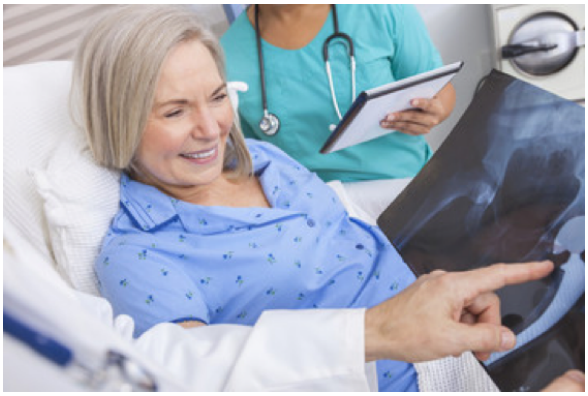
Comprehensive Care for Joint Replacement Model (CJR) News: Issue 33. July 9, 2019

CENTER FOR MEDICARE & MEDICAID INNOVATION

CJR News



In This Issue:

We Want to Hear from You!

Help us improve *CJR News*! The CJR Learning System Team needs your help to make *CJR News* as useful as possible. Please take 1-2 minutes to provide your feedback on ways to improve the *CJR News* here.

Model Updates

The Centers for Medicare & Medicaid Services (CMS) has posted the Second Annual Evaluation Report.

The CJR model continues to demonstrate that a mandatory model for episode-based bundled payments is a promising approach to reduce payments for lower extremity joint replacement episodes, according to the evaluation report covering the first two performance years. A range of hospitals, with various resources and circumstances, significantly reduced gross episode payments, predominantly by discharging patients to less intensive post-acute care (PAC) facilities. Even with the shift to less intensive PAC, quality of care was

preserved. After accounting for reconciliation payments made to participants, the CJR model likely resulted in net savings to the Medicare program.

The evaluation found that 77% of CJR participant hospitals earned reconciliation payments in one or both performance years, which reflects that all different types of hospitals were able to achieve success. The researchers found that CJR episode payments decreased by 3.7% more than comparison hospitals in the first two years of the CJR model, representing a $146.3 million gross savings. CMS distributed $128.9 million in reconciliation payments to hospitals. After accounting for these payments, net savings to Medicare is estimated to be $17.4 million or 0.5% of baseline payments.

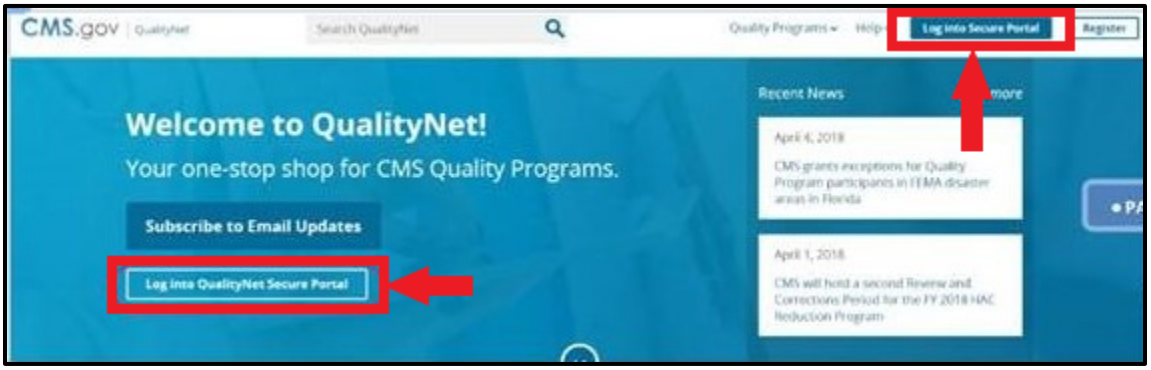
The evaluation attributes these savings to changes in PAC use: inpatient rehabilitation discharges decreased, while length of stays at skilled nursing facilities decreased. The researchers found that the CJR model did not impact quality of care, as measured by unplanned readmissions, emergency department visits, mortality, and patient surveys.

The evaluators collected robust information from hospitals through interviews, site visits, and a survey. Hospitals strategies focus on reducing PAC by focusing on patient education and early discharge planning, physical therapy post-surgery, and care coordination with PAC providers, which aligns with the goals of the CJR model. The report includes an in-depth look at how 11 different hospitals responded to the CJR model, check out the full case studies here.

For the 2-page *Findings at a Glance* document, click here. Read the full evaluation report here and access the appendices here.

CMS announced a redesign of the QualityNet website.

On July 26, CMS will deploy a redesign of the QualityNet website. This update will change the look and feel of the website, but the functionality will remain mostly the same. **The CJR model will continue to use QualityNet's Secure File Transfer for performance year (PY) 4 patient-reported outcomes (PRO) and risk variable data submission**, and the only notable change for CJR participant hospitals is the location of the log in link on the QualityNet landing page. Please see the image of the updated landing page for the location of links you can use to log in.



After logging in, follow the instructions in the PY 4 Guidance for Secure File Transfer document, available under the Libraries tab on CJR Connect.

As a reminder, for successful submission of PRO data in PY 4, hospitals must submit post-operative data for patients who received elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA) in PY 3 **and** pre-operative and risk variable data for patients undergoing an elective primary THA/TKA in PY 4.

All pre- and post-operative PRO data submitted in PY 4 should be entered into the **CJR PRO Data Collection Template** and submitted using the QualityNet Secure File Transfer by **August 31, 2019**.

Webinar News

Upcoming Events

Using Data to Drive Improvement: Data Collection, Analysis, & Reporting

July 31, 2019 ● 2-3 PM EDT ● Register

During this webinar, the Providence St. Joseph Health System team will share how they are using a Value-Oriented Architecture tool to drive improvement. They will share how the tool is used to lower costs while maintaining or improving the quality of care for CJR patients. The Providence St. Joseph team will also share information about the routine use of the tool and the improvement projects that have been implemented as a result of its use.

By the end of this event, participants should be able to:

1. Understand value-oriented architecture; and
2. Recognize how a CJR participant hospital has used a value-oriented architecture tool to drive improvement.

We encourage all data and quality staff who are working on continuous quality improvement and care redesign to join this event. However, participation is not limited to those in any specific role.

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Optimizing Patient Care Post-Hospitalization

August 14, 2019 ● 2-3 PM EDT ● Register

This webinar, focused on the Right Care, Right Time implementation strategy, will feature a presentation from a CJR participant hospital on strategies for optimizing patients' care after surgery. Attendees will have the opportunity to ask questions and share their strategies, successes, and opportunities for improvement related to patient optimization post-hospitalization.

By the end of this event, participants should be able to:

1. Identify risk factors that need to be managed following surgery; and
2. Understand how CJR participant hospitals have used post-acute home visits to optimize beneficiaries' health.

We encourage all clinicians and staff working on care management, navigation, and/or coordination to join this event. Participation is not limited to those in any specific role.

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On-Demand Events

Click on the links below to access these recordings:

- Q1 2019 CJR Hospital Monitoring Report: Preview and Opportunity for Hospitals to Provide Feedback 06 05 19
- Quality Payment Program's (QPP) Intersection with BPCI Advanced Webinar 05 23 19
- CJR Model Final Performance Year 2 (PY2) and Initial Performance Year 3 (PY3) Reconciliation 05 21 19

Recent Webinar Highlights

Cross Model Learning Network (CMLN) Webinar: Trauma-Informed Care (TIC): Engaging Patients and Staff to More Effectively Prevent and Treat Opioid Use and Misuse

On Wednesday, June 12, the CMLN hosted an informative discussion with Matthew Vail, MA, LCSW, a clinical social worker in the Department of Social Work and Community Health at Rush University Medical Center, and Steven K. Rothschild, MD, a family physician, educator, and researcher in the Departments of Family Medicine and Preventive Medicine at Rush University, about their organization's efforts to transition to a trauma-informed care approach to care delivery and strategies to prevent and treat opioid use and misuse in trauma-affected persons.

Watch the recording to listen to Mr. Vail and Dr. Rothschild discuss the impact of trauma on patients and suggest strategies to engage patients, clinicians, and other members of the care team to create a health system that understands and recognizes the important effects of trauma, supports healing, and seeks to not re-traumatize.

You can view the recording and associated materials here, and share your thoughts and ask questions on CMLN Connect.

Optimizing Patient Care Pre-Hospitalization

The CJR Learning System held the "Optimizing Patient Care Pre-Hospitalization" webinar on June 19, 2019. This webinar featured a presentation from NYU Winthrop Hospital, a former BPCI Awardee and current CJR participant hospital, on how their team is identifying risk factors that can be managed prior to surgery and how they are using pre-hab visits to optimize beneficiaries' health.

Ellen Jordan, BSN, RN, Nurse Navigator, Transitional Level of Care, began the webinar by providing an overview of NYU Winthrop Hospital and their nurse-led transitional level of care (TLC) program. Ms. Jordan discussed pre-habilitation and how the hospital's 4-8 week program effectively increases strength and function for CJR patients. Following her initial overview, Ms. Jordan reviewed home safety, medication management, and described a risk stratification tool developed by her hospital based on Project BOOST (Better Outcomes for Older adults through Safe Transitions), Project RED (Re-Engineered Discharge), and the New York State Transitional Level of Care model. While describing her role and NYU Winthrop's patient care protocol, Ms. Jordan highlighted the importance of shared decision making and some of the key aspects of patients' health and wellness that she assesses pre-operatively, such as patients' support systems and their health literacy levels. Ms. Jordan emphasized a patient-centered approach and the importance of setting expectations with patients pre-operatively as key practices for meeting patients' needs. Lastly, Ms. Jordan highlighted her experiences walking with patients through their homes to identify potential hazards and post-surgical challenges.

Elizabeth Trent, CMA (AAMA), AAS, Orthopedic Navigator at Forbes Hospital, provided a reaction to Ms. Jordan's presentation, as well as an update on Forbes Hospital's pre-operative home visits, which she originally shared on the "Using Data to Drive Improvement: Addressing Social Determinants of Health" webinar on January 17, 2019. Ms. Trent noted that Forbes Hospital's pre-habilitation visits are determined by the surgeons for specified patients. She also highlighted Forbes Hospital's mandatory two-hour pre-hab class for patients. Ms. Trent noted that Forbes Hospital encourages patients to go home after surgery, and they are able to provide physical therapy and secure the necessary equipment ahead of time, especially after patients have completed the pre-operative visit and the mandatory education class.

To learn more about the work being done at these hospitals, please visit CJR Connect. The slides, recording, transcript, and on-demand link from the June 19th event are available in the CJR Libraries under "Webinar Optimizing Patient Care Pre-Hospitalization 06 19 19 Materials."

CMLN Webinar: Addressing the Opioid Crisis at the Community Level: Vermont's Hub and Spoke Model in the Treatment of Opioid Use Disorder

On June 26, the CMLN hosted a discussion with Beth Tanzman, MSW, Executive Director of the Vermont Blueprint for Health and architect of Vermont's Hub and Spoke model. In response to the rise in opioid misuse, Vermont developed the Hub and Spoke model, an innovative system for Medication-Assisted Treatment (MAT) designed to support people in recovery from opioid use disorder (OUD). MAT, which entails the use of medications combined with counseling and behavioral therapies, is more effective at treating opioid addiction for most patients than abstinence-only or counseling-based interventions alone. Starting from waiting times of 3 months or more, Vermont built its Hub and Spoke model so that patients with OUD could begin treatment either immediately or within a few days of their first contact. Ms Tanzman discussed how the Hub and Spoke model increased provider capacity to engage patients in MAT, how Vermont engaged providers as well as state and federal partners to build a network of care that creatively addresses the opioid epidemic right in the patient's neighborhood, and which aspects of Vermont's experience might be replicable in other states and for other CMMI models.

You can view the recording and associated materials here, and share your thoughts and ask questions on CMLN Connect.

CMS Care Transitions Summit

This is the final article in a series of articles about the CMS National Care Transitions Awareness Day Summit. The first article is located in the May 2019 CJR News and the second article is located in the June 2019 CJR News.

CMS National Care Transitions Awareness (NCTA) Day Summit Highlights

Care Transitions Spotlight Overview

CMS hosted the National Care Transitions Awareness (NCTA) Day Summit on April 16, 2019. The goal of the Summit was to increase awareness of the importance of safe and effective care transitions, as well as expand awareness about the role of community partners, focusing on providers, payers, and other business entities. The Summit highlighted some examples of best practices in care transitions during the Care Transitions Spotlights portion. This included the Transforming Clinical Practice Initiative (TCPI), Patient-Centered Outcomes Research Institute's (PCORI) Project ACHIEVE, and the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) care outcomes and transitions.

David Polakoff, M.D., MSc from the University of Massachusetts Medical School presented first on the Southern New England Practice Transformation Network, which is a part of CMS' TCPI. The Network is working to reduce unnecessary hospital readmissions and emergency room visits for urgent eye conditions. Dr. Polakoff noted that patients requiring urgent care for eye symptoms often seek care in hospital emergency departments even when an optometrist's office offers this care at a lower cost. The Network's Emergency Department Avoidance Initiative included over 1,500 optometry practices that implemented programs to educate and encourage patients to seek urgent care from optometry offices. After 16 months of

collecting data from the initiative, the cost savings are estimated to be $205 million from serving over 200,000 patients.

Then, Mark Williams, M.D., FACP, MHM, Principal Investigator from Project ACHIEVE, shared preliminary results from a 5-year patient-centered study of care transitions. Project ACHIEVE is attempting to identify patient and caregiver priorities and effective combinations of transitional care strategies. Dr. Williams and his team conducted focus groups and interviews with 138 patients and 110 family caregivers, which revealed three key items that mattered most to patients and caregivers: (1) to feel cared for and cared about; (2) to feel prepared and capable; and (3) clear accountability. Additionally, site visits conducted by the team at 22 hospitals revealed that effective transitional care requires: (1) true community partnership; (2) high-quality communication; (3) patient and family engagement; and (4) ongoing evaluation and adaptation.

Jane Brock, M.D., MSPH, Clinical Director from Telligen, discussed the QIN-QIO Program's 388 community coalitions dedicated to improving care coordination. Dr. Brock noted that QIN-QIOs interventions target improvement in medical and community settings based on specific healthcare conditions, readmission risk, and social determinants of health. The data presented by Dr. Brock shows that QIN-QIO Program has allowed for thousands of avoided hospital readmissions, hospital admissions, and adverse drug events.

Following Dr. Brock's presentation, Carla Thomas, MS, CTRS, CPHQ, Director of Care Transitions at Health Quality Innovators (HQI), the QIN-QIO for Virginia and Maryland, shared QIO program care transitions. Ms. Thomas described three key strategies: (1) improve provider processes; (2) increase community supports; and (3) empower beneficiaries. Her team has found that relationships are key and that consistency leads to more improvement. HQI's regional impact in Virginia and Maryland has led to 47,000 fewer hospital admissions, 13,000 fewer hospital readmissions, and over $640 million in savings.

To access resources from the April 16th NCTA Day Summit please visit the NCTA website. The National Care Transitions Awareness Day Summit & Grand Rounds Speaker Bios are currently available here. The slides from the event are available here.

Blue Button 2.0

Help your Medicare patients take charge of their healthcare! Using MyMedicare.gov's Blue Button, Medicare beneficiaries can download and save a file containing their health information, which can then be used for personal recordkeeping or can be shared with providers. Blue Button 2.0 allows beneficiaries to connect their downloaded health information to phone-based apps or computer programs that help them keep track of regular tests and services and set reminders for appointments. Other apps can help patients manage their medical information and keep better track of their medications, allergies, and diagnostic results. Beneficiaries can learn more about Blue Button 2.0 here.

CMMI Update

The CMS Innovation Center website contains useful resources and announcements about CMS's innovative health care payment and service delivery models. Below is a recent noteworthy update.

Year four of the evaluation reports and financial and quality results for the Independence at Home Demonstration have been posted.

Under the Independence at Home Demonstration, the CMS Innovation Center will work with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs. Year four evaluation reports and financial and quality results have been posted.

Find out more information about the Independence at Home Demonstration here.

What's New on CJR Connect

New Resources in Libraries

The following resources are now available in the CJR Connect Libraries. To access these resources directly, log into CJR Connect, then copy and paste the link into your browser:

- Navigating the CJR Model Podcast Series (This content pack contains episodes of the Navigating the CJR Model Podcast Series. The podcast series will feature varying topics and speakers that will provide important information aimed helping participant hospitals succeed in the CJR model.)
- CJR News (This content pack has been updated to include the CJR News from June 11, 2019.)

Please do not reply to the cmslists@subscriptions.cms.hhs.gov email address, as this is an unmonitored inbox. You can continue to contact CJR Support for questions, assistance, suggestions for Learning System events, or to be added to the CJR News distribution list at **CJRSupport@cms.hhs.gov**.

Want to check out past *CJR News* newsletters? Find older issues in the CJR Connect Libraries.