CJR Data Affinity Group
Interpreting and Communicating High Cost/Low Quality Drivers: Deep Dive on Physician Data (Group A) Transcript

Laura M: Hello everyone, we will begin in just a few minutes.

Greetings everyone, welcome. We are glad you are able to join us for the CJR Data Affinity Group session on interpreting and communicating high cost/low quality drivers. We will be looking deeply into physician data today. We have some presentations today that we're looking forward to sharing with you. We are hopeful that you will enjoy that. We also will want you to participate in the session as fully as you can. We will be sharing some ways that you will be able to participate to share with one another. I will be facilitating today, this is Laura Maynard with the Lewin Group and I am a part of the CJR Learning System team, as is Isaac Burrows, he will also be facilitating discussion today. Isaac is with CMS with the Learning and Diffusion Group at the Center for Medicare and Medicaid Innovation. Our agenda for today includes some logistics and welcome information. Then we are going to have a presentation from Seton Health. And following that we will be having some group discussion. During that group discussion time, we are going to be asking you to share some information about your organization, about your hospital. We will want to know what you do that is similar for what you do with Seton and what you do that is different as well as what is working for you and what challenges you may be having. Hopefully, we will be able to encourage some discussion and dialogue around that. We will end up with some reminders and next steps moving forward for the Data Affinity Group. Currently, the phone lines are muted but will be open falling the presentation. We will remind you at that time, so that you can mute your own line if you background noise. And please don't put us on hold so that we won' hear the hold music. During the presentation, we will be muted after the presentation we will unmute and everyone can talk. We will also encourage you to use the chat feature to communicate with one another throughout the webinar. We will have some polls and we will have a post-event survey. To use that chat feature, if you go to the top of your screen on the right hand side, there is a little blue bubble, and under it says chat. If you click on that, it will open a chat box. In that panel that is on the right-hand side of your screen, there is a sign that says send to and a little arrow over to the right of that, you want to click that arrow and choose all participants. Now if you need just technical help, click to send to all panelists and we will assist you.

To have a conversation with everyone and ask questions of the speakers, please click 'All Participants' and type your questions and comments into the chat box. We are going to practice doing that. First remind you that closed captioning is available if you use the media viewer or you can use the link that will be posted in chat to access closed captioning. Again, a reminder to chat to all participants, and let's test out that group chat. To send to all participants, please type in your name, your hospital, and something that you are hoping to learn about using data to engage physicians. So please go ahead and practice that, get comfortable with that, and as we move forward through the presentation you can use that chat box to ask questions of one another or of the presenters and to have conversations with one another. So your name, your organization, and something you are hoping to learn about using data to engage physicians. Click 'Send to All Participants', type into the chat, hit send, and we will be able to communicate with each other.

Just a reminder for context about our data affinity group, that our general goals are in part to increase CJR hospital participant interaction with one another and mutual support. To identify and discuss common drivers of both low quality and high cost, and to increase your use of dashboards to encourage and monitor improvement. So one key goal in addition to improving performance, improving the use of dashboards and having discussions together, is to increase interaction and mutual support for each other. So at this time, I am going to turn it over to Isaac Burrows who is going to say hello and introduce our speakers.

Isaac B: Thank you Laura this is Isaac Burrows at the CMS Innovation Center. I appreciate everybody jumping on today for this discussion on physician data. I appreciate your engagement in this group. Again, this group is here for you, so we really are dependent on you all for feedback throughout this process to assist each other in your interactions and discussions around this. I'm looking forward to hearing some of your responses. It is a really good presentation today from Angela W. and Dr. Karl Koenig at Seton Health. Angela is the director of clinical effectiveness at Seton Health and Dr. Koenig is an orthopedic surgeon and also the medical director for the integrated practice unit for musculoskeletal care and the assistant professor at the Dell Medical School at UT. With that, I will turn it over to folks at Seton.

Angela W: Good afternoon and thank you for giving me the opportunity to share our experiences using data to drive improved outcomes for total joint replacement procedures. As Isaac mentioned, my name is Angela Winegar and I am the director of clinical effectiveness at Seton healthcare in Austin Texas, which is part of Ascension, Texas's ministry. My own background is in health economics and reimbursement policy and I lead the clinical effectiveness and outcomes research team which is a part of Seton's analytics department. Our objective is to drive and improve value for all of our patients through data, sharing results with both clinicians and administrators. Dr. Koenig is joining me as a presenter on today's call and he serves as the surgeon champion for the total joint replacement program at Brackenridge, which is one of Seton's urban hospitals, and is also the teaching hospital for the Dell Medical School at the University of Texas. Dr. Koenig is an orthopedic surgeon by training, but also serves as a medical director for the orthopedic integrated practice unit. I'd like to take some time to acknowledge Lauren Waters who is the clinical outcomes consultant responsible for our musculoskeletal service line. Her efforts have been instrumental in compiling the dashboard and the processes that all be going over today. I expect the conversation to take about 15 or 20 minutes, in which time I am going to focus on the physician-specific data that we are reporting and the tools and forms we use to share those data with our surgeons and other clinicians. Before diving into the meat of the conversation, let me just take a moment to share a little bit about our hospital system. As I mentioned, we are part of Ascension Texas, and we serve 21 counties in central Texas. Ascension Texas consists of 12 inpatient facilities including Providence Hospital in Waco, which is not a CJR participant area. The Seton system is located in the Metro Austin area and has seven facilities where joint replacements are performed including one academic medical center and one critical access hospital, which is excluded from CJR. We have six facilities in bundled payment programs, five in CJR and then our next location opted into a BPCI program in 2015. During the course of a year throughout our facilities we see about 1500 different total joint replacement patients. About 55% of those are

Medicare, about 90% of those are elective and 10%, come as trauma cases. All of the procedures are about 95% of them are performed by non-employed surgeons. Dr. Koenig, Would you like to join me in providing some background as to where we stood going into this program?

As I mentioned, we are part of Texas and we serve 21 counties. Ascension Texas consists of 12 patient facilities including Providence Hospital in Waco, which is not a CJR participant area. The Seton system is located in the metro Austin area and has seven facilities where joint replacements are performed, including one academic medical center and one critical access hospital, which is excluded from CJR. So as a result, we have six facilities in bundled payment programs, five of them are in CJR and our main location opted into a BPCI program in 2015. Over the course of a year we do about 1500 primary total joint replacements, and of those about 55% of those are Medicare, 90% are elective and 10% come as trauma cases. And over 95% of the procedures are performed by non-employed surgeons. So just to give you a little bit of background as to where we started from, and what was the call to action, Dr. Koenig, do you want to speak here?

Dr. Koenig: Sure. Hello everyone this is Karl Koenig. Can you hear me?

Angela W: Yes.

Dr. Koenig: Ok. I am one of the surgeon champions here at the Seton system. What really brought us working together with our colleagues on the data side had to do with trying to improve our performance overall but really around this bundle initiative because we realized that if we're going to work together and take risks on these types of procedures, you really need to understand your data, and what we knew about our patient outcomes were really only what we saw in our own follow-up clinics. And most of your patients who have problems actually end up going somewhere else, and so you don't really know all your outcomes in that regard. We found that what we knew about patient experience was really just some reports that we would get back from the hospital occasionally on surveys and patients often complain about parking issues and difficulties scheduling their appointments and things that are important but we don't have a lot of direct control over so we wanted to have better experience metrics. We also found that specific financial performance indicators were not really available and certainly we did not have a way to compare ourselves in terms of operational efficiency between one surgeon and another. And so we might get some data back around that but not necessarily something that was actionable because we didn't know how we were performing. So certainly we have some work to do in terms of getting better data reports.

Angela W: And just to add to that, the analytics team really struggled with the fact that our data existed in multiple non-interoperable sources. So any time we are trying to collect to get a well-rounded picture of the performance of a program, you want to include data from all sorts of different sources. That presented challenges for us in the past. And then lastly, Seton's mission is founded on the principle to deliver the best care to all of our patients, regardless of their socioeconomic status or insurance coverage. In keeping with that mission, we made the promise to ourselves and to our surgeons that for almost all of our total joint replacement metrics, we were not going to isolate patients who were enrolled in a bundled episode but rather

we would look at the total joint replacement program as a whole. I think this is really important from the physician's perspective as well, because we really believe we provide the best care possible for all of our patients and don't really differentiate between them so when we talk about setting up data collection, there is the question that comes up about how do you keep track of a bundled patient. From a clinical standpoint, it's much better to just take advantage of this opportunity to improve performance and to try to do the same thing for all patients who and undergoing these procedures, regardless of their payer. It is much easier to keep track of and we believe we are doing the best thing for all patients and it is easy to sell that to a clinician that we are going to make improvements across the board.

Angela W: To facilitate the conversation, I want to break our discussion into 3 sections, starting with the which metrics are reported here at Seton, and then covering how are data that are reported displayed, and concluding with the process and structure we have in place to share these results. I think we talked about this in previous Data Affinity Group discussions, and our first task was really similar to what a lot of hospitals are also undertaking, and that is to define the desired measures for our dashboard, first identifying the core objectives that will define success in this population. So with that in mind, we prioritized focus areas needing process improvement work and laid the groundwork for identifying the essential metrics. The first objective was to improve patient outcomes. This is first and foremost in everybody's mind. We want to improve their functional status and decrease complications and mortality and to decrease readmission. Similar, readmission is important from the payer's perspective. Also important from the payer's perspective are things like discharging more patients to self-care and home health agencies when appropriate. Focusing on quality and duration of post-acute stays and tracking of overall episode costs over that 90 day period where we have that data available. Our final objective is to decrease the variation and the cost within the inpatient setting. To do that, our team focused on has focused on implementing a perioperative surgical home, encouraging the use of cost-effective implants, standardizing clinical pathways and decreasing time in both the OR and in the hospital overall. With the desired metrics in mind, we created a homegrown data mini data warehouse specific to the total joint population. We leveraged people process and tools to do that and multiple departments and stakeholders were involved to ensure that we were collecting the right data and defining the metrics in the most appropriate fashion. We tapped into the expertise of clinical subject matter experts and we looked to administrative leadership to understand what their priorities were. We leveraged the expertise from supply chain and our finance department which gave us additional insight into the internal cost that were accruing as part of this program. And then we also leveraged the medical literature which gave us access to proven methodology and external benchmarks. As depicted by the yellow boxes in the middle of the diagram, we used a structured requirements gathering process that involved proposing metrics, accessing feasibility, documenting those metric requirements, and finalizing the metrics in population through a formal approval process. The result being a comprehensive data repository of encounter level data and that enabled us the ability to create two different visualizations for targeted for different audiences. The first being our physician value scorecard which contains over 50 metrics tabulated by surgeon, and our executive dashboard which shows a longitudinal view of six key performance indicators. Both reports show the same data and are able to be viewed at the facility and the surgeon level.

In addition to thinking through the metrics from the standpoint of the objectives we are trying to achieve, we also wanted to define our metrics to evaluate the success of the program through throughout the duration of the patient's continuum of care. So we start looking at what metrics we can consider in the pre-surgical period up to the 90 days before surgery. And then we have plans to start tracking the patient reported outcomes that are obviously collected after discharge, 270 days after discharge. This diagram here gave us the mechanism to communicate a snapshot of the development status for each metric which is depicted by the red, yellow, and green fonts. But then it also shows us the stakeholders who would be most vested in the results at each point in time. So our goal was to deliver reports showing that we are achieving desired results but also have the data available to identify and address the opportunity if we didn't see the results we were looking for.

The next session of the discussion is focused around two main reports that we produced for physician-specific results. This is a pretty complex slide. I hope you are able to see it. It is our first report. This is what we call the surgeon value scorecard. We have one scorecard for each site which includes all of the DRG 470 total joint replacements performed during the most recent six-month period. Aggregating it to six months and limiting it to DRG 470 decreases the impacted of outliers on individual surgeon results. So as you can see the left column gives you the name of the metric that is being captured. We have also identified the source in the middle for an internal reference point. We show an average for all surgeons at that site, and then we do show and individual column for each of the high volume surgeons performing on that site. So it is broken out into 6 sections, the first being the overview section, which gives us your basic volume and demographic information. Within the next section is our clinical quality section where we track percent of patients discharged by location and other outcomes such as mortality and readmission and ED utilization rate. Length of stay is an important measure as well. Also included in the section is the pre-op and postop process metric that have been identified as important leading indicators of success. At the bottom, we have 2 patient experience metrics that we get from our HCAPS data. On this second page, it's really all about financial results. We are able to break out those financial results into implants specific to hip and knee and then known implant costs. Each of the non-implant costs are broken down into subcategories that we modeled after the Medicare cost reports. Then finally we do cover a few operational measures such as room time, surgery time, and PACU time, and here is where we do present a little bit of data that is specific to the bundled patient population. It's an aggregate level view of the average 90 day episode cost and average 90 day readmission rate as sourced from the CMS claim specific to the bundle specific population. Dr. Koenig, do you mind speaking for a second about how this data has been used by the surgeons?

Dr. Koenig: Sure. Obviously we find this to be a very robust report. Luckily, we were engaged early on in terms of trying to shape the report in ways that it is useful to the clinician to try and improve things. We certainly found it to be. So as I look at this report, and I am naturally competitive as most surgeons are, so I go and look at my own data to see how it compares to the averages in certain sections as well as to my peers. I want to see what is the delta between me and what others are doing in that area. I also found out that it is broken down into categories in a way that I can actually try to effect some change and so if I find that my implant costs are the highest around then I want to take a hard look at that knowing that the data does not really backup the fact that I would use more expensive implants for particular cases. But one

particular anecdote as we released this was one of my colleagues noticed that we call the medical supply costs were quite high for him in compared to others and that was driving up his average overall spend. And when he really thought about it, this is where we can go delve in with the folks in the operating room about which extras that we are using for the case that are costing quite a bit more. Our whole plethora of devices that are available to us, we generally have some idea about the expense of really big ticket items in the operating room. But the smaller ticket things that don't make much of a difference, this can really add up to high cost. This was an opportunity for someone to go in and investigate that further and start to figure out where variation may have been unwarranted and where some changes could be made. We found it very useful in the beginning.

Angela W: Great, thanks. The second report is a Tableau representation of the same data, but it is limited to six of our key performance indicators for the program. We can PDF this report for email distribution but preferably we are steering our audience to our Internet site, where the user can then filter the data by DRG, site, surgeon, payer, the trauma status, and bundle status as well. And the visualization allows review of the longitudinal performance throughout the network and for different subpopulations. So for example, in the upper right hand corner, you can see the average length of stay for the last 12 months for hips and knees separately, and the objective of this is the executive level review snapshot of where we are with our success in the program.

But as we all know, the best dashboards in the world are useless if we don't have the right forms in place to communicate the results and generate actions. These next few slides focus on how we share physician data and Dr. Koenig is going to speak primarily to that. Before we get into that, I will summarize that at our BPCI site, we have been active a little bit longer, we have been distributing the surgeon value scorecard to orthopedic surgeons on a monthly basis, and discuss the results at a monthly continuum of care meeting. It is multidisciplinary, so nurses are in attendance, PTs, some representatives from the post-acute facilities and home health who attend the meeting as well. As opportunities are identified at the meeting, we take a deep dive into the data at a biweekly ortho workgroup. As I mentioned, additionally, we present the executive dashboard on a periodic basis to governance councils such as our network surgery counsel and the musculoskeletal steering committee. And then lastly, we encourage one-on-one physician education sessions.

Dr. Koenig: And certainly, I have found that all of these venues are useful in one way or another. Particularly I find the one-to-one education really important. I sit down with Lauren Waters from Angela's team about once a month to really look at the data that we have and try to make sure that we are comfortable with it and that it's making sense of what we see in reality. That feedback makes the data reporting more robust and makes me more comfortable as a surgeon champion when I go and speak to my colleagues that the data is solid and something that makes sense for us to try to make changes based on so that is extremely useful. In terms of the things we do to share data, is my boss Kevin Bozic was really the champion at the BPCI bundle site. We decided we would try to share unblinded data in all the venues that made sense to really set up a culture of transparency around the data from the very beginning. This is always a little bit scary at first, but it really turned out to be the best way, so if things can get out on the table people can start having discussions. At the same time, when you are sharing

this data in a public forum where which particular surgeon is attached to which data point, it doesn't really make as much difference then, it makes sense to keep that data blinded so there's not a lot of voyeurism going on at those levels. We find that combination makes the most sense in order to try to make people comfortable with making change. We want to share the data not in a punitive sense, but more in an opportunity to improve. So until we know how we are performing versus others, and we can't really improve and that is the power of the unblinded data. To give you a few anecdotes of things that we actually have found as we released the data, as I mentioned before, that medical supply cost question, one of my colleagues saw a big discrepancy between himself and the rest of us in those costs and found that some of the choices that he has made in the past as the prices in those devices had gone up, that there was a cost that he was not fully aware of. And that allowed him to make a change in the things he was using in the operating room. Another surgeon was concerned that the complexity of his particular patients wasn't being accounted for in the data. So that gave us an opportunity to educate on how we were doing risk adjustments and make sure that everyone was on the same page with that. That is definitely one of the first questions that everybody always has, it is my patients are sicker, my patients have bigger problems, so first of all we have to make adjustments for those but then be transparent about how we are making those adjustments. Another surgeon came to us and was really complimentary saying that this was exactly the kind of data that he needed to see if he was going to control the costs and try to work in a learning health system so that was very encouraging. Another saw that the driver of his cost of care within the percentage of the patient's name being discharged into a skilled nursing facility and he really felt that he had made changes in his practice and expectation setting so more of them were going home. When he saw the actual data, he saw that wasn't really being carried out by the team and the hospital and the care managers. Probably around people following what they were used to and traditions, and not everyone had been communicative with the changes that he had made in his practice. So this showed a prime opportunity for someone being made aware of their data to go make changes. These are some of the really positive examples that we have seen.

Angela W: So just to wrap up our conversation. I do want to highlight what I consider to be our critical success factors and that being first we have created a homegrown data warehouse that has allowed us to merge disparate non-interoperable systems and to address the needs of multiple audiences. This started out as a pretty manual operation and I am fortunate to work in an analytics department so I have some access to some programmers and with their help, we were able to automate a lot of the data extraction into that format. The second real critical success factor here is, we have been dependent on surgeon to surgeon communication and for surgeons to be champions of the data and I can say with kind of a sad experience but it just doesn't work to have an administrator or a data analyst sharing their results pressing for change; it is so much more effective when it comes from a peer and there is that sort of collegial nature as well as competitive nature but more collegiality to drive improvement. That ties into the last bullet here. We had to ensure that we created a culture where dashboards are perceived to address why doctors went into the profession, not to be punitive, but to capitalize on their desire to provide the best care possible and to give them the data that would enable that improvement in care.

Dr. Koenig: I just want to echo that the relationship between that analytics department and the surgeons both in designing the dashboard and making sure that its data is useful in measuring our performance that we find to be actionable and useful, and measuring our performance and the care of our patients, is really crucial. I think financial metrics need to be a part of that is an important part of what we do, but also making sure that operational efficiency and patient experience are brought into that as well as looking at complications so we feel like we can see were not measuring up to the standards around us and try to make change and certainly the way we have designed these dashboards allows that kind of adjustment. It also sets the stage with getting a trusting relationship between the analytics team and the surgeon champions as well as the surgeons in the community so that we can start those next levels of physician engagement. Really working on internal cost savings for the benefit of hospital and the surgeon and then talking about other opportunities that can come up with bundled payments in the future as well as co-management agreements with employed and non-employed surgeons. Everybody has to feel comfortable with their data and make sure that it is the right dashboards for measuring their performance before we can start actually trying to adjust reimbursement. Thanks.

Angela W: Thank you also for your time. This forum is pretty neat. I will open it up for questions, but I am also excited to hear from the group and how your experiences have been similar or different from ours here at Seton.

Isaac B: Thank you so much Angela and Dr. Koenig, that was a great presentation. It is interesting to see especially how you have your own homegrown data warehouse. You mentioned that initially it was a manual process, is that now all automated in terms of bringing in the different data sources into a single physician scorecard/dashboard?

Angela W: We have automated everything that is on the dashboard presently. So that we get a data feed from our constituent departments, so finance and the supply chain department, give us a data feed every month and that allows us to click refresh, occasionally new surgeons enter into the population, so there is some changes that have to be made to the programming behind the scene. But mostly, it is just as quick as a refresh and a rerun of the code. It generates into an Excel file. I am talking about the surgeon value scorecard it automatically populates an Excel file which we email to the surgeon population then bring it to the meeting as well to review in person.

Isaac B: Sure, yes that makes sense. Dr. Koenig, I think you mentioned the care continuum meeting. I am curious as to how you incentivize the surgeons to be present at the care continuum meetings. I am curious if the dashboard and data you are providing has any impact on that.

Dr. Koenig: I can answer for myself personally I'm a little bit different than most surgeons because I have an intense interest in this data, but it has been really important to me throughout my career to try and make improvements in the way that we care for patients and I have been starved for the data to actually do that. So, certainly with my colleagues when I speak to them, I point out to them how little they know about their actual outcomes other than what comes back to their office and that when you get real data, it can really give you some insight into the things you are trying to do. Specifically with joint replacement, because they are so successful in

general, we ae talking about 90-95% of patient satisfaction rate, extremely low infection rates, so unless you're being robust in your data gathering, you won't be able to detect any changes that would allow us to improve our practice. So for me, that is really important to be engaged from the beginning. Once I ask for data like that, then I have a very significant vested interest in making sure that the data is accurate and the way that it's being selected reflects my true practice and the true reality that we see on the ground. It is not a hard sell to get me to come to meetings where we are setting up my performance data, so I do not know if that answers the question.

Angela W: Yes, I will add on a little bit to that. We've been distributing the surgeon value scorecard since August and there was a lot of interest and excitement around that and a little bit of nervousness too. I do not know if it was because of the holidays or what, but we did see a little bit of a dwindling attendance from the surgeon population. Maybe the fact that they understand the data and there getting it in their email anyway, so they are not as excited. Something we've been talking about is to make attendance at the continuum of care meetings required or a certain percentage of attendance required to be placed on the call schedule. A lot of surgeons who don't have an established practice but want to build their practice, are really eager to get on the call schedule. To have them participate in this quality improvement discussions and so using that as an incentive to have them participate in these quality improvement is one mechanism we have been talking about improving.

Isaac B: That is great. On slide 19, you have quite a number of metrics on the scorecard. I'm wondering if you can chat about if there was a hospital here on the line who may be did not have the capability to produce that many numbers or that sort of robust level of the scorecard. What are some of the key components you think are the most important or most impactful for the individual surgeons.

Angela W: Thanks. Actually, on the slide, I didn't point it out when I was presenting, but they are kind of called out right there. They are the ones that we have highlighted in yellow. I think the discharge disposition is a big indicator of patient satisfaction. If they are educated and have the expectations upfront that they're going to have the capability of going home after the surgery, that can be a big satisfier. Of course, it does cost the payer less in most cases. And then we track length of stay that is just something that is a focus throughout the hospital and all sorts of different conditions. We are focused on getting surgeons who, I don't want to use the word standardized because it is kind of a scary word for a surgeon, but to really review what evidence exists in terms of postoperative and care protocols. So when it comes to using drains and CPM and some of the stockings or some of the incidental orders that might come through in the postoperative space, that is what we are concerned to be our pathway. It has its advantages if you can get everyone to agree on a similar protocol for most patients because the nursing staff does not have to know the preferences of each different surgeon, but it also just yields more consistent care with less variation, so we've been tracking that as well. We've been tracking the implant costs because it's something that's the surgeon's decision ultimately what implant he or she wants to use and so that is just something that they can control.

Isaac B: That is great, thanks Angela. I will pause here, are there any comments on the phone?

Dr. Koenig: This is Karl I just want to say thank you for the opportunity. If there are any questions that you have specifically at the surgeon champion, please forward them electronically and I am glad to try to get back to you. Thank you very much.

Angela W: Thank you Dr. Koenig.

Laura M: Yes, thank you. Participants, if you are on the phone, your lines are now unmuted. If you have further questions for Angela or comments to make, please feel free to go ahead and unmute your own line and speak up.

Isaac B: Angela, we had a question earlier asking about if you all have collaborative gainsharing agreement. And how this impacts.

Angela W: Looks like the questions was in and out. I think it has something to do with whether or not we have collaborative gainsharing agreements with the surgeons here. The answer to that is, yes for our BPCI program. They have a gainsharing program, they have more upside gain than they do downside risk. It is quite a substantial, it is a differential there. We have not entered into any gainsharing agreements with our CJR program as of date, although I think legal is reviewing them or may have finished reviewing them. We were targeting early January. So, I think the physician engagement team and the contracting team has that in their hands and we are excited to be able to start sharing the reconciliation amounts as they become available. In our initial results it shows that there may be some. It is not substantial, but there might be some. We are using that as a little carrot to get everyone engaged.

Laura M: That is great, thank you so much Angela we appreciate that. The rest of you, please continue chatting in questions or comments. We are going to move on forward. I want to show you the results that we have from the poll that we took on the prior webinar. This is just a way of showing you that within this Data Affinity Group you do have some of this happening. So we would love for you to talk about it and share about it a little bit. The vast majority of you indicated that yes you have physician champions in your CJR model. Some do not, but most do. Also a majority indicated you have had success in building engagement among your physicians by using data. We know that many of you have these activities happening and you are doing this. We would like for you to talk to us about it. If you wouldn't mind sharing with us, how do you share your data with your physicians? How do you choose what to share, what's working, and what might be going better? How do you share it, particularly is it blinded or unblinded? Is it a report or is it discussed? How do you know what to share? How do you pick it? What works and what might be better? Is anybody willing to speak up on the phone to share about that? Tell us how you do it. I know some of you here have practices that you're doing and I know you have successes that are happening and would love to hear you share a little bit.

Angela W: Something of be interested in hearing is whether other systems have found success in sharing blinded or unblinded data and where they landed on that decision.

Laura M: We will clarify, are the phone lines actually unmuted? Are we able to hear you all? If you are more comfortable chatting it into the chat box, that will work too. Let's try this in a simple way. If you're sharing data with your physicians, unblinded, so the physician's name is

on the data and you are sharing it with them so they know who is who, put yes into the chat. That way we will see that some of you are and we will be able to have a little bit of discussion about it. As we are giving you a chance to chat that in, we have had another question come through. Angela, the question is about a sample copy of your surgeon value scorecard and the executive summary documents. Do you have any of those that perhaps don't have actual data in them or a template that you might be able to share?

Angela W: I do not know what the right forum for that is. If anybody has any specific questions probably the best way to reach me would be through the CJR Connect group we have, and we can collaborate off-line if you will. I don't think this forum would exist for me to put that up right now, right?

Laura M: No, but we would be able to distribute it if you're comfortable sharing it with the group.

Angela W: Yes, I think I would want to do it on a one-on-one basis if that is ok.

Laura M: Sure, that will be fine. I am getting a couple of folk responding yes that they share the data unblinded. Lynda Burrell indicated that they have a monthly management meeting and also a monthly hip and knee meeting and shared the unblinded data in that way. I've only had two type in yes that they are sharing unblinded data so it may be indeed that the majority of you don't share quite that way.

Angela W: I am really excited to see how people are sharing data unblinded. This is our first here at Seton. We had never shared data in an unblinded fashion. We have always de-identified the surgeon or the physician, whatever the unit was. I think I was very cautious about how that would be perceived and what the response would be and so it is really great for me to know that this is a good practice that is being used throughout the country. That gives me a little bit more confidence that as surgeons start to meet and talk with each other and through their forums that this is going to be the new and exciting way to share data. We have seen some tremendous results, and like I said, it is a combination of collegiality and competitiveness that yields better results.

Laura M: We have had a couple others type into chat that yes they do use unblinded data, so of the group it looks like perhaps about three or four are doing it in that way. I will ask if you have additional questions or comments for Angela just continue to type those right into the chat box or if you have questions for one another. What questions or suggestions you might have for each other? Feel free to type those right on into the box. While you're doing that, we are going to launch a couple of poll questions so that we can get some information from you that will help us inform our planning for our next breakout session. In this session, we have been looking at physician data. We are going to be looking into February's sessions on sharing you data with post-acute care providers. Do you do so, and if so, how often. So if you wouldn't mind, click on the poll, just click the one that applies for questions one and two, and then click submit at the bottom. Do you share data with post-acute providers, yes, there are three no options, no but we are exploring it, no but were interested in it, or no we don't plan to do that. And how often do you share data with your post-acute care providers. This will give us a little bit of framework as

we planned for the February conversations we're going to focus on post-acute care providers and our relationships with them. There is still an opportunity to click on the poll and still able to click your answer. Also in our polling, we want to ask you to type into the group chat box, how you engage your post-acute care providers. What are the ways that you engage and develop relationships with post-acute care providers? As we move forward, go ahead and type that into the chat box. And I will move ahead to talk a little bit about those next sessions that are coming up for the Data Affinity Group. Group A is going to be meeting on February 15 at 2 PM, Group B is on February 14, and will be focusing on identifying and communicating those low-cost high-quality drivers, but we will be looking more deeply into post-acute provider data. That is going to be followed in March, likely March 30, with an all-participant webinar for all of the hospitals in the CJR model on sharing what we have learned in the Data Affinity Group. So what has been useful for us, what you have learned, what you've experienced, what actions you have taken as a result of participating in this group. This will be a good opportunity to go ahead and share what we have learned with the rest of the hospitals in the model.

I encourage you to continue discussion about this on CJR Connect. As you know we've got a data affinity group that is a private group on Connect and in that group we can continue talking in the ways that we do on these breakout sessions and the webinars. It tells you on this slide how to post a comment or share a resource. If you don't have a Connect account, the instructions are on the slide also. We've had some questions coming in regard to processes and conversations so continue that within the chat. I also want to remind you that if you have got models related questions, those go to CJRSupport@cms.hhs.gov. There will be a post event survey that will pop up for you following this event, and we encourage you to complete that survey. That provides us with really helpful information that we can use for our planning. At this point I'll check to see if there are any more comments, questions, or thoughts. Isaac, did you have anything further you wanted to say in closing?

Isaac B: I don't think so. Again, I appreciate everyone's participation and please let us know if you have thoughts on how to improve this group, things we can do differently. I'm really curious to see folks' data on post-acute providers. Our sense from the CMS perspective is that moving further outside your hospital facility and those sort of partnerships and what's that like in terms of providing data to post-acute is sort of less developed amongst our CJR participants, not in a bad way, just as a we haven't gotten there yet. Looking forward to that. Thanks everybody for participating today.

Thank you very much and please complete that survey when it comes up. Thank you.

[Event concluded]