours. Post Op day _____.**	**Day 3-6. Post Op day_____.**	**Day 7-10. Post Op day_____.**	**Day 11-14. Post Op day ______.**	**Day 15-21. Post Op day____.**
Discharge Planning	Site of discharge identified Y/N	Pt/family will state projected discharge goals. Initiate patient activation / education. Determine if rehab home assessment is needed	Pt/family will state projected discharge goals.	Patient/family will have a clear understnading of care upon discharge.	Patient/family will have a clear understnading of care upon discharge.	Pt's discharge environment will be appropriately equipped. Ensure home assessment is completed if applicable.	Pt will be discharged to a safe environment with an appropriate discharge plan. Follow up appointments are scheduled.
Pain	P.O.med routine established Y N. Sufficient comfort level to allowprogram compliance Y/N.	Patient will communicate pain level and previous relief history.	Pt's pain control will be sufficient to allow full program participation.	Pt's pain control will be sufficient to allow full program participation.	Pt's pain control will be sufficient to allow full program participation.	Pt's pain control will be sufficient to allow full program participation.	Pt will be discharged, unimpeded by pain.
Alteration in Functional Mobility	Ambulate 3-4 minutes BID and more as tolerated with support. Actively participates with ADLs. Fair endurance 30 minutes.	Amb 3-4 min BID and more as toleraed with support. Actively participates with ADL's. Performs exercises per treatment plan.	Continues to increase ambulation. Begins stairs or per MET level progression per MD	Continues to increase ambulation. Progresses with stairs.	Continues to increase ambulation. Climbs full flight of stairs.	Continues to increase ambulation. Climbs full flight of stairs.	Patient achieves level of mobility appropriate to function in discharge/transfer environment.
Cardiac Output	Cardiovascular assessment indicates adequate tissue perfusion. Maintains hemodynamic stability w/o IV drips. Is off telemetry.	Patient demonstrates a stable cardiovascular status.	Patient demonstrates a stable cardiovascular status.	Patient demonstrates a stable cardiovascular status.	Patient demonstrates a stable cardiovascular status.	Patient demonstrates a stable cardiovascular status.	Pt is discharged with a stable cardiovascular status.
Potential for post-operative complication. **cross reference care map inserts for anticoagulation Problems of immobility.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Anticoagulation Y/N. No S &S of thromboembolism Y/N. No S &S of wound infection. No problems related to immobility Y/N.	Pt will be discharged free of post-operative complication.
Assessments/ Consults	Discharge Summary Y/N. Insurance authorization Y/N.	MD orders obtained. MD, Nsg, OT, PT, SS, Activities, Dietary assessments started.	All assessments completed: MD, Nsg, OT, PT, SS, Activities, Dietary.	All assessments completed: MD, Nsg, OT, PT, SS, Activities, Dietary.	Home assessment completed. Meds reevaluated and ordered.	Discharge orders written. Follow up appointments scheduled as appropriate.	All documentation complete.
Specimens Tests: * if patient is on							

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Aegis 90-day Milestone Pathway

TOTAL KNEE REPLACEMENT CARE PATH

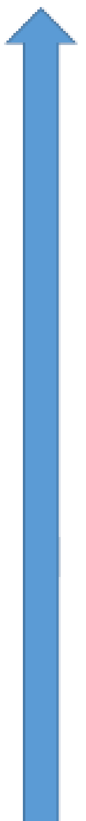
Total Knee Replacement - 90 day Milestone Marker Care Path				
Skilled Nursing Facility Home Health Outpatient	**Skilled Nursing Facility Home Health Outpatient**	**Skilled Nursing Facility Home Health Outpatient**	**Not SNF Home Health - Milestone 4 Outpatient - Milestone 5**	**Wellness/Caregiver Home Exercise Program/ Independent**
Milestone 1	**Milestone 2**	**Milestone 3**	**Milestone 4**	**Milestone 6**
Post Acute Day 1-2	**Post Acute Day 1-5**	**Post Acute Day 1-8**	**Post Acute Day 1-23**	**Post Acute Day 36-90+**
1. Verbalize understanding and demonstrates knowledge of TKR precautions.	1. Transfers with 26-50% assistance	1. Basic ADLs with 25% assistance (bed mobility, eating, toileting, transfers)	Community mobility no longer takes clear and taxing effort	1. Maintain functional ability as demonstrated by repeat key assessments
2. Transfers to chair and tolerates sitting up to 4 hours	2. Demonstrates understading of red zone triggers	2. Household mobility with/without assistive device	**Milestone 5** **Post Acute Day 1-35**	2. Prompt identification, commmunication and referral if change in function/medical status
3. Ambulates in room with/without assistive device and with/ without assistance	3. Resting pain is ≤ 5/10 for last 24 hours	3. Asymptomatic surgical incision	1. Able to complete IADLs independently	3. No hospital readmission

Aegis 90-day Milestone Pathway

RED = should be done by that discipline
* details of BOOMER in CJR Playbook

GREEN = could be a state practice act issue that limits a discipline

BLUE = could be either discipline if properly trained

	Milestone 1 Post Acute Day 1-2	Milestone 2 Post Acute Day 3 - 5	Milestone 3 Post Acute Day 6 -8	Milestones 4 and 5 Post Acute Day 9 -35	Milestone 6 Post Op Day 36 - 90+
	Physical Therapy				
Assessments	Vital signs Edema Skin incision/skin temperature TUG Functional Reach Pain ROM Strength Functional mobility Weight bearing- note status and ability to maintain	PATIENTS ENTERING PATHWAY: Complete all assessments as demonstrated in Milestone 1 + remaining components of BOOMER* (step to test and and static stance) PATIENTS PROGRESSING FROM MILESTONE 1: Monitor all key areas demonstrated in Milestone 1. Document vital signs, pain, edema, and cummulative BOOMER score. Identify any issue preventing progression to Milestone 3.	Retest BOOMER - details in CJR Playbook Gait Speed test- details in CJR Playbook Edema Skin incision/skin temperature Pain ROM Strength Functional mobility	Vital signs TUG Skin/incision Edema KOS- ADL Pain ROM Balance Strength Mobility For Outpt(Milestone 5) also complete these tests Lower Extremity Funational Scale (LEFS(6 Minute Walk Test (6MWT) Patellofemoral mobility (assess if hyper/hypo mobile and impact)	
As needed/ per MD order	ROM affected knee: < 10° - 60°	ROM affected knee: < 10° - 70°+	ROM affected knee: ≤ 5° - 90°+	ROM affected knee: 0° - 105°	
Interventions – Pain Edema	Electrical stim (IFC) for pain/edema. Train/transition ice for swelling/pain to Wellness team.	Assess effectiveness of intervention, and modify as appropriate.	Assess effectiveness of intervention, and modify as appropriate.	Assess effectiveness of intervention, and modify as appropriate. Patellofemoral taping if appropriate and effective.	
Interventions – Mobility	Pre-gait and gait training. Identify safety issues. Passive low load stretch for extension.	Gait on uneven surfaces; up/down 2-6 steps. Dynamic balance activities/neuromuscular re-ed.	Advance high level mobility and dynamic balance activity. (For OT should be services within the practice act.)	Community Mobility - continue high level mobility and dynamic balance translated into functional task and patient's lifestyle.	
Interventions – Strength	HEP - open chain exercise - AA to independent as follows: Heel slides Glut sets SAQ/LAQ SLR Train/transition open chain exercise to Wellness/RNA program Train/transition UE exercise to Wellness / RNA if not independent	HEP - closed chain exercise which may include (expand per clinical judgement): Partial squats Leg press Functional sit to stand Standing exercise FTF E-Stim for targeted muscle training Core strengthening exercise	Continue closed chain exercise and progress as appropriate. NMES at 60° flexion. 	Continue closed chain exercise and progress as appropriate. Advanced strengthening exercises which effectively translate into functional task completion.	
Interventions – Education	Establish CPM program if ordered. Caregiver training on CPM. Passive low load stretch for extension with caregiver education. Sign/symptoms of DVT. Importance of nutrition.	Safety instruction regarding discharge to home and activity restriction. Education regarding signs and symptoms of exacerbation of co-morbidity.	Patient demonstrates understanding of the care pathway.	Patient demonstrates understanding of the care pathway and importance of continued focus on maintaining strength, endurance, and functional ability. Patient verbalizes understanding of importance of early identification of exacerbation of co-morbidity.	
Orientation	Overview of 90-day care pathway. Review goals / expectations: Avoid re-hospitalization. Routine participation. Positioning in bed - no pillow under knee. Therapy transitioning to 6 - 7 days/week. Inclusion of Wellness. Complex disease management. Transition planning. Education on healing process. Education on Red Zone Triggers. Education on fall prevention.	Ongoing reinforcement of orientation concepts with re-training as needed. 			Assess/treat as appropriate and ordered if patient referred back for SNF/HH/OP services within this post op period. Review functional level and restart the milestone pathway accelerating through pathway as gauged by functional milestones. Identify/focus on issues placing patient at risk for rehospitalization, consider living environment and support network.

What Can You Leverage?

- Any bundled payment experience in Model 3 and Model 2
- Any ACO experience
- Clinical pathways - be innovative
- Care redesign approaches and the use of accelerating systems to process patients through more rapidly
- Attending M.D.s connected with the hospital collaborator
- Demonstrated positive outcomes
- IT experience and capabilities (e.g., 90-day tracker)
- Existing PAC provider partnerships

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What Is Financial Success in CJR?

- Increased volume as measured by admissions
- 3-day stay waivers can bring incremental volume – 3-star and above facilities
- Opportunity to accept risk-gain share dollars are voluntary (new money is available in reducing readmissions)
- Demonstrate strong transitions of care to reduce readmissions
- Understand and support key hospital metrics – e.g., LOS, re-hospitalizations
- Eagerly support the hospital quality measures

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Next Steps/Needs

- Communication with hospitals
- Assess readiness for care redesign strategies
- Clinical Pathways
- Develop operational plan/model that incorporates the use of care coordination and communication strategies with the hospital
- Consider risk-bearing capabilities
- How will you demonstrate value?

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Resources

List of selected geographies and participant hospitals

- https://innovation.cms.gov/initiatives/cjr

MedLearn Matters article (MM9533)

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533

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