Care Coordination and Management Series:
Developing Community Partnerships
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Isaac Burrows: Hi. Good afternoon everyone, and welcome to the CJR Learning System event, Care Coordination and Management Series -- Developing Community Partnerships. We're excited that you've decided to join us today.

I wanted to walk through a little bit of the agenda this morning, or this afternoon, I should say. We'll be getting a presentation from panelists representing three hospitals; Covenant Health, Florida Hospital Waterman and St. Mary's Health. At the end, there will be an opportunity to have questions, discussion, and dialogue.

As you can see, again, my name's Isaac Burrows from the CJR support team here at the CMS Innovation Center. My colleague Alicia Goroski from the Lewin Group will also be co-facilitating this event. Alicia.

Alicia Goroski: Thank you, Isaac, and welcome. I am going to go over a few logistics. First, audio for today's event is streaming through your computer, so you should be hearing us through your computer. If at any point -- and I am seeing a few folks who are now asking for the dial-in. We do have -- our group chat monitor today is my colleague Nicolas Stettler-Davis. Nicolas, we do have a telephone option available if you are experiencing any issues listening to the audio through your computer. He will be sending you a message, but make sure you look at the bottom of that chat pod because you'll see a new tab pop up from Nicolas.

So thanks, everyone. I will just also reiterate to make sure your computer speakers are on if you have computer -- turn those on. Make sure they're not muted. Nicolas will work to get that dial-in number out to folks who need it.

Again, just want to do a quick orientation to the platform. You will see several different pods on your screen. You'll see the slides, and just below the slides, you should see live closed captioning. To the right of that, you will see event resources. You are able to download the slides for today's event as well as a text alternative.

The group chat pod that you'll see right below the video, which you should be seeing me right now, the group chat is visible to everyone. We are going to encourage everyone to use that to engage both with one another as well as to pose questions to our panelists as we move into that portion.

So again, you can use that chat pod to submit any questions or comments. Once we move into our panel discussion, if your question or comment is for a specific presenter, use the @ symbol and their name, or their hospital name, so that we can know who that question is for. And again, then you do need to make sure you click on that chat bubble that is just to the right of where you'll type your question in so that it gets sent.

All right. So now, we will go ahead and move into the panel discussion for today's event. I'm going to go ahead and introduce all three panelists at this point.

We are pleased to have on the call with us today Megan Confer, who is the Post-Acute Care Specialist with Covenant Health. We also have Titus Gambrell, who is the Interim Chief Nursing Officer and Regional Director of Case Management at St. Mary's Athens Hospital. And finally, Stephanie VanBibber-Martin, who is the Transitional Care Coordinator Supervisor at Florida Hospital Waterman.

We've set up today's webinar a little bit different than we have in the past. We're posing two questions to our panelists, and then you'll hear from each panelist as to how they approached each of the questions.

The first question that they'll be discussing is: How did you initially develop relationships with your post-acute care providers? Now, I would like to turn it over to Megan for the first response.

Megan Confer: Good afternoon. My name is Megan Confer, Post-Acute Care Specialist at Covenant Health. We have a small team here. I also work with Rachel Stehling. She's the Executive Director of Care Management in Transitions of Care.

We are a part of Providence St. Joseph Health that spans across California, Arkansas, Washington, Montana, Oregon, New Mexico and Texas, but Covenant is here located in Lubbock, and it services 60,000 square miles going between Albuquerque, New Mexico, and Dallas-Fort Worth, and there's about 70,000 people in that service area.

In January of 2016, we started meeting with our post-acute care providers. We have 27 providers between our skilled nursing and home health providers. We haven't tapped into the outpatient rehab as of yet. We're starting LTAC in inpatient rehab in a little bit, but we really focused on our SNFs and home health first.

We used what I call a three-pronged approach. We started out with quarterly meetings with all the providers and met with them, explained to them what our goals were for Covenant, the different projects we were working on, the CJR project. As those communications kept going on, we were able to meet with them monthly. So then with open communication, meetings and then also involving them in our process improvements. By involving them in the care pathways, they're more committed to Covenant's goals and they're actually part of things instead of me just being in the care pathway, they actually get to implement that.

I was also very lucky to work with several of these agencies that are working with ACOs in different markets, some in Amarillo and Dallas, and see what they're using, what models are working for them, what's not working for them. Some things that don't work in the Dallas market work here in the Lubbock market and vice versa.

So that's what has really helped us build our relationships. Just really communicating with them, meeting with them and showing them the value of these meetings and processes.

Alicia Goroski: Thank you, Megan. I'm just going to go ahead and jump in here and thank you so much. If I can ask all of our speakers -- and again, Megan, when you speak next time -- if you could just make sure you're really close to the phone and speaking up really loudly. We did hear for a few folks it was hard to hear. But again, thank you so much for sharing.

And then also just a reminder: Anyone who did dial in, please double-check that your phone lines are all muted. You can mute that -- there's one of two ways or you can do it both just to make sure. Mute it on your phone or up above at the screen. You should see a green icon with the telephone. You can click on that, and it should say Mute My Phone. Thank you.

Next, we will go ahead and move on to our second panelist to talk about how they engage with their post-acute partners. Titus, I'll turn it over to you now, and you should see Titus on the video as well. Titus, I think you may still be on mute. Unmute both on your computer -- there we go.

Titus Gambrell: Thank you again, Alicia. A little bit about St. Mary's Hospital. This is the hospital that actually we were involved with CJR. It's a 196-bed hospital in Athens, Georgia. The health system itself is a multi-hospital system. We have acute rehab, home health and a couple other hospitals including a critical access hospital with swing beds. Service area is pretty large with 17 counties, rural and urban settings. Actually, our joint replacements come from multiple locations well outside of that 17-county service area.

We're part of Trinity Health, which is a health care organization out of Lavonia, Michigan, and we have a convener that we work with called Remedy Partners. Our joint replacement program is very vibrant. We are Joint Commission Certified in hip and knee, and one of Healthgrades Top 100.

We have a high volume of lower extremity joint replacement, to the tune of around 1,200 annually. We do have experience in bundled payments with both medical and surgical bundles, and that indeed has helped us learn -- helped us early on as we got into the CJR program.

A little bit about our relationships and how we partner with our community providers. Prior to CJR and even any bundled payment for us, we were very engaged and involved in the quality improvement organization in our state called Alliant. We've been involved with it actually since the inception of a community health care coalition that began in 2012. The focus at that time was really about readmission reduction and community collaboration.

We worked through those early years with the QIO and increasing our participating entities from more or less short-term, long-term, acute-care hospital and skilled nursing facilities and home health to also include hospice, pharmacy, physician practices, dialysis, Agency on Aging, etc.

I share all that to say as we got into the CJR program, the community health care providers were actually very interested in learning more and knowing what our program was about, how they could be of assistance, how we could work even closer together on this initiative. We expanded our representation with patient navigators. We have a pharmaceutical company that actually is on board and some chronic disease management professionals.

One of the things that was very helpful to us, I feel, in our success that we've seen so far with our post-acute network providers and collaborating with our CJR program, was a fair -- it was kind of a -- that was a fair theme, if you will. What we did is invited our community health providers in our immediate service area to come to the hospital. We had rooms set up with tables. It was much like what you would see in a trade show. And asking them to come with us -- come here and share with us what their services were like, their metrics and their outcomes. We encouraged our hospital leaders, case management staff, nursing and therapy physicians as well to actually come down and participate and go table to table, interacting with those health care providers, so that we learned more about them. They learned more about us. And it also helped them learn about each other. It was very successful, and it is an annual event for us at this point.

A couple times a year early on we started out with breakfast, and it was just with the --separating the skilled nursing facilities and home health care to come and meet with us. We eventually joined those together as we went to the CJR program.

We invite multiple departments from St. Mary's to participate in those breakfasts. It's a great time to have dialogue around any challenges maybe from ED to skilled nursing facilities, home health and hospice, challenges that may come up from time to time. It's also a great time for us to share our success and enjoying the fruits if you will of our labor. It's always important to recognize the good whenever you can.

Some of the things that led us to taking a look more at the data is our information sharing. We have patient navigators who are in place here at the hospital, and we have post-acute network representation from our convener. We actually chose to keep a very active interaction with our post-acute network providers versus having someone act and interface on our behalf. Our meetings with our post-acute leaders, including as I mentioned before our skilled nursing facilities, LTAC and home health, we have those as well as meeting onsite between the patient navigators and the staff to provide staff education at those locations and increase interaction and dialogue.

We have had occasion where we've brought in regional and corporate representatives from the post-acute network providers in our community where there's a really strong presence of two big corporations that have skilled nursing facilities as well as providers in home health care. We found that they were willing to engage with us, and we were most definitely interested in bringing them to the table as well.

We also have some post-acute focus group meetings where early on it was mainly just looking at reducing readmissions. This was even part of bundled payments. But we've expanded that to strategize on our challenges or our opportunities, perhaps I should say, with our proper patient placement as well as clinical and care pathways that may be a bridge from our organization to theirs. We take the time to share insights into our performance and they share theirs as well.

We do have some discussions and sharing of data, but we are trying to really remain focused on the care of the patient and the patient outcomes. Performance is more about the patient-centered care.

We have a preferred provider list that we developed, which was very difficult for me and some folks in our community. The difficulty came because we've had close relationships with our post-acute providers, and it was difficult for me to think of saying one was better than the other. So our approach to that was that we developed some criterion that looked at what we defined as centers of excellence. That included onsite visits from us to them, them to us. We actually did some outcomes. Of course measurement. We looked at the data. We included in that consideration the responsiveness to our patient navigators and the work done with our bundled payment programs. Also feedback from orthopedic surgeons and their practices, patient feedback as well.

We considered the Medicare star rating and listed those three or above as in our high-tiered grouping. We definitely took a really close look at specialty programs that they indicated that they provided, and we actually asked them to provide some validation. Instead of saying that we specialize in joint replacement care, rehab, we want to see what was the evidence that they used and what were the care pathways behind that.

We looked at weekend therapy availability and how quickly the home health could get their home health care staff in to visit the patient at home, as well as the performance of the outpatient clinics that we work with.

One thing that's been important is transparency and looking at crucial conversations when it has to happen, where we've had some difficulties with performance at some of the providers. And likewise, they've identified things that we could improve on. And so, those are really important to have, and it's a great time to kind of put personal feelings aside and really try to look at how we can work together and improve on things that impact our patients and our community at large.

Originally we focused on readmissions. Then we actually moved past that to some other projects like medication reconciliation that we were working on together. And then also partnering or collaborating on our care pathways so it is truly a bridge from one level of care to the next. And part of our commitment most recently is to join in and do a root cause analysis for our readmissions and our extended length of stays so that we can better learn from those situations, including interviewing our patients that are involved as well as caregivers both at the in-home, family and facilities.

We actually have invited them to join our joint committee, joint replacement committee, and also our CJR bundled payments program.

Alicia Goroski: Great. Thank you so much, Titus. I know we'll have another opportunity where we'll come back to you. But let's next kind of move on and hear from Stephanie, talking about how at Florida Hospital Waterman how they actually developed those relationships with their post-acute providers. Great. So, Stephanie?

Stephanie VanBibber-Martin: Thank you, Alicia. Yes, my name is Stephanie VanBibber. I'm the transitional care supervisor here at Florida Hospital Waterman. Just to give you a brief overview about our hospital. We are part of Adventist Health Systems. We're in the Central

Florida region. We are a 269-bed, short-term acute care hospital with all private rooms. And we are a recipient of the Joint Commission Certified Gold Seal of Approval for our knee and hip replacements.

We've also received an A rating through the Leapfrog Group since 2013 for the safety grade, and just this past year we were named a Top General Hospital by the Leapfrog Group as well.

Talking a little bit about building that relationship with our post-acute providers, we were fortunate that we had already established a post-acute continuum collaborative meeting. That's something that we actually hold quarterly here at Waterman. We've done that for several years now. And at the beginning it was primarily with our skilled nursing facilities and our home care agencies -- or, our LTACs, and then this last year we invited our home care agencies to take part. And it's really helped, having all the different providers come and get their feedback.

Initially it was to focus on our readmission analysis and kind of dive into why patients are readmitting and how we could all work together, and since CJR started we've incorporated the CJR post-acute utilization piece into that collaborative. So it's worked out as a smooth transition.

We also have speakers for these collaboratives. We try to focus on different things, different topics that would benefit all of us. As an example, in February of this year we had an Abbott representative come and discuss malnourishment. So we're looking at core measure patients, our heart failures and COPD, but now that we've incorporated the CJR, the promotion of healing for these patients and incision care, how that continued nutritional supplementation is helpful. So we try to find things that we can work on together and develop as processes.

Moving on to the second half of those meetings, I always go over the CJR discharge disposition utilization. We're looking at that per quarter for our skilled nursing facilities and our home care agencies. So just seeing how many of our patients are going to each of these dispositions. We're also looking at the appropriateness of those discharges. Our patients that are going to skilled nursing facilities, we noticed early on in data collection as we're tracking these, patients that are ambulating 200, 300 feet with supervision, we need to make sure those are going to the appropriate level of care. So just to keep in mind it's the lowest level of care that's appropriate for that patient, keeping safety in mind.

We are looking at the average length of stay by skilled nursing facilities as well and the total number of therapy visits by home care agencies, since this does affect the additional reimbursement on top of the episodic payments.

And then the other thing that we did, at the very beginning we established site visits. I went out to our primary skilled nursing facilities that received the bulk of our CJR volume. I met with their administrators, the director of nursing, their rehab directors and their social services departments and kind of went over what CJR was, what to expect, giving them education but also reviewing their practices, what were they doing as a facility to promote rehab and getting those patients up and moving. We did learn by doing these site visits that these facilities typically were providing therapy five to six times a week, so once we found that trend, we were able to get everybody on board to do seven days a week for our CJR patients to promote that rehab.

We also went over our goals, our expectations for these patients. We looked at length of stay, what was our expectations, and typically we were thinking that patients that go to a skilled nursing facility if they're getting the optimal therapy there should have a length of stay around seven days for our elective surgeries. Hip hemiarthroplasties of course are more. Looking at those therapy visits, making sure those are increased.

And then we're also looking at when they leave the skilled nursing facility, are they going home with home care or are they appropriate for outpatient therapy? We don't want to have too many layers if it's not needed, so patients that were appropriate for outpatient therapy, we were encouraging that.

And looking at those discharge barriers, identifying those early. We start that process in our case management department at the hospital, but making sure that when that baton is passed that their social services is accepting those patients early on, looking for lack of caregivers, transportation issues, and working on those pieces.

And I think probably the thing that has helped the most and something I probably should have started even earlier was the physician collaboration. We met with the surgeons, and we'd gone over CJR and what it was, but we ended up holding one-on-one meetings with these orthopedic surgeons. Once we had the data collected from Quarter 2, we were able to sit down and show them the trends, show them how everyone was doing, and our goal of our discharge disposition ratio, what they agreed on was 85% home with home care versus 15% skilled nursing facilities. That's also contributing to our hip hemiarthroplasties. We figured that 15% for the bulk would be our hip hemis, as our elective procedures we were hoping most would go home.

So once we did that, we also looked at our protocol for home care, and the surgeons felt that an appropriate home care number of therapy visits would be seven to nine. We educated our home care agencies and our skilled nursing facilities on these meetings. We told them the expectations of the surgeons. Not discussing skilled nursing facilities as the primary discharge option prior to surgery; that's something that would be assessed and determined after surgery. So the goal in everyone's mind in getting the patient prepared is home with home care.

And then at the end of the year, we did an end-of-quarter review for data comparison with our surgeons, and it was interesting what we found. We were sitting at about 50/50% with our skilled nursing to our home care discharge dispositions when CJR started, and we were actually at Quarter 4 sitting at 82% home with home care and 18% to skilled nursing facilities. So we made a huge change just in this last quarter.

And then for making sure our quality and our outcome measures, that our patient still is coming first, our CJR readmission rate in Quarter 3 was 5.88%. We were staying in the mid-5% range. And on Quarter 4 we were at 1.53% on our readmission rate. So it's made a huge difference not only for the hospital but also for our patients. And the feedback I'm getting from our surgeons is the patients also are coming in on their follow-up appointments and doing better, so everybody -- it's really been wonderful for all of us.

Alicia Goroski: All right. Thank you so much, Stephanie. And now we are going to pause for just a few minutes to answer any questions that have come in during this first portion. So, Stephanie, being the most recent presenter, you have a couple of questions. The first -- and I think you actually did go ahead and cover this, but just to confirm. There was a question asking what your average length of stay was, and I believe you mentioned that it was seven days. Can you just confirm that?

Stephanie VanBibber-Martin: Sure. For within the hospital, or are we looking at more in the skilled nursing facility arena?

Alicia Goroski: I think, yeah, Mary Brady, please feel free to clarify your question. It may have been about -- inpatient. Thank you.

Stephanie VanBibber-Martin: Okay, yeah, typically for our elective surgeries it's two to three days. And of course our hip hemiarthroplasties, depending on their comorbidities and what all they need, sometimes of course that is extended to four to five days would be the average.

Alicia Goroski: All right.

Isaac Burrows: That's great. Thank you. I want to pose a question, and I'll start with Stephanie and then we'll go in reverse order. I'll go to Titus and then Megan, and talk about any potential barriers that you had when you were sort of establishing these post-acute partnerships, and how did you sort of make your way through that? Were there any challenges relationally in your markets between the hospital and the post-acute providers at all? Maybe talk a little bit about that. We'll start with Stephanie.

Stephanie VanBibber-Martin: Okay. Yes, what we found, actually it was interesting to see in our skilled nursing facility especially, who's engaged and who wasn't as engaged. Even when we would do our site visits, there was a big difference in who participated and the level of engagement that they had. It probably took I would say about the first quarter, so about three months, to really get them on board, and that came with really they weren't receiving -- the doctors, the surgeons, were not recommending them as much just based on the length of stay of their patients and where they were at.

So they actually came to me and wanted to have one-on-one meetings at that point quarterly just to go over what they could do as a facility to improve. So they did eventually get on board, but it did take a little while, where the other ones all kind of fell right into line, so it was great.

Isaac Burrows: Titus, can you jump in and share a little bit?

Titus Gambrell: Absolutely. It's interesting that it's almost identical to Stephanie's experience in that there was some interest, greater in some places than others. Then I think they began to see the patterns of how discharge choices were going and physician actually preference was sometimes involved. Of course, always keeping in mind the patient's choice. That was never a compromise in the least bit. But I think those providers that saw the things around them

changing, they began to -- those that weren't quite maybe as willing or interested in coming to the table began to come to the table.

That ended up with a very positive -- it's not competitive, necessarily. It's just really all of us kind of pulling together and seeing how can we get to the same level of standard, which is it's elevated in reality. It's elevated that standard of care in our community.

One thing for us that was maybe a little different is I had mentioned earlier about our joint replacements coming in from multiple areas, not just our immediate 17-county service area. We find ourselves with a bit more challenge with those providers, the home health outpatient even as well as the skilled nursing facilities that were organizations that we don't normally work with. It took a great deal more of effort to reach out to them and to build a rapport and communication with them than it did those that we were familiar with already.

Isaac Burrows: Great, thanks. Megan?

Megan Confer: We had some barriers at the beginning with a few. Some of our bigger agencies were on board, and like I said, we had quarterly meetings at first and then we moved to monthly. They were actually -- once they saw what we were trying to do and they were more involved in the process, they were calling for their monthly visits. And that was probably started in the last I would probably say six months.

So just to show them that this is something that we're not just implementing without them being involved. We actually wanted to share with them this is what we're trying to do, come help us. And that actually helped them get on board instead of us just implementing here's this process and this is how you're going to do it.

I do see some questions on here that I was going to answer of the gain sharing. We've started the process for the gain sharing. Our gain-sharing model has been approved. We just have to get our physicians to sign the contract. We do have quality outcomes for our skilled nursing that we look at. Our home health quality outcomes are a little bit harder to look at because we only have CMS data, so we just go off of CMS data. The home health agencies are able to provide us with quality, but it's just from their standpoint.

Alicia Goroski: Yeah. So, thank you, all three of you, for kind of answering those questions. I think actually a lot of the questions I'm seeing now are a perfect segue into our second question that our panelists are going to respond to and dig a little deeper into, and that is sharing with us really more about how you share data with the post-acute care providers. What data do you get from them, and how have they improved quality?

We are now going to hear -- Titus, we're going to come back to you, and I know you touched a bit on this when you first spoke, so at this point definitely feel free to dig in a little deeper on any of the items that you guys are doing over at St. Mary's.

Titus Gambrell: Thank you, Alicia, and actually being very kind. I actually I think went through almost all of my information. But there is some other things I will share, and there's a

question for me I'll go ahead and take and address as well. The question being I did mention that we're a 196-bed hospital in our CJR hospital, and then we do 1,200 replacement cases per year. That is only at the one hospital. Now, of those 1,200 cases, around 40% are Medicare. The rest are some other type of payer source.

We're fortunate to have some really highly reputable orthopedic surgeons in our community, and so that in fact pulls in some of these patients that come in from outside of our immediate service area. The good thing about that is that we're not on any type of gain-sharing program as a result of CJR. We had entered into some quality collaborative with some sharing of data really closely between ourselves and the orthopedic surgeon. We looked at patient satisfaction. There were several other metrics that we consider and looked at that actually is part of a true enough collaboration between the orthopedic surgeons and ourselves.

Their outcomes were measured just as it had been before CJR, and their reputation of course is very important to them, and so it is just as well. Being with all that high volume that we do have with joint replacements, we have plenty of opportunity to continue to look for ways to improve. And that's both inside our hospital as well as the surgical procedures. We used to do a lot of anterior approach with our hips, which has actually done a reduction in length of stay at the hospital and, to a large degree, maybe quicker rehabilitation post procedure.

Our length of stay in the hospital is fairly short. On a rare occasion, but on occasion, we get our hips out in one night and our knees typically are one-night stays.

One thing I want to share with you, talking about our patient navigator and our site visits, getting back onto that with some of this information again in more detail, is for those of you maybe who have never heard of a patient navigator, there's a great deal of evidence that shows that that particular role has been very positive or had a great impact on the chronic disease management. Once upon a time, it actually started out with cancer patients, but it's progressed over the years since then.

And so, use of patient navigators in elective surgical procedures is not really common, but it's an area that we chose to go in because we had had great success with that in our other bundled payment programs we were in.

The great thing about that is the navigator has been extremely crucial in continuing to build upon our relationships with the post-acute network. As they make visits to the locations, they are sharing information, including some data, and likewise the facilities and the home health care agencies when the navigators are in there with them they're sharing information back. It's become a real -- it's increased our transparency greatly, and it's also helped us with education of the staff in those locations. And of course, we learn a lot, too. The navigators come back armed with information that they share with us to help our hospital as a whole.

Touching real quickly on the post-acute leaders, the meetings that we have, when I mentioned about growing outside of just the facility leaders but also the regional and corporate, I want to emphasize something we're really excited about is our physicians, our orthopedic surgeons here on our campus, are wanting to meet with the nurse practitioners, physician assistants and

physicians that are caring for patients in the post-acute setting so that they can also learn from each other and share from their perspectives, which is different than ours perhaps as a nurse or case manager or the discipline.

So, we're excited to see that those are actually growing to include more at the physician level. That's very exciting for us.

Our focus group meeting, just a real quick point on that, is actually we have all types represented at this meeting, such as we mentioned earlier the skilled nursing facilities as well as the long-term acute-care hospital in the area and our home health. Then we decided to do them separate. Now we've decided it's better -- we're ready to bring them all back together. When we separated the meetings out with them, it felt like that was an opportunity to talk about location-specific or level-of-care-specific dialogue.

Our preferred provider list, another point I want to make on that, when I mentioned it was difficult for me as much as it was for anyone in our service area. Again, we honor patient choice to the utmost. We really focused on learning how they're caring for our patients so that we do have some assurance that the level of care is there, coupled with our outcomes that we can measure. So we speak with the patients really frequently. The navigators do, to kind of get an idea of how things are going with that particular provider. We relay that word back to those providers so that they get that feedback from what we're hearing from the patient as well.

Alicia Goroski: Thanks, Titus. I'm sorry to jump in. I just want to make sure we have plenty of time to hear from Stephanie and Megan. I'm going to go ahead, and I know there are some other questions. We will have some time for Q&A again after this question. So, thank you.

Stephanie, I'm going to now turn to you and have you talk about how you've done data sharing with your post-acute care providers.

Stephanie VanBibber-Martin: Okay, thank you, Alicia. All right, the first thing that we do, we do weekly -- I want to keep these patients front and center with the skilled nursing facilities and the home care agencies, so we do a weekly communication. Our point of contact is either the director of nursing or the administrator, sometimes both, regarding those patients.

I send a CJR update. It's a standardized form that they fill out. It's an interdisciplinary form, so each discipline will complete their section and then it's returned to me. And I actually keep this in my own spreadsheet so I can keep track of these patients and how they're rehabbing.

With the physical therapy, we're looking at gait distance and several pieces of therapy, including pain level during treatment. We want to make sure that that pain is being managed, and making sure that they are receiving that seven days a week of their therapy treatment. Nursing issues with their incision status. If there's any other clinical issues going on with these patients that might delay their discharge.

And we also look at occupational therapy, the ADLs, their functional capability to go home, when that's appropriate. And also ultimately our discharge plan. From the very beginning, we

want social services there to start looking into that and what is our tentative discharge date for the patient.

So it just kind of keeps them front and center. I know that a lot of these facilities now have a CJR-specific meeting where they meet weekly and go over these patients, and at that time they complete these forms. So it's very helpful.

Also with the home care agencies, kind of similar but I do weekly calls with them. I contact the DON or the supervisor of the home care agencies and speak with them one on one every week, identifying the CJR patients, making sure are there any barriers, are we looking at transportation issues on the back end with outpatient rehab when the time comes. And then also looking at those number of therapy visits per patient episodes on discharge.

We track length of stay, but really it comes down more on the number of therapy visits and recert. We of course don't want those patients to be recerted unless there's something else going on with them and they need that care.

And then we also make sure that these agencies are familiar with the surgeon's protocol, that they received it and they're aware of the seven to nine therapy visits. I do want to add to that, of course if a therapist goes out on Visit 7 and the patient is not doing as well as we anticipated, then the surgeon is to reassess that patient and he'll order more therapy. Patient care is still front and center, but we just noticed the cookie-cutter of extending therapy on all patients, so this way we're kind of doing it in reverse and patients that need it are receiving it.

And then once again, to go over our post-acute care collaborative, this might answer some of those questions. We do provide transparency in these meetings. I have every home care agency side by side on their average number of therapy visits, and I have every skilled nursing facility side by side on their average length of stay based on the surgery provided. So everybody gets to see it. We are very transparent with that.

And that allows us to identify those facilities that are showing improvement and allowing them to engage on what they're doing as a facility, what are they doing that's improving their numbers. And it also allows opportunity for collaboration on these processes.

And then what I do as well is I provide one-on-one sharing of readmission data from the previous quarter with each facility and home care agency. What I give them, it's a CIN number and then also discharge date from the hospital so they can then go back to their records and analyze those patients and see if there was anything that they could have done; what's the root cause for those patients returning to the hospital.

I think that's it.

Alicia Goroski: Yes. All right. Thank you, Stephanie. We're now going to transition over to Megan, although I will just -- Stephanie, there were a couple of questions, so I'll just kind of point you over to the chat for everyone to take a look at those. And we will again have a few minutes to verbally answer questions after we hear from Meg at Covenant Health.

Megan Confer: At our monthly meetings with each post-acute care provider, I have an individual scorecard for them that goes over length of stay, Case Mix Index, percent of patient readmission, percent of ER readmission, cost per case and risk-adjusted cost per case.

We also have a section there that breaks down by DRG, so I can show them -- my screen is small here, but they have their total hips and total knees broken down individually, and then we have all DRGs lumped together. And then if there's a certain DRG they want to look at, we show them that on an individual basis.

And then we do give them a group scorecard that does bump them up against the other post-acute care facilities here in Lubbock to see how they're doing, and they kind of asked for that at the very beginning so they could kind of start, how are we comparing to others and how can we do better? So we do that on a monthly basis.

Alicia Goroski: All right. Thank you. I'll just point out, you can expand the slide, the data-sharing slide, that's currently showing. You click where right up above it you'll see four arrows point outward and it does say Full Screen. Just if you're wanting to get a closer look at that. And again, just a reminder that you can download the slides and get a closer look at that.

All right. Isaac, did you want to start us off with a question?

Isaac Burrows: Yeah, real quick, following up on Megan, was that dashboard that you showed with the group information where it says Facility 1, 2, 3, 4, is that blinded or unblinded? Do they all sort of know what their competitors are?

Megan Confer: We have a data-sharing agreement with all the facilities, so it is unblinded. That was just kind of a little template that I threw on there. At the beginning of the year, it was blinded except for that facility, and then once we got our data-sharing agreements signed, it is now all unblinded.

Isaac Burrows: Okay, great.

Alicia Goroski: All right. You all kind of talked a little bit about this, but I am going to start us off with a question that you can all jump in and answer. Megan, you just talked about this. There was a question about whether you were sharing specific length of stay and visit and episode information between the providers, and I know you all touched on that, again, but if we can just kind of go through and have you each say, yes, we're sharing this, and blinded or unblinded. Because I know that often is a -- sometimes folks start out by sharing it blinded at first, but then you're able to get to the unblinded. All right, so, Meg, do you want to go ahead since you just presented and shared yours most recently?

Megan Confer: Sure. Yes, we're sharing. Do you want me to share what we're sharing unblinded, or just that we're unblinded?

Alicia Goroski: Yeah, go ahead and -- yes, kind of those -- what's being shared unblinded?

Megan Confer: Everything on the individual scorecards, so the length of stay, Case Mix Index, cost, star rating, risk-adjusted cost per case, all of that's unblinded.

Alicia Goroski: Okay, great. And now, Stephanie?

Stephanie VanBibber-Martin: When I'm doing one-on-one visits with the skilled nursing facilities, I'm showing it blinded, but when we represent and everyone has their representatives there, the post-acute care collaborative, everything is unblinded. And that once again is going over their average length of stay and, for the home care agencies, the total number of therapy visits per episode.

Alicia Goroski: Great. And, Titus?

Titus Gambrell: We actually have not quite got to the unblinded stage.

Alicia Goroski: And I think there are a lot of other folks in that same boat. I'll actually pose now a question to the audience. Go share in group chat how are you guys doing this? Let us know. Share with everybody whether you're sharing blinded or unblinded and kind of what data elements. Great. All right, Isaac, I will turn it over to you to pose the next question.

Isaac Burrows: Yeah, definitely. I want to go back to Stephanie's update form. I thought it was really a unique aspect of something. There were a couple questions -- we won't put you on the spot right now, Stephanie -- about whether or not you'd be comfortable sharing that update form. I guess you shared a number of information and fields of what goes in that form. How did you go through the process of deciding what was important and what was not important, what were you going to share and not going to share?

Stephanie VanBibber-Martin: I actually had reached out to another center, an orthopedic center, who had been involved in the BPCI program for over a year. So to not reinvent the wheel, just kind of went over with them what they were doing, and they shared some information and allowed me to then be able to use that. I then went to the skilled nursing facilities and did the site visit and reviewed the form that I created and kind of got everyone's feedback, and these were the criteria points that we came up with that everyone was comfortable with.

I don't at all mind sending a copy of that information, if anybody wanted it.

Isaac Burrows: Great. What we can do is we'll put it on the CJR Connect site along with the webinar slides and the transcript and the other resource materials after this. When we post that in a week or so, we'll get that up for everybody. Alicia?

Alicia Goroski: Great. All right, I'm going to take us back to there was a question -- this one was initially, Stephanie, posed to you, but again I think we can have Titus and Megan jump in. You had talked about gain sharing earlier. What about specifically gain sharing with the post-acute care providers? Are you doing that? And if so, can you talk a little bit about that?

Megan Confer: This is Megan. At this time, we're doing it with our -- we've gotten a model approved for our physicians, and we will eventually move into the post-acute. We just haven't done that at this time.

Alicia Goroski: Okay. Thanks, Megan. Stephanie?

Stephanie VanBibber-Martin: This is Stephanie. Yes, we are currently in the process of getting a gain-sharing contract with our surgeons. That's kind of our focus is more surgeon centered. We have four orthopedic surgeons, and I think two of them it's almost completed.

Alicia Goroski: Okay, great. I am going to -- we're going to ask you to multi-task here for a second. We're going to go ahead -- we do have a couple of poll questions for the audience, so we're going to go ahead and push those out. We'll just ask -- we are not going to actually be sharing the results on today's webinar. We'll actually be sharing these in the future. We'll leave these open for a couple of minutes, but this way you guys can be answering the polls while we go ahead and pose the next question. Isaac, I'll turn it over to you. Are you there, Isaac?

Isaac Burrows: I'm here. Thanks. Yeah, no, I think that's great. I think it's an interesting conversation around gain sharing and how -- using it as a potential tool to align the incentives between the risk-bearing entity -- the hospital in this case -- and the post-acute partners. Oh, good, the poll questions are piling in. Thanks for responding to the poll questions.

I wanted to ask Titus -- sorry, I apologize. I wanted to ask Titus if there have been any -- what are your next steps, I guess is what I'm trying to say. What are the next steps in what your organization plans on doing to further these relationships?

Titus Gambrell: Thank you, Isaac. Just to kind of jump in real quick, we do not do any gain sharing, and I'm not sure if at this point we will consider that.

What our next steps really are for us is to try to further drill down on the centers of excellence. I mentioned that as far as our -- I don't like to use the word preferred provider, but we're referring to them as our centers of excellence. And so, it's to really begin to work with those that are not maybe at the top and to see what we can do to work together and collaborate together and improve them. Only because we have such a large geographical service area that not everyone wants to go to those facilities that have made the center of excellence cut. That's our next project.

Alicia Goroski: Great. Thank you. I just want to actually -- I'm going to wrap us up. We have just two minutes left before the webinar ends, so I just wanted to take a moment to thank all three of our panelists. Thank you to Stephanie, Megan and Titus for sharing your experiences. It was great to see the engagement also from the audience. And I think Linda had shared -- I saw some sharing going on right at the end of the data's being shared unblinded. So again, thanks to everyone for your participation today.

We did want to go ahead and announce a couple of upcoming events. Registration is now open. You should have received an email -- it's also been posted to CJR Connect -- for a special event

later this month on increasing mobility in acute care and its implications and interventions in BPCI and CJR. This will be a joint event with the BPCI model.

And then, we will be continuing this care coordination and management series. We will be announcing the date, the exact date. It is going to be in April. It will be the second webinar of this series. And then we'll have a third call in May. So again, stay tuned for upcoming -- the final date and the registration for that.

And finally, just a reminder to again continue this discussion on CJR Connect. The CJR community is quite active on CJR Connect. We encourage you to continue that. As Isaac said, we will be posting the recording, the transcript, everything from this event in the next couple of weeks, and we'll also include that document that Stephanie agreed to share with us.

Again, if you do not currently have a CJR Connect account, you can request one from the link on Slide 25.

And finally, send any questions to CJRsupport@cms.hhs.gov. We ask that you please take a couple of minutes to respond to the post-event survey. When you leave this webinar, automatically the survey will pop up. However, if you do have your pop-up blocker enabled, you may not receive that. You'll also get an email in about an hour with a link to that post-event survey. We really value your feedback and use it to drive future events, so please take a couple of minutes to fill that out.

And with that, I will thank everyone, and I hope everybody has a great rest of the week. Thanks.