Interpreting and Communicating High Cost/Low Quality Drivers: Deep Dive on Post-Acute Care Provider Data

Listen to the Webinar Recording Here

Isaac B: Hey everyone! This is Isaac Burrows with the CMS Innovation Center. We are just going to get started in a few minutes and allow for a few more folks to come in. So, we will get started shortly. Thanks for joining us today.

Good afternoon, everyone, and welcome to our data CJR Data Affinity Group. This particular breakout, we are going to be talking about taking a deep dive into post-acute care data. So we are excited that you are here to join us and join in the discussions. Both myself and Laura Maynard will be facilitating this today. And we will have-- you will have an opportunity to go through and ask questions. We will have presentations from SCL health and St. Francis. We will go around and get ready for it-- call on people and really get some good insight from your peers as to what they are doing with data. So, go ahead and prepare yourself for that. But we will finish up with poll questions and some announcements. So right now, I will turn it over to Laura to go through some of the logistics.

Laura M: Thanks so much, Isaac. I appreciate it. I'm looking for my little video camera. I seem to have misplaced it. Anyway, I will just keep talking so our meeting logistics and norms for today. All of your phone lines are currently muted. We are going to mute the phone lines during the presentations, but we will unmute your phone lines for discussion later. So please feel free to speak up and discuss verbally. I hope you're prepared to do that. We will also be using the chat feature as well as the phone lines to facilitate plenty of participation and conversation.

Closed captioning is available by clicking on the media viewer in the panel on the right side of the screen. For group chat, you look up at the top of your screen there is what looks like a little cartoon talking bubble and underneath it, it says chat. If you click on that, it will open up the chat panel for you to type in. There is a section on the bottom of your chat panel that says send to. You want to change that over, click over to the right of that so it says all participants, that way everyone on the webinar will be able to see what you are saying. You can have a conversation and chat back and forth. If you're having any technical problems you can chat to all panelists and someone will help you with that, but for conversation and questions, please put that into the chat box into all participants.

We are going to test our group chat, so I want you to practice using the group chat right now. Click on that chat button and type into the box your name, your organization, something you hope to learn about using data to engage with post-acute care providers. So you will notice that we are using a little "@" symbol. If you have a question during the presentation for a particular presenter, you can use that "@" symbol to indicate that your question is for them. If you want to have a conversation with someone else and chat, you can use their name, "@" and their name to have a conversation. But for our introductions, just type into the chat box your name, organization, and what you are hoping to learn about using data to engage your post-acute care providers. Type it in a box, click send, and we will all be able to see it.

Continue doing that, typing right on into chat, and we will then begin our initial presentation. So we are really happy to have with us today, Pam Masters. She is a program manager for

accountable care at SCL Health and she is going to be speaking with us a little bit about their practices in terms of their post-acute care providers. So I will turn it over to Pam.

Pam M: Thank you. SCL Health, if you want to go ahead and move to the next slide please. Thanks. SCL Health is a 12 hospital system that is located in Kansas, Colorado, and Montana. And, there are five of those hospitals that are participating in CJR. We all work together-- we came together and came up with a plan of action for building our process for the CJR population. I am located in Topeka, Kansas, at St. Francis Health and we are at 259 bed hospital and we perform about 200 Medicare, CJR patient surgeries annually.

Next slide please. When reviewing the literature and historical data that we discovered some common themes that led to our project goals. First, we found that our costs consistently exceeded target when our patients were discharged to skilled or inpatient rehab. We also have an MSSP and we found that our MSSP population, our skilled utilization, and skilled length of stay exceeded target. We decided to hire a nurse navigator to manage the pre-admission risk and the 90 day post-discharge episode. We determined best practices to implement preoperatively, intraoperatively, and postoperatively. We engaged with our surgeons, anesthesiology, our hospitalists and primary care providers, and we implemented objective discharge criteria to determine the most appropriate level of care.

We also developed a plan B order set that is a safety net for patients that are discharging home with home health, where if they get into trouble and they are not doing well, they are able to go directly to avoid ED or unnecessary hospitalization. In order to do all of those things, we had to engage with our community partners and what we did was we formed a transitions of care Council.

Do you want to advance to the next slide, please? For pre-CJR data, we found we had a 30% discharge to skilled and inpatient rehab, while we only had a 3% discharge to home health. And, that gave us some room to shift appropriate patients to home health services. Locally, we have 2 inpatient rehab facilities, 11 skilled facilities, and 5 home health.

And we chose, based on our volume, to align with 4 skilled facilities and 3 home health as preferred partners. And we chose those partners based on quality indicators. We used the star rating, our readmissions rates, our referral conversion rate, and our ED visit rate.

You can advance to the next slide please. For our post-acute care collaboration, first, we needed to engage our post-acute care providers. And, we did this by meeting with them and sharing some information. The first thing we shared was that CMS innovations generally start in acute care, but they do eventually move to post-acute care. So, we felt like they would eventually be impacted and they'd be ahead of the game if they chose to engage with us now. We also believe that, by being a preferred provider and being on the options list, they would likely receive more referrals for patients who weren't familiar with the local SNFs, but trusted that if we partnered with them, they have high quality.

We asked our skilled facilities to consider the mindset that this population would be managed like a managed care population rather than a fee-for-service. And we asked therapies at skilled

and home health to start treating within 24 hours. And then, we asked our home health to frontload therapies for the first week to see them every day. And then, we have the nurse navigator participate in on-site plan of care at the skilled facilities and then also participate with the home health's plan of care. Our transition of care council for the preferred providers, we asked them all to sign an alignment agreement with us and that just discusses the monthly transitions of care council meetings. We have monthly meetings and what we do at those meetings is we discuss root cause on any readmissions. We talk about length of stay and we did ask if they aim for a goal of 8 to 12 days, as appropriate for the patient, of course. We ask that they report on any delay in care and talk about high-risk patients, and do a review of those. We report on any patients that chose to go to facilities outside of the preferred network and then, we report about the percentage of patients that discharge to skilled. And then everyone gives any updates or changes in their practice, and then we also give any updates in our program that we have implemented.

Everyone is able to share best practices and any innovations that they participate in and then there is quarterly data that everyone reports. And, this is available for everyone to see at the meetings. So, the skilled facilities share their star ratings, length of stay, hospital admissions, ER utilization, incident reports, fall rates, and staffing. And then, the Home health, they report on their star ratings, length of stay, hospital admissions, and ER utilization as well as readmissions, and any-- their patient experience scores. They also talk about if they are able to see the patient and they require-- the requested time within 24 hours and then if the home health was able to frontload those first five days. Next slide please.

These two graphs and the two graphs on the next page show our outcomes. Our initial discharge to rehab, which includes both skilled and inpatient rehab, was at 30%. And, we did have a slight decrease down to 24%. Our inpatient rehab went down from 13 to just .6, but our skilled utilization went from 17 to 14. And really, the main thing on that was in quarter three we had an increase in patients with fractures, which are always more complicated. The second graph shows a baseline of 70% discharge home and we did increase that to 76% by the end of the year. Our home health referrals went from 3% to 15.5 % by the end of the year. Next slide please.

And then our-- the two main things, really, is our length of stay for skilled decreased from 22 days a patient to 13.9 days per patient, and that includes the fractured patients. And, our inpatient hospital length of stay went from 3.89 to 2.77. And, with our risk management and nurse navigator interventions, our readmission rates showed a slight decrease from 11% to 9.5%. And, final slide please.

Our overall goal of improving outcomes and reducing waste is being met through the innovations that we have implemented and our collaboration that we continue to develop with our community partners. While, ideally these relationships could have been developed without a mandated program, the CJR program really instigated accountable action throughout our system at all five of our hospitals and also, from what I've seen across the nation, and it allows this transparent partnership to be built. And, that is everything, so thank you for the opportunity to present.

Laura M: Thank you so much, Pam. And, I would say at this point, we would like to open up the phone lines and see if anybody has a verbal question or comment, so we are going to unmute your lines. If you are-- have background noise where you are put your own phone on mute because for the participants we are going to unmute your phone lines. And, see-- does anybody have a question that you would like to pose over the phone?

I'm hearing a little bit of background noise, but not hearing anyone giving us a question verbally. Does anybody have one that you would like to speak up and share?

Isaac: Hey Laura, I am happy to kick things off.

Laura M: Okay, great.

Isaac B: That was a great presentation, Pam. Let me start things off by asking essentially,-- it sounds like you have an interesting dynamic there with your organization and with your post-acute partners sort of aligned and reporting to you versus you reporting to them out on data. What was sort of instrumental in that? I am curious if you share any of your acute-care data with them or if you're only getting sort of that--I am wondering if it is bidirectional I guess is the question I'm trying to ask or if there's-- kind of what went into those partnerships you developed.

Pam M: It is bidirectional. We share-- we are pretty open with our data as well. They know that as the hospital we have a lot of skin in this game, so we feel like in order to build a trust and build these relationships that we are going to have to be transparent and so we have chosen to you that -- chosen to do that. We also provide education to them on any of the best practices that we are implementing.

Laura M: We've had a question come through in the chat as well from Dale wanting to know if you had, Pam, if you all had developed this just through relationship building or do you have any kind of financial agreements in place?

Pam M: Currently we do not have any financial agreements with the post-acute care providers. Prior to this role, I was a case manager, so I had already had relationships with all of them and it made it easier to sit down and kind of start that conversation. We might do that in the future. There has been discussion around that, but at this point it is just collaboration and improving patient outcomes.

Laura M: Excellent.

Isaac B: This is Isaac again. I have another question. So, just want to follow up and ask in terms of—sorry, on behalf of Angela Winegar, are you sort of using the CMS claims data at all, that you are receiving a quarterly basis, soon to be monthly? Have you found any use in that or are you analyzing and looking at the post-acute claims? Are you using that at all?

Pam M: The system, which is located in Denver, they are using some of that data and they are rolling it out to us. Locally, I do not have a data analyst here in Topeka, so as far as working with post-acute care, we are just using -- we are going patient by patient and talking about what we could have done differently and why did we fall outside of our goal for this patient. Once we start getting more of that data from the data analyst, we will be able to look more closely at that, but for now, not really.

Laura M: Another question came through regarding whether all of the hospitals have the same process or does it differ somewhat depending on the community and the hospital.

Pam M: So, we are the only hospital located in Topeka that is part of SCL Health. And so, we have our own. Denver, the other four hospitals are located there, and so they have monthly meetings, but they are combined. There's is pretty similar to what ours is as far as the data and what we share and I think we chose some different data points as far as with our selection of preferred partners, but as far as the monthly sharing of data, it is the same.

Laura M: Thank you. Any other questions for Pam at this point?

Alright. Well then, we may have some more later. And, if you have an additional question for Pam, just put the "@" symbol and Pam and we will put that in the chat box, and we will see that we get that to her. But, at this point, we will transition to our next speaker. And we are going to hear from Hailey Hill. She is the bundled payment program coordinator at St. Francis Medical Center. I will turn it over to Hailey.

Hailey, are you muted ?

Hailey H: Can you hear me?

Laura M: Yes. Now we can.

Hailey H: Okay, perfect. Thank you so much. My name is Hailey. I am the bundled payment coordinator at St. Francis Medical Center and I'm going to share with you exactly how we are engaging our post-acute providers and what exactly we are sharing with them. So, you can go onto the next slide.

Okay, so this is a little bit about our facility. St. Francis Medical Center is a part of Franciscan Missionaries of Our Lady Health System located in Louisiana. We do have about five hospitals located across the state and our hospital is located in Monroe, Louisiana. We are the only CJR hospital in our health system. We did have one sister hospital who was in BPCI, but they are not in a CJR MSA, so their program will be coming to a close I think this year.

We do have 504 licensed beds. Our DRG 469 and 470 volume for fiscal year 2016 was 439 cases. And we are running about 56% of that volume being true CJR volume. A little-- a few facts about our hospital, we do own our own skilled care and inpatient rehab, so generally hospitals who own those typically have higher utilization rates of skilled and inpatient rehab and for us that was very true. We were sending about 60% of our elective volume to skilled

care, whether it be to our own or to the community. And also, our orthopedic surgeons, none of them belong to our hospital. They are all non-employed surgeons, so that can make making redesign changes a little challenging. Next slide.

So our first step with CJR was really to define a governance structure. I'm not going to spend a lot of time on this slide, but we did develop one and we have, of course, a CJR oversight committee, a compliance team, a gainsharing team, and then a care redesign team. And, the first task for the care redesign team was really to dissect the total joint patient pathway journey. So, you can go to the next slide.

And this graphic dissect the patient journey into three phases. The first phase, of course, is the pre-operative phase, and then we have the anchor hospitalization, and the post-hospitalization. What our care redesign team did, they really analyzed each element under each phase. So, for example, under the pre-operative phase, we did a flowchart for joint boot camp and we mapped out when the patient arrived, all the materials they received in joint boot camp, every educational element that the patient was presented through the end of the class. And the same thing was done with the pre-admit clinic and so on. So, when the patient was in the hospital, we did a flowchart for each department, as well, that the patient went through. This allowed us to identify opportunities that we can work on to really improve our CJR program. I have listed some of those opportunities that we did identify, but the main one I want to focus on is communication with post-acute providers. So, we can move on to the next slide.

So, we knew we wanted collaboration and we really looked at our problem and defined the problem as there truly being a major lack of communication between our hospital and our post-acute providers. Our old process consisted of sending a referral to a home health or skilled care, them receiving the patient and us discharging the patient, and really the communication stopped there. We really did not have the care coordination to support a 90 day episode. So, we came up with a few different solutions and I have those listed on the slide. We wanted to develop clinical pathways for post-acute care, improve our discharge planning to really make it as efficient as we could, and then develop some type of communication platform.

So, I worked with our senior services director and we kind of brainstormed on what exactly, what kind of platform would work for us and would be most beneficial for both her goals and my goals and bundled payments. We came up with the idea of hosting a quarterly post-acute meeting; and, we decided on quarterly just because we felt that monthly would be a little too frequent and we were not sure we would have the content to present every month. So we stuck with quarterly and we did break up our post-acute care providers the two groups; group one being home health, hospice, and DME, and then group two being our inpatient facilities, our nursing homes, skilled care, inpatient rehabs, and long-term care facilities. We broke them up into two separate groups because we really wanted to promote conversation among the group and we really thought that if we had all of them in the same room then no one would really talk to each other and it would be more of a presentation kind of platform than true conversation and problem solving. So after we kind of developed what kind of platform we were going to use, we had to figure out what exactly are we going to talk about in these meetings and my coworker, she had her senior services initiatives, and the main goal being there keeping the geriatric population in the community and out of the hospital. And then, of course, my goal of

bundled payments, and I kind of came up with a recurring series, "Are you ready to bundle?" that we have in every meeting and we talk about bundled payments. We also include a quality presentation from attendees. So, we allot about 5 to 10 minutes every meeting for a couple of the attendees to present quality initiatives that they have implemented in their facilities that have really impacted care. And then recently we have added an industry expert education piece and that was requested by our post-acute providers. So, we will have a physician come in for 15 to 20 minutes discussing a topic that they have requested more information on. And, of course, we always end with a question-and-answer open forum.

Regarding participation, we have had really good participation in these meetings. Our group 1, we've had about 25 attendees representing 13 providers. So, that is our home health and hospice group. And to give you a little background, we've got about 18 home health providers in our immediate service area so we have a really good turnout there. And then, our group 2, our inpatient facilities, we have 30 facilities within a 50 mile radius of our facility. And then, we have got about 40 attendees representing 21 facilities that attend our meetings. Next slide.

So, now I will talk to you about what exactly I am actually presenting the attendees when they come, regarding bundled payments. So we had our first post-acute community meeting in April 2016 and to kind of kick off the meeting, I really offered an overview of CJR, what it was, kind of the overview of how it works, what hospitals are looking for in post-acute providers, and really how this program will affect post-acute providers moving into the future.

I was also very transparent with my data . I used the CMS claims data and really show them how we performed against the trended target for each performance year that was provided. We did this so that they knew that we were really going to have to make some serious changes to be compliant with those target prices. I also showed them our readmissions, what will we have in remissions for, when was the patient remitting, where were they readmitting from, and, of course, the volume of readmissions. And then, I also shared with them where our patients are going when they leave the hospital, what is our discharge distribution. And I will tell you, our biggest focus is on our elective volume because we did have 60% going to SNFs. So that was our biggest opportunity for improvement. Our fractures were very well-managed and we historically came in under target, so we did have some focus on our fracture patients, but the big focus was on our electives. I also offered our providers an audit of the patients that they cared for during the historical time period. I gave them an overview of how each DRG and fracture combination performed against the trended target and then each patient that they got, I actually did a patient pathway analysis where I said, okay patient A was a DRG 470 non-facture. They were discharged from the hospital, they had a 20 day length of stay on skilled care, they were then discharged to home health and then readmitted on day 40. And I would also include costs that were associated with each care setting so they were able to really look at a 90 day episode and see how this impacts our hospital and I think it was really eye-opening for the post-acute providers to see that information.

Our next meeting was in July and, of course, I had kind of our standing updates on there, but other things we implemented were length of stay expectations. And, based on our target price for our elected patients, our target is $18,085, very low, we kind of deducted the hospitalization costs, the physician fee, average cost, and determined that we were looking at about a 5 to 7 day

stay for our elective patients, if they did have to go to skilled care. So, we implemented those length of stay expectations and then we also implemented a length of stay notification so if a patient exceeded the length of stay, they would be contacting me and letting me know this patient has got to stay two days longer than originally anticipated and they would let me know why. Of course, we know that we will have patients that do sometimes exceed that length of stay.

We also implemented health pathways that began in August that really kind of narrowed down the amount of visits the patients were receiving. When we looked at all of our home health providers, it was just kind of all over the board on how many visits the patients were receiving. So, we did implement home health pathways to provide some consistency, but still allow the pathways to be modified to fit each patient's needs as well.

In October, we still at this point had no current financial data from CMS to really share, but we did update on our goals for discharge disposition. Our goal for our elected patients we wanted by quarter three of 2017 to hit 80% of patients being discharged home with either home health or outpatient. So, we shared those goals. We update on our quarter three performance where we had 50% of elective patients being discharged home. And then we also educated our providers on a new initiative that we started at the hospital, an ONQ and multimodal program, and that was really to reduce the use of narcotics were patients to improve pain management and to reduce our length of stay.

So, really for the provider, what they needed to know was that they may be getting these patients, since we are trying to reduce the length of stay. Finally, in January, I actually had 16 completed episodes that I could share with them to show the financial performance. And, I actually give them a look at episodes in April and May, even though they were not necessarily complete, so I can kind of show them how we were performing. I also was able to announce that in quarter four of 2016 we had increased our elective patient discharged to home to 70% which was huge for us and I also provided education on the SNF three-day waiver and on how to utilize that waiver. Next slide.

And then, finally, just to kind of share with you what kind of impact we have seen throughout the hospital and through the community and for our bundled payment program. So, we have actually reduced our average home health cost by $1071 with home health pathways. We reduced our length of stay from quarter three from 3.44 to 3.12 in quarter four. And, just to kind of give you a little background on that, that was when we introduced that multimodal and ONQ program, so we've continued to see the length of stay drop in January and February. We have also increased the amount of elective patient sent home from 45% in April up to 90% in January. And that was really through changing physician discharge habits and changing patient expectations.

And then, hospital in communitywide, we have actually drastically decreased the amount of patients who are sent from nursing homes that have expired in our hospital through providing additional education on the post and advance directives, we have reduced our readmissions by 13%. We have also reduced referral acceptance time from four hours to two hours. So, what that means is that when we send a referral to a SNF we were waiting four hours to get an

acceptance, basically, back from them. So, we reduced that down to two and we set a new goal to 30 minutes so we're hoping we can achieve that.

And then, kind of communitywide, we have identified transportation issues that really affect all providers that we are working on with our local legislature.

So that is all I have. That is the end of my presentation. I would be glad to answer any questions.

Laura M: Thank you so much, Hailey. That is a lot of really good detailed information. Really, really helpful. So, I would ask that if anyone has any questions for Hailey or questions for St. Francis Medical Center, feel free to speak up on your phone or type into the chat box.

Isaac B: Hailey, this is Isaac. I think that was a great presentation and there was a lot of really good insight. I'm curious, you all have a number of interventions that you have done with your post-acute providers. I'm curious if there were a few of those that you feel are most critical or what aspects of the information that you're sharing or what you have done to engage your providers has sort of been most critical to your success in changing?

Hailey H: I think really the most important thing was really putting that communication platform out there just because we had never brought in all of our providers in the community into one room and really had conversations and really were there to answer questions for them and vice versa. So, I think that probably was the most important strategy we implemented was that communication channel. But then, I also think too, sharing the historical data with them and showing them how the bundled payment system worked and how much skin in the game the hospital has, I think that really made an impact with them because they know that it's mandated on us and they want to be a part of it.

Isaac B: Great, thanks.

Laura M: Looking into the chat box, people are asking how are you communicating with your post-acute care providers and tracking your patients that go to each of those different providers?

Hailey H: So, communicating with post-acute providers, other than the meetings we are doing, we communicate by phone or by email. They usually call me when they get one of my patients, especially if it is one that has not gotten a CJR patient before. And just-- they say, hey I'm getting this patient and I want to make sure we have everything in mind to do everything like you want. They also send me an email letting me know that the patient has discharged or if there is a change in the patient's status. So, unfortunately for us, we are in the middle of a transition of EMR systems and we're transitioning to EPIC so we are hoping that after we do that, we'll have a little more opportunity for a little better communication, but right now it is strictly email notifications and phone calls.

Laura M: Thank you. I am seeing other questions coming through. You have addressed transfers of the dying patient. In terms of preventing that, have you helped nursing homes,

SNFs, etc. improve their medical management oversight with medical providers who may need a little bit of help with responding?

Hailey H: I will try to answer the best I can, just because this is my coworkers expertise, but I do know that she has worked with several of the nursing homes around the area to really provide some additional education to the medical staff and their physician that's overseeing their patients. And, I know that a lot of them are working to also have nurse practitioners that are there five days a week to really help with that as well. But, I can get more information if I need to for whoever asked the question.

Laura M: Okay, great. Very good. Thank you so much. Well, at this point, I want to involve everyone who is participating in this webinar and thank Haley and Pam for sharing and giving us so many great ideas and insights on how they are working in relationship with their post-acute care providers.

At this point, I want to shift the focus just a little bit and we are going to launch a poll. We are going to have a poll question regarding how you participated in this data affinity group. So what we want you to click on and when we push out this poll question is as a result of participating in and learning from this CJR data affinity group, my hospital has, and we want to click all that apply . Have you taken action, have you changed the way do some things, have you improved your processes, have you discussed new possibilities or new directions, have you reached out to other hospitals to share ideas or tools, or have you not really done much of anything with it yet?

We are going to give you about a minute to respond, so click on your answer and then we will show these results once we have given everybody a little more time. You can pick more than one. Some of you I know have done more than one of these activities. It is interesting to see what you have done so far as a result of being a part of this group. We will just give you a few more seconds. If you have not clicked a button yet, click on your responses. And we are going to close out that poll question. And, when we can, we will push the results so you can see that.

Okay. So, it looks like most have discussed new possibilities or new directions. That seems to be our largest amount. A few have not done anything at all yet. A fair number of you have taken action and changed the way do some things. We would love to hear more about that. So thank you for taking the poll and sharing that with us.

Now we want to discuss the question that we sent out in advance. As a result of participating in this data affinity group got what it has the hospital done or learned? This is where we really want to hear from you. We want to know what haveyou done, what have you learned. Is anybody willing to either speak up on the phone or type in a chat and we would prefer that you speak up on the phone for this? Is anybody willing to go first or would you like for me to just start calling on you down the list?

Isaac B: Laura, I think they want you to call on them. I think the people have spoken.

Laura M: I think they do. I think they want me to call on them, so I am just going to start. I will start in the middle and work my way outward. Dale, I am going to put you on the spot first. You have participated in this pretty thoroughly. And, I will say to those of you that we call on, if you absolutely do not want to speak, you can just pass, but we would love to hear as a result of being in this group, what has your hospital done or what have you learned. So, Dale, would you go first?

Dale: Oh, that's a big spot. We are very, very small. We have one orthopedist that primarily does joints here. We are a very small, community Hospital and a very old Medicare population in New Jersey. And while we have worked very well to perform the surgery and discharge patients home and with a small number going to SNFs or rehab, with virtually none going to rehab, our engagement with our nursing homes have sort of been directed by the system. We are part of the RWJ Barnabas Health System, which is now the largest health system in New Jersey, 15 hospitals, and that is fairly new for us. So, there is a lot of management of this program that has been coordinated by the system. So, there are some things that are beyond our control at this point. So, we are waiting for data at this point to come from the analysts that they contracted with in regards to cost, etc. And, while we have a very good working relationship with those with the star ratings that we know we can work with, we are nowhere near as far as the rest of you may be in your collaboration because it is sort of at the system level right now.

Laura M: I am sure you are not the only one in that circumstance, so thank you for sharing that. I know that that resonates with some other participants as well. Thank you, Dale. We will jump back up now and ask Amy if you would be willing to share. Can you tell us what your hospital has done or learned as a result of participating in this group?

Amy: We have had some meetings with providers as far as trying to solicit information from them on quality metrics and things along those lines. So we have a better handle on who our different providers are and who we kind of want to route care to or at least who the preferred providers are. So that has been very helpful.

Laura M: Thank you. Thanks so much for sharing that. We will jump on down to Angela next, but I don't see that she is on the phone. Angela, are you on the phone ?

Angela W: Yeah. Can you hear me?

Laura M: Yes. Now I can. Great.

Angela W: Okay. Yes. I am glad you called on me actually because I don't know why I did not think of this sooner, but we used the methodology that the IU health team had presented during one of the early conversations around comparing types of costs, internal costs. And we had looked at sort of the high-level categories of cost and we were sharing that data with our surgeons. And, so the surgeons came back and they said well, wait a second, why are we using—why are my medical supplies costs higher, and we were able to use methodology that Ed Lee presented as part of one of those early calls to really look into the suture costs in particular. And, we found out that one of the surgeons was using a Mersilene suture which is used for more of a bowel surgery and has extra properties that are indicated in that high-risk

surgical site infection population. And, he complied quickly with changing into the typical Vicryl suture and his costs have gone down. So, that was kind of a breakthrough moment for us that we were able to use that methodology very quickly and get into it and provide some great cost-savings and gain some trust with the surgeons in terms of how the data really impacts the value of care that they can provide.

Laura M: Thanks for sharing that. I really appreciate it. And, that gives me the opportunity, since you mentioned Ed Lee and IU Health, I will jump to Ed next. What has your hospital done as a result of participating in this group?

Ed L: Let me first say that I am flabbergasted by the shout-outs. I appreciate that. I think the main thing has been I believe it was the previous presentation by Angela, forgive me if I got the name confused, where they presented the slides, I think they call it a surgeon value report, that triggered a lot of conversations after that meeting about how we can get more consistent information to the surgeons so that they are constantly aware of what we need to be focused on. So that actually is what we were meeting about before this started and we have our first version drafted on how that would look.

Laura M: Wonderful. Thanks for sharing that. Thank you. John Joseph? And, I am sorry if I am mispronouncing your name,

Jean Joseph D: What I would say is that our hospital is a very small one, of the CJR participants. We have for the year 2016, for the first half of the year from April to December, seven patients, if I may, is that okay?

Laura M: Yes.

Jean Joseph D: We have those seven patients. Two of them went to a rehab center and at the end of staying too long there, for those patients we passed the limit of the target price. And for the other patients, we have a good relationship with one of our rehab centers , outpatient, they stayed for eight days there and we could see that in a result , expenditure went very low compared to the target price. It was at least 30% or 40% lower than the target price. And we wanted to use to rehab centers. Those patients we usually do not want them to go to this place, but they wanted to go, and we could not force to go to another place. We do not have that good of a relationship with them, so they ended up staying there for a long time, and we ended up having two times the target price. And then, 50% of our patients went home with a good result when it comes to the target price. Also, our way of communication, we have a website and capture. We have a real-time dashboard. We can follow the patient from the facility with ER. We have two facilities and they put that information in for us and we can see and capture the problem before even the facility captures it. The physical therapists, when there's a problem, they have to notify us through the website so that we can see exactly in real-time so if they have to come back to the clinic or the emergency room so that we prevent the patient from ending up--having a complication. That is what we have for now and we hope we will continue to follow you-- your program so that we can improve in our program.

Laura M: Thank you for sharing that. Wonderful.

Jean Joseph D: Alright. Thank you.

Isaac B: Yes. That is great. Thanks Jean. Just to summarize, as you can see, we are trying to sort of get at the purpose of this group and in trying to measure that and seeing sort of what changes you have implemented, what you have learned as a result of this affinity group. So I think that the information that you all have been sharing and as I think back to some of those previous presentations on physician scorecards and discussions whether or not to provide blinded or unblinded data, how to engage with both your surgeons and your post-acute partners, I think are important strategies in developing an understanding of how, once you know what your target price is, different ways of sort of improving the quality while decreasing the cost and whether it be internally in your organization and looking for that internal cost savings or looking outside of your hospital at other areas like in the post-acute costs. Again I appreciate everyone's engagement and I will pass it back to Laura now to post some additional poll questions.

Laura M: Thank you so much, Isaac and thanks everyone for sharing. Those of you that did not get a chance to share verbally, feel free to type into the chat box to let us know what your hospital has done or learned as a result of participating in this group. So, at this point, we're going to push another poll question forward. We went to gather additional information from you. We will just run each one of these polls for just a minute, so that you will have a chance to give us that feedback. We are not going to show the result at this point but we'll get those results to you later. We want to know, here are the goals of the data affinity group listed on the slide. We had hoped to increase CJR hospital participant interaction and mutual support. We wanted to identify and discuss common drivers of both low-quality and high cost, and to increase the use of dashboards to encourage and monitor improvement. So click on those to say, just pick one, how well have we achieved those goals? Those were our goals and how well have we done that? So, we have got another half of a minute to click and let us know your opinion of how well we might have achieved those goals. So, just a few more seconds. We want everyone to have a chance to respond. This is going to be very helpful information for us as we work on future affinity groups.

Isaac B: Laura, we should mention in these poll questions, we are not necessarily going to publish them but they are more for our own internal use and we appreciate the engagement.

Laura M: Yes. Thank you. Alright, so I think we can now push forward the next poll. Closed out that one. For our next one, on a scale of 1 to 10, with 1 being the lowest and 10 being the highest, how would you rate your level of expertise in analyzing data to implement the CJR model? We will give you about 60 seconds to think about it and click on that scale from lowest level of expertise to highest in analyzing and using your data, how would you rate your level? Just another few seconds more so that everyone has a chance to participate.

Okay, so that poll is closed now as well. We will move on and share some information with you. We have a new idea I want to share with you about action groups. We thought about shifting from just affinity groups to beginning to talk about action groups. And, there is a difference between them, and I just want to share a little bit on that. This has been an affinity

group and you mostly have shared ideas with one another, learned a lot from each other, taken that back to your organizations, and discussed it and shared it. It has been a learning experience. In an action group, though, you agree to work together to test a change or implement a change. You need to have—you have a chance to actually do something. Make a commitment to work on something, test something. And, if it has already been tested, then you get a chance to implement it. If it is testing a new change, then you get a chance to do that. There is an expectation in an action group that you're going to do something and report your progress on that to the group and share the tools that you are using to do it.

Because it is a little different and a little more active, it tends to be a closed group. New people can't join once an action group begins. It is intended to develop trust and transparency within the group. Goals for action groups are more to implement and test a change and to support each other in doing that. It also increases sharing of ideas and strategies. But it is a little more focused and there is a little higher expectation for participants. So, given that, would you be interested in participating in an action group working together to test or implemented data related change? I am going to push another poll to say yes, no, maybe.

This one being fairly straightforward with only 3 choices, we may not need to let it run the entire 60 seconds. But, we will give it at least 30 or so, so everybody gets a chance to participate. We are going to close that poll and be done with that one.

Our next poll, if you're interested in participating, our next poll question is which of the following topics is of most interest to you for action group? If we were going to move into action, would we want to use data to engage physicians and look at actions around that, would we want to use data to develop partnerships with post-acute care providers, or is there another topic that is very action oriented that you would like to join in a small group with and everybody try that same action and talk about how it works in different settings and in different locations? Pick one and if you pick C, other, please type that topic that you are interested in into the chat box so we can see it. We will give this one just a few more seconds and then we will close it out.

Isaac B: Laura, let me jump in and clarify one thing. I just want to let everyone know we want to offer the opportunity at CMS for others, for you all to engage in a variety of settings. That is why we have the Connect site. That is why we have the affinity group, which is kind of a small informational based group. But we are sort of also offering the opportunity for the action group and we are trying to gauge that so we appreciate even if you are, if you need more time, if you want to think this through, please feel free to send emails and there will be a survey as well but we will talk about that.

Laura M: Absolutely. We will be gathering more information about this. This is just an opportunity while we have you on the webinar to gather a bit of info from you to see is there interest in moving forward and if so, we need to have some input in that. You will have many other opportunities to do that. One of those other opportunities is to continue this discussion on CJR Connect. We have the data affinity group there. You know how to use it. That is listed out here on the slide. And, we can continue the conversation there. We have a few upcoming events and webinars we wanted to make you aware of. One that is not listed on the slide, but

that is coming up on Wednesday, February 22nd at noon Eastern Standard Time is "Advancing Care Coordination through Episode Payment Models - An Introduction." So, during that webinar, CMS is going to be discussing different aspects of the advancing care coordination through episode pay models, cardiac rehabilitation payment incentive payment model, and changes to the CJR model final rule. So that will be a very informational webinar. It is listed on CJR Connect. There is more information available about it also in the bulletin.

Other upcoming events, we have a webinar on March 9th in our Care Coordination and Management Series on developing community partnerships. And, we will be having at the end of March, on the 30th, a webinar sharing some of the learning from this Data Affinity Group out with all of the CJR participant hospitals. So, we may be calling on some of you to help share on a webinar-- to talk a little bit about what you have done, what you have learned, what was helpful that might be helpful for other hospitals as well.

Send any model related questions to CJRSupport@cms.hhs.gov, and please, following the session, take a few moments to respond to the post-event survey.

Isaac, do you have any final comments?

Isaac B: No, I don't think so. Thanks everyone for your engagement. I hope these are helpful to you. If they are not, tell us on the post-event survey. If they are, tell us on the post-event survey. So please fill out the post-event survey. No, seriously, we appreciate everyone's engagement in this and we will chat with you next time on the 22nd for the next webinar. Thanks!

Laura M: Thank you all!