CJR Hospital Highlights – May 2021

This month's case study comes from the CJR Performance Year (PY) 3 Evaluation Report. If you want to read the full case study, please refer to page 37 of Provider Experiences Under the CMS Comprehensive Care for Joint Replacement Model: Case Studies from Three Mandatory Markets.

Hospital A is a small, partially-physician-owned, specialty hospital. Hospital A has 12 beds and performs an average of 30 Medicare lower extremity joint replacement (LEJR) procedures annually. Hospital A is considered a "boutique" hospital and prides itself in offering easy scheduling for patients and surgeons, patient amenities, a high nurse-to-patient ratio, quiet rooms, and prompt in-person communication. The patient mix at Hospital A is younger than the average. As they do not have an intensive care unit, higher-risk patients may be referred to another hospital in the same MSA.

How did Hospital A respond to the CJR model?

In response to the CJR model, Hospital A implemented a variety of different activities. The two activities described below were reported as being particularly successful.

> **Strategies for care coordination.** Hospital A highlighted their efforts to improve and standardize care coordination, but recognized that care coordination decisions are driven by each surgeon's preferences. They reported that some surgeons conduct one-on-one pre-operative education, during which they communicate hospital LOS expectations and inquire about the patient's home environment. Other key staff involved in care coordination include a post-surgical unit manager, inpatient nurses and physical therapists, and a PA hospitalist. The post-surgical unit manager is involved in case management tasks such as communicating with the patients and caregivers post-operatively, ensuring that post-discharge needs are met, faxing order sets to PAC providers, and collecting CJR PRO data. Inpatient nurses provide education to patients and are available to answer their questions. The PA hospitalist is responsible for inpatient medical management, which involves the management of medication regimens, complications as a result of anesthesia, and comorbidities. The hospitalist communicates with the surgeon and post-surgical unit manager to determine the appropriate discharge setting.
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> **Focus on patient and caregiver experience.** Hospital A reported an increased expectation of patient engagement in their LEJR recovery as a result of the CJR model, which they consider to be a positive change. Surgeons at Hospital A communicate with the patient about expected length of stay and ambulation, and encourage patients to identify a caregiver. One Hospital A surgeon expressed that pre-operative education and expectation setting decreases anxiety and empowers the patient. One interviewee also reported increased reliance on caregivers in the home for patients in the CJR model.

What was the impact of the hospital's efforts?

> **Increased reconciliation payments.** Hospital A earned a reconciliation payment in PY 2, and nearly doubled the amount of their reconciliation payment in PY 3.
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> **Improved quality scores.** Hospital A's quality scores improved from "acceptable" in PY 1 to "good" in PY 2 and PY 3.

What are your thoughts on Hospital A's experience? *Is your hospital doing anything similar? Please share your reactions with your peers by posting to the* CJR Connect *Chatter feed in the "CJR All" group!*

This hospital's tactics and approaches align with several CJR "drivers" or implementation strategies: *Right Care, Right Time* and *Coordination Across the Care Continuum*. Want to learn more about the specific CJR drivers? Check out the CJR Toolkit!