# CJR Data Affinity Group: Interpreting Data and Communicating Data: Using Dashboards to Build Engagement and Drive Results (Group A) Transcript

Please stand-by for real-time captions.

Thank you for joining us. We will begin a couple minutes after the top of the hour.

Hello, everyone. We're going to go ahead and get started. This is Isaac Burrows from the CMS Innovation Center. Thank you for joining us today for our CJR Data Affinity Group Breakout on Interpreting and Communicating Data Using Dashboards to Build Engagement and Drive Results. As you can see, we are coming to you live from the CMS Innovation Center, and you can see my face. In a second we will introduce ourselves in the room. We wanted to engage with you today.

Facilitating beyond myself, we will have Laura Maynard as well from our Lewin colleagues. And we will be excited to chat with you today about what you all are doing and how we can collaborate together.

In terms of reviewing the agenda for today, what we'll do is we're going through logistics right now, and folks from Catholic Health will jump on and give their presentation, we will have open discussion, there will be some polling at the end, working towards our next session and then some reminders and some next steps.

The telephone lines are open. From time to time we'll mute them during the long presentations but that being said, if you are going to mute the line yourself, please make sure you put yourself on mute and not on hold. Even though you put yourself on hold we do hear the music and as much as I'd like to hear the music and dance along, please put it on mute and not on hold. Please participate and engage in this. It'd be great for you all and Laura will help push us along in that but please use the chat box, you see that feature. As we go through this, there will be polls, we'll talk over the phone, etc. If something happens with your screen freezing, you can always use F5 or Apple + R if you have a Mac.

Okay, moving on. Again, closed captioning is available if you need it. When you are chatting in the chat box, make sure you select all participants; you can chat to each other. If you want to chat with someone in particular, just use the @ symbol and then their name. That way, we can all talk in the same form and same venue.

With that being said, I think we can move along Laura. Why don't we go ahead and actually practice that in the chat box right now. If everyone can go ahead and type in their name, their organization, and one thing they hope to learn from the presentation, that'd be great. We'll pause for one second and allow people to start typing in. Realize that if you don't type in, we're going to call on you.

This is Laura, and I will give you fair warning, we're going to call on you anyway. So, you may as well go ahead and type in. If you find that little chat box, it's on the right-hand side of your screen. It says chat and it has an arrow beside it. When you click that, it will say send to and click on all participants. Then type right in there right now and let us know one thing you're hoping to learn about dashboards today. What are you looking forward to learning in the session? We want to begin, also while you are typing that in, with introducing ourselves, and introducing you all to each other. As Isaac mentioned I am Laura Maynard, this is Isaac Burrows, I'm with the Lewin Team that is a part of the CJR Learning System team. We have several of our team on the webinar. If you are looking at the attendee list, and you see two Laurens and two Jennifers, and Elizabeth, Kristian, Alicia, all of those are members of our Learning System team.

Isaac, can you introduce those who are in the room with you at CMMI?

Sure. This is Isaac Burrows, I am from the CMS Innovation Center. I am the Learning System Lead for the CJR model and a few other models. In the room with me, we have Lieutenant Maria Agresta-Workman and David

O'Reilly, who are project officers for the CJR model. They are available for questions as well when we get to the end.

Great. We are going to also have you introduce one another. I see you doing some great introductions in the chat box and that's wonderful, love that. Also, include in there as you are chatting those in, something you are hoping to learn. But I want you to practice with unmuting your phone and talking to us verbally as well. That will really facilitate conversation after the presentation. Not only will you only be able to ask questions of our presenter but you'll also be able to talk to one another and share your practices and approaches. As you are going along I would like you to do that. Therefore, I will be calling on you sort of roll call style. When I do so, if you could let us know your name, organization, and who is with you on the call. I am going to start out and get the ball rolling with Cathy Newman from the Francis Hospital. Cathy, can you unmute your line in introduce yourself?

You will need to unmute for us to hear you. Can you hear me?

Just barely.

Try again.

Hello there Cathy Newman from Texas.

Wonderful. Is anyone with you today? Or is it just you?

Just me.

Thank you. Thanks for joining us, I appreciated it. Chelsea Williams, can you introduce yourself and if anybody is with you?

Hello, this is Chelsea Williams. I am with St. Luke's Health System in Kansas City, Missouri. And my colleague Jamie Johnson is on the phone as well.

Wonderful, that's great. Thank you so much we're glad to have you with us today. Thank you. Okay, how about Tammy Nelson? You're on, is anyone with you? Can you introduce yourself?

Hello. Yes. It is just me here. I am with Keck Hospital of USC and I am working with the quality department here.

Wonderful, thanks so much for introducing yourself and joining us today. Brenda from Brian Medical Center. Can you introduce yourself and tell us if anybody is with you today?

Sure, I am Brenda Lieske, program manager for Neuroscience and Orthopedics program at Brian Medical Center. With me today is Leslie, our care transitions director. Great, welcome! Thank you so much. How about Jennifer Tillman?

Hello, I am Jennifer Tillman and I'm with Ascension and I work out of our national office in St. Louis. I'm on the call alone today.

Okay, well welcome, thanks so much for joining us. I am glad to be here. I see Joseph is on but I do not see a telephone by his name yet so he may not yet be dialed in. I will jump on down to, let's see, we've got, anyone from New York Presbyterian or from that group? Lauren, are you with us?

Yes, I am.

Great. Do have anybody there with you?

No, just me.

Okay, thank you. Welcome, thank you for being with us. Shannon, can you introduce yourself?

Hello, I am Shannon from Promedica.

Great, thanks for being with us. Okay let me see who else I have not called on yet. I will go back to Joseph Vicknair, are you able to introduce yourself on the phone?

We're here. Good afternoon everyone, I am Joseph Vicknair. I have Ann with me and we're with P&S Surgical Hospital in Monroe, Louisiana.

Thank you for calling in. Who have I missed? Ashley Fritz, I see that you're here but I didn't call on you yet.

Hi, I am Ashley Fritz from Promedica Health System.

Okay, welcome. Anyone else that has not spoken yet? Anyone that has not been introduced yet? Alright, thank you all for participating in that. I hope that will make it easier when we get to the point of having some discussion with one another, sharing back and forth, we will have a sense of who is on the line. I really appreciate your sharing and am pleased to hear what great geographical spread we have. We've got folks from all over the country with us today that's exciting and I hope you will be able to have some good conversations with each other.

I want to do a brief overview of the Data Affinity Group altogether and what our goals are that will keep us grounded and why we are here. The goals are to increase CJR hospital participant interaction and mutual support, getting you talking with each other and give you a forum and a venue to talk to one another and support one another in this work. We also have a goal of identifying and discussing the common drivers of both low quality and high cost. So we'll be focusing on that. And also the goal is to increase the use of dashboards to encourage and monitor improvement.

Here's an overview of our framework of the affinity group. The breakout sessions A, B, and C. This is Group A. We are meeting today. Our next Group A meeting will be on January 18th, at that point, we'll be talking about Deep Dive on Physician Data. As you can see, the other groups are here and if you want to attend more than one group or you have others from your organization that want to attend a different group, that will work just fine as well. You're welcome to do that.

I want to share the results with you from the polling we did on our October webinar that was for our entire Data Affinity Group. That was on October 27- we had the whole group together. We had a few questions on the topic of today's break out session. Does your organization have successful practices to share with respect to using dashboards or sharing and communicating data with your partners? The responses to that, we were basically asking "have you got something to share?" 56% of you said no, we do not. That was interesting. I'm hoping that those of you who are in that group will be here to learn from the others and ask questions and hear what they are saying. 28% said yes and 17% said maybe. We're hoping that that group of you will really speak up and share what you're doing and what you have got going on and how you're approaching things so that others can learn and have dialogue with you about it. Another survey question that we asked: which partners are you sharing your data with? Select all that apply. Almost everyone is sharing, 86%, with your clinical leadership and your organizational senior leadership. Another very large percentage, 71%, is sharing with quality improvement and patient safety leadership. So we have a good bit of sharing with organizational leaders. It drops down when you get to front line clinicians; only about 57% are sharing there. Only about 62% are sharing with their finance department. It drops dramatically when we get to post-acute care providers, with 19% sharing. So just to give you the context of the whole group, this is the type of data sharing that has been going on. How often do you report that data and share the dashboards with partners? About 38% do so monthly or quarterly, 30% ad hoc, very few in real time or weekly- although many are identifying this as something that they want to be moving towards.

This will give us a bit of context for our conversation today to know where the entire group is as well as this particular break out group that you're sharing with.

## Catholic Health Presentation

At this time, I'm going to introduce our speaker. We have from Catholic Health, Christina Kane, who is the vice president of musculoskeletal rehab services and she is going to be sharing with us so we're going to be muting all the lines during the timeframe while she is speaking so that we will be able to hear Christina speak. If you have questions while she is speaking, if you have something that you want to ask about or share about, type that right on into that chat box. It will not be a distraction. Go ahead and type it in and we will address your question after Christina's presentation. Christina, I will hand it over to you.

Thanks, Laura. Hi, everybody. Good to hear from so many different people that are on the call and just wanted to mention that as we move forward through the presentation, really, I am interested in hearing what all of you are doing, we're definitely a work in progress. I will share with you and give you context of how we worked towards developing our CJR dashboards, which are closer to the end of the slide deck but wanted to give you some framework and context as to how we got to where we are today with the CJR reporting. To give you a sense of Catholic Health, we are in the Western New York area, Buffalo, New York. There is no snow yet we're supposed to get some Sunday, we will see what happens. Basically, we're located throughout the West New York area, the eight counties. We are a four hospital and five campus system and with a couple of rural hospitals that we affiliate with. Just in that list of services that we provide to note that we do have four skilled nursing facilities- two of which provide short-term rehab and we also have a home care agency as part of our offerings and also we have an affiliation with Catholic Medical Partners, which is our ACO partner. So interesting thing about being an ACO partner, although it's helpful, in some ways our providers in some areas are already talking about cost-reduction and utilization and how to make sure we are providing correct care at the right time. It is also a little bit of a, what we have found, we have done some analysis between our CJR population of people and our ACO members. They are not one in the same. Only about 32% of our ACO members also are in CJR. Some of the benefits of being in the ACO are not necessarily linking with our work in CJR although we are definitely working together and collaborating on that. So from an orthopedic standpoint within Catholic Health, we do about 3600 in-patient surgeries. The majority of those are joints but not all are joints. About 50% of our volume is designated and completed at Kenmore Mercy Hospital, which we've talked about as our Orthopedic Campus of Excellence. Also of note, I'm sure some of you are in similar situations- our surgeons are all independent providers. So they choose to bring patients to us and any of you who are in a similar situation know that we've had a slow start in good collaboration with our surgeons around CJR. The other thing that's important and that has had some impact- how we plan for CJR. Although we've got a large (3600 surgeries) number of surgeries being done, only about 500 of those based on historical trending fit the CJR patient population. We have a high penetration of Medicare Advantage in our community so as we move, one of the challenges that I face and I'm interested in hearing what other people say, is that because this is a small part of our population, it's hard to get collaboration and integration from our senior leadership team around making changes for that small population. But, we are starting to make some headway in that but I'd be interested in hearing what other people say if you're in similar situations.

Moving on, Kenmore has a long history of working and specializing in total joint replacement. That is important because what I've tried to do as a service line leader is to integrate and implement the types of standardization and types of work that we do at Kenmore into our other four hospitals. Kenmore has about a 15 year history of working and improving on their total joint replacement outcomes. You can see some of the work that we've done with Joint Commission, 5 stars in health grades and we also have been participating in AJRR. Again, another kind of question for people out there, we are participating and submitting data in Level 1 and we did do a pilot with them a couple years ago in Level 2 data. We really haven't seen them moving forward as quickly as we would've liked to on more of the quality data. We're kind of in a holding pattern with AJRR at this point. But really what we've tried to do as the service line leader for the system is trying to integrate best practices that we found worked at Kenmore, in to our other hospitals. It's always a work in progress as we try to standardize different

processes or different reporting. Sometimes we take two steps forward and one step back. But we're always working on that and one of the challenges I found is that the service line developed over the past 5 years. Kenmore has been around for 15 years, really perfecting and working on total Joint replacement. The service line is newer- only about 5 years. We developed some centralized reporting through a system level governance council, which is our orthopedic leadership that meets quarterly. Each hospital has its own site committee. We work on quality and any other issues or processes that are site-specific. The other thing I just want to mention as I am starting to show the dashboards is that it's important if you're going to be sharing data, to have a resource or a way to improve on the data. So we do have an RN that reviews our cases that might flag with a complication, to look at opportunities for improvement. It's sort of answering the "so what" question. Dashboards and sharing information is important but you have to be able to act on what you're sharing when you're seeing any issues that come up. I think that's been a challenge for us over the five years. - if you're going to be sharing data, have a resource or way to improve the data.

Again, we developed our dashboards as a way to streamline our reporting on our outcomes. The majority of what you're going to see are clinical quality outcomes that we've developed. It's just a way to present data in a standardized way to all the different stakeholders around orthopedics. One of the challenges I mentioned before, you really do not have national comparison database for all payers in orthopedics. At least in AJRR is working towards that. We do a lot of work with Health Grades to try to compare ourselves, work towards 5 star ratings and maintaining 5 star ratings. But we know that there are limitations because Health Grades is only Medicare and Medicare Advantage, which is the majority and AJRR has been slow coming up. So what we've developed over the last 5 years, our data on our dashboards is based on a data company called Midas. I don't know how many people are familiar with Midas but when you compare yourself with the data that is in Midas, it's about 800 hospitals across the country. It is all payer but it is not risk adjusted data. So what I'm going to show you on our dashboards is our data that we get out of our database through Midas data vision. And the reason that we use this is that it's the best that we had at the time when we started our dashboards. It's definitely a work in progress as we start to get more data directly from CMS for CJR.

This is a format that the Midas data comes in. That's how it comes into us. As you can see by this picture, it is very difficult to look at; it becomes very difficult to explain all of the different metrics on this chart. We always have this to be able to go to if we have questions around what we are reporting on our dashboards. The goal of the dashboard was to take this Midas data format and put it into a more usable format.

This is our first iteration of our dashboard. Again, this is my tool to be able to report to a variety of stakeholders how we are doing with our clinical quality, what our volume looks like, and at the bottom as I will point out in a minute, we started to pull in some of the CMS publicly reported data to be able to keep everybody's attention to those matters. On the left-hand side are procedures we monitor through our orthopedic service line. You can see hip fractures, the replacements, and the next column over, are all the different metrics, specific to those procedures or those interventions. You can see there is mortality, complications, length of stay, readmissions. For hip fractures, we tracked our time to surgery. We have been doing some performance improvement in that area. There is volume and then we tracked our surgical site infections. So this dashboard, again, is a high level quality dashboard. What we did start to do is bring in the CMS outcome and the publicly reported data to keep our eye on that.

What you will see, the current year to date rate for these different metrics, what our target is. And then the colored column is a quick view, green means we are at target, yellow means we are better than we were last year but we're not at target yet. Red means that we're not at target and we're worse than we were the previous year. It is a nice snapshot to focus discussions on red areas. Unfortunately, that is what happens when I present this data at a meeting, people want to know why are we red and what are we doing to help improve that?

It is a nice quick view of how the service line is doing. This is Kenmore data specifically for the second quarter of 2016. Each hospital has their own dashboard and we have a roll up dashboard to the system, depending on the audience I'm presenting to, I will bring different dashboard to different meetings. Speaking of that, the stakeholders that I share this data with is our quality enhancement committee of the board, so that's our system

level reporting that I do. We also have orthopedics governance and site committee meetings I mentioned earlier. Hospital position leadership is another venue I share these dashboards with. And for each of the hospitals, I attend their two PS meetings twice a year, and the dashboards for that specific hospital are included in the QPS packet of information. Depending on the hospital and who participates in the quality and patient safety committees, they also are seeing this information and I am sharing the dashboards with them.

The next iteration of reporting that we have been doing is physician-specific quality reports. So again, we're using the same type of format taking the same procedures, similar measures, similar metrics, and letting the physician know how they are doing in relation to the target for the hospital that they work in or their own target. We're working on this. We've only submitted twice with these quality reports. We are starting to show them with the physicians and tweak them as we meet with the doctors. Similar format, variance, what the physician performance is this year and what they were performing at the previous year. This is new for us and we are taking it as we get feedback from the physicians as to what they would like to see. One of the recent additions, average cost per case, we are trying to be more transparent with our physicians around cost and as our belts all get tighter, working with them on internal cost savings, not just around CJR but our population in general. One thing I would like to say is that we'd like to add CJR performance.

In the future, as we start to collaborate more with our physicians, the physician specific dashboards are confidential, we tried to have them share between myself and the physician when I go out and meet with them to share their data, I have obviously, a staff person that helps the we have a couple people in quality that developed the dashboards for us. We try to use this as a tool to work with the physicians and make sure they know how they are doing. There have been a couple times we use the dashboard like this to meet with the physician when they appear to be an outlier in different areas. It helps them to see how everyone is performing in general, comparing it to themselves. As I mentioned, this is a newer dashboard to us. We've gone through our second iteration of distributing this to them and in the last couple of times; we've made changes to the dashboard as we go.

So really, the next iteration of the dashboard is what we wanted to talk about, the CJR dashboard. It is still a work in progress. You can see, similar format- people are familiar with this format. I do not have to explain every time I am presenting, how the dashboards are made and what elements are composed in it. You can see here for the CJR dashboard, focusing on the quality piece at this point. The composite weight of the quality score, what the measures are in the quality score, the measurement periods which we know are different from some of the measurement periods for orthopedics and value based purchasing. We have these outlined on the dashboard; also we have what the current dashboard reporting period is. Again, it shows how we are doing, yellow, green, and red. At the bottom we have our discharges to home care and nursing facilities. Yesterday, we had this presentation, we talked a little bit about some additions to put on the dashboard and how we might be able to use this for each physician- specific versus for the hospital. Right now, the CJR dashboard is shared throughout our care redesign team. I shared this Tuesday with our care redesign team. Our orthopedic governance and site steering committees, I bring this dashboard to those committees. We also have a post-acute care provider network. One question that came up: how we are communicating with the skilled nursing facilities that are accepting our CJR patients. The CJR dashboard is one way we do that, with the addition of how that specific SNF is performing based on our data collection. At this point, it is really manual. We do not have not set up any automatic way in our system to collect information so it is a little bit resource heavy now as we move forward into looking at other tools.

Hospital leadership, hospitals that are financially at risk for the program, they will be seeing the CJR dashboard, and not yet for board reporting, but I'm sure as we get into this payment model a little bit further, it's going to be something that I will be asked to report on.

Just some lessons learned from developing these dashboards is the data integrity. You need to, as a presenter of the data, understand where that data is coming from, what the methodology is for determining for determining how far or close you are to a target. When someone sees red on the dashboard, they want to understand that. A lot of times, the physicians will clinically question why the dashboard may be red, but if you understand where

the data is coming from, and are able to give the physicians the details they need to understand which patients may be flagged for complication, it just helps them in their awareness, as I said in the beginning, ensuring ability to follow through. It is great to report data but if it's not actionable and if you don't have the ability to make it actionable, it can be frustrating for those that you are reporting to. The next step, to increase our physician collaboration, using the CJR dashboard, and getting beyond our physician leadership and getting into trenches with the physicians who are doing the majority of our total joint replacements, we are looking for resources to be able to track patients both pre-and post-operatively. The data collection that we do now as I mentioned before is a heavy manual process, so we're looking for ways, resources, to be able to make our data collection more efficient and again, enhancing our and posting to our post-acute providers so they know how they're performing and what our expectations are around their performance. With that I will close out my presentation and hope we can have some discussion if anyone has other ideas and things that they're doing well beyond what they're doing, I'd love to hear about it.

## Q&A

Thank you. I wanted to, folks on the line, if you have questions, go ahead and type them in to the chat box, I will kick off with a couple.

Can you talk about, maybe a little bit, if you're using the quarterly data you get from CMS for the CJR patients and if so, how are you are incorporating it into the dashboards you just showed?

You know, the first data we got from CJR, from CMS related to CJR, we definitely presented that but because of the timeframe, the 90 days, and not having a lot of cases that have gone through their total 90 day periods, we didn't integrate into the CJR dashboard as of yet. But with the recent data submission that we have, I actually have a meeting next week with the analyst to take that information and put it into the CJR dashboard so we have more of an accurate sense for our spending for the 90 days and utilization. We're diving into that now, yes, that is the intention.

Great, I think you mentioned in one of the last slides, you're essentially using that information to start getting engaged with your post-acute providers, is that right?

That is true. We are engaging with the post-acute care providers but it is more of a manual process in that we know where our patients are being discharged to and there is accountability to other nursing homes to follow our care path. I mentioned yesterday, we tried to target a seven or eight date length of stay in the nursing home unless there are other issues. We reach out to the nursing home to provide us with, retrospectively, how our patients did with their length of stay, what they're discharge destination planning was. It's retrospective and it's not real-time. We are doing that outreach- we are sharing information with them and they are sharing information with us. As I mentioned, it is manual and time-consuming. Yes, that makes sense. I will pause for a second. The phone lines are open now if you have a question, feel free to unmute yourself and ask Christina a question. I will pause. Just a reminder we have all the phones on unmute. If you have a question, speak on out.

This is Chris again from Catholic Health, I'm curious from the other people on the phone, if you all are using resources -- I know there are a lot of organizations out now that are sort of selling the ability to track where your patients are, resources around data analytics, patient engagement, if someone is using something or have developed their own internal what that might be?

This is Lauren from New York Presbyterian. I have the same question. We have a lot of vendors come and it's overwhelming. There are so many people out there; it's hard to know what is actually useful.

Yes, that has been our challenge too. Again, the resources and the cost associated with integrating something like that, regardless of how many CJR participants who have has been a challenge for me I wonder if that has been a challenge for anyone else in your organization?

Can you talk about the operations on how these dashboards are created? Is it a manual process? Who in your organization is producing these?

We have the Midas database is accessible through the QPS people. The first time we build the dashboard, it is a manual build out of Midas. As we update the monthly, it's 75% automatic from Midas into the dashboard but 25% is manual for QPS (our data center staff) to put it into the format that you see. Initially, it was a lot of work, but now as I mentioned, it's 75% automatic and 25% manual. I know yesterday we are having some conversations with some people about IT language that I am not familiar with, as to how the data gets put in. It is pretty automatic for us now.

I know you had some dashboards that were physician specific. I assume those are in the CJR episodes, the surgeons you are engaging with. What are some of the outcomes from the dashboards? How do you feel it has influenced the providers?

We haven't gotten to the point where we have a CJR specific and physician specific. Right now, our physician dashboards are taking that larger hospital dashboard and breaking it into specific physician performance. The couple times I've met with physicians to review their dashboards, their initial response is always to question the data. So when I did my second round of meeting with the physicians to review their dashboards, I brought patients specific information and what I've seen is a lot more responsibilities that the physicians take to ensure that their patients are having good outcomes. It's not the surgery, it's more of those medical complications that get documented like acute renal failure or something like that that they're taking more active roles in and making sure that the patients are medically being followed as well as surgically. So I have seen changes in their behavior, in a good way, towards taking responsibility for those types of things. More so than maybe before.
I appreciate the feedback. I will turn it over to Laura for additional conversation.

This is Lauren Hedinger from New York Presbyterian. I may have missed this, but the dashboard, for your hip and knee patients or is it just CJR focused?

The first one I showed, the larger dashboard with more metrics, is for all the population with orthopedic, and then the last dashboard I showed was specific to CJR. Okay.

About sharing internally, instead of sharing with the physicians and post-acute care, others on the call, do you share your dashboards just internal to your hospital? Or do you share with specific physicians that may or may not be employed by your hospital? Do you share with your post-acute providers?

This is Lauren again from New York Presbyterian. We are in the beginning of the post-acute provider relationship; we are just starting to look at overall data with them. We haven't dived into CJR data yet but we're beginning to discuss it. And the plan is to eventually, discuss it on a regular basis to review some of the quality of metrics we're monitoring.

Thank you for sharing that. Anyone else handling that differently? Sharing with post-acute providers regularly? Or sharing regularly with your physicians? There was a comment here from Jennifer Tillman about them using Health Loop for lower extremity joint patients, education tracking, and alerts for the patient. I'm curious, Jennifer if you can jump on a talk about is that for you all are you using that internally or using that to leverage the post-acute relationships and reaching out to the providers?

Actually, this would be at the system level and we are piloting it at four of our hospitals. We are working with several hospitals throughout the country with the Ascension Health System. The Health Loop form would be more for the patient-family engagement, education, collecting PROs and early alert system that goes to our providers if the patient is showing any early signs of complications or infections. But we use the CMS claims data for reports coming from Data Gen and it is up to them how they want to share that with post-acute providers or the individual physicians. We leave that decision up to them. And we're in the process of developing another report that should be finalized the next week, it takes data not only from claims, but data from NHSN, from

Premier, and several other sources. It puts together the information, complications, infections, the cost of data and a whole bunch of other stuff. Again, the hospital decides who is that it is appropriate to share with.

That makes sense. Cathy Newman, would you be willing to jump on the line and tell us what you all put in your dashboards the goes to a variety of people within your organization. Do you tailor those differently for the different departments? Or if it's one single dashboard? What kind of metrics do you put in there?

I would be glad to. We include, all of our quality data, length of stay, contribution margins, and any readmissions, and the complications like infections, readmission tallies. It is a really quality and outcome focused dashboard with some cost and length of stay in there too. But we have not done that to the CJR population, we're looking at our Hip and Knee patients at this point. What I'm looking for is how to isolate the CJR patients and their outcomes without it being cost prohibitive to do it manually. We have Midas also. We use Midas as our software to input our data and extract things from. We're working through that process.

That makes sense. Thank you for sharing that. I think what you're saying, would lead in perfectly to another learning. This is a plus for another learning event we will have in early December, which will be about identifying and tracking CJR beneficiaries, what folks are using, how they are identifying those DRGs and tracking those patients that will be useful. Thank you.

We had a comment early on, when folks were posting on things they are hoping to learn, I was going to call and ask Brenda who had asked that she would like to learn what the top five data elements that you recommend to track are. What are the top five that you track at your hospital?

Currently, we are limited; we do not have a full dashboard yet. We did make progress though- we have a co-management agreement that we have with one of our orthopedic groups of surgeons. We changed the definition of the population for the cases that they track to match the CJR definitions. So for that particular agreement we're looking at length of stay, complications, readmissions, we look at discharge destinations because we knew through some previous work the biggest opportunity was to decrease our use of post-acute care facilities. We encourage them to help patients return to home rather than going to a skilled or a swing bed. From other operational and efficiency standpoints, with that particular group, we track first case; on-time starts in the OR. That was a key measurement that the orthopedic surgeons were interested in, and from a post OR standpoint, we track -- we have certain criteria, how many of our patients are able to ambulate at least 30 feet on the day of surgery?

Thank you, thank you for sharing that, Brenda did you have any particular questions about that for the rest of the group? Did you want to ask the question for the whole group about data elements?

No. I am just looking for ideas; we do not have any outside vendors that help us with our data. It's all internally created. So that also means we are internally creating any type of dashboards we're using. I am working with our patient financial service director, to help create that. There was a question earlier, how do you identify those patients? We do not have concurrent coding on the floor, so we do not know which patients are included in the CJR until after discharge, after coding, but I have a person in the quality development department that is developing identification of those patients. We have 90% of our patients coded into the DRG so then we've created our own spreadsheets, pulling information from local data stores to create a great big spreadsheet that we're using to track these patients and that's how we're using the information to drill down to create reports. It's all internally created, so we're looking for ideas of dashboards that other organizations use, what type of data points they use, it is helpful to see examples.

That is an interesting of idea of sharing examples and templates, that might be something that we could look at, finding a way for you all to do with one another to find a way to post templates or examples of your dashboards and share them back and forth with each other. Is that something that would be interesting? Would you like to see samples and examples of other dashboards? I know I would.

With anybody else be interested in that? That's something that could come from the affinity group, sharing examples of what your dashboards look like. We have not tested this but I'm going off script, but there is a raised hand button, you can see by your name or somewhere near you, if you have to raised hand button, if you're pulling together your dashboard or whatever approximates your dashboard manually, if you are having to do that manually, can you click your raised hand button? And then we can see how many of you are doing that manually. It would be interesting to see how many of you are doing that manually. If you are able to click on the raised hand please do so.

That is great. I appreciate that, Laura. I personally talked to organizations that are printing out ADT summaries every day, going to the floors and then putting hands on charts. I think it is something we should definitely chat more about. Definitely, we would do that.

## Polling

In the interests of our time and keeping things moving, there's a little bit of hand raising going on, we will continue the conversation of the manual pulling together as opposed to doing it automatically. We will continue with that. As we continue with many of our other discussions, the next thing I will ask is we will push out a quick poll, we won't be sharing the results of the poll today, we will show this in January. It will give us ideas for conversations that we will talk about in the next session, and using the data with your physicians. Do you have a physician champion for your CJR model? Yes or no or you don't know. Have you had success in building engagement among physicians using your data? If you can click on one answer to both of those questions, we will give you a few minutes to do that, so we can get a sense of this going into the next set of webinars or in the next breakout sessions.

Go right ahead and be responding to that poll there. As you click on your answer, type an answer into the chat box for your next question: how do you determine what metrics are valuable for your physicians? This is information that we will use in our next session and we will use this to inform our conversation. We encourage the discussion on CJR Connect. We have a specific group for the Data Affinity Group, just go on to CJR Connect and click the groups tab, click on Data Affinity Group and you can post your comments to this group and the other two affinity groups as well. You can continue your questions, comments, sharing ideas, things you would like to learn from one another, you could do that there in that group. If you do not have a CJR Connect account, the link is here on the slide.

Our next data affinity group webinar for group A is going to be on January 18th at 2 PM. If you have a question or want more information, email us at ls-cjr@lewin.com and we'll respond to that. As we also want to have a reminder, if you have any model related questions/program questions, please send those to CJR Support@cms.hhs.gov. We appreciate you responding to the survey that helps us with planning our future activities for the affinity group. At this time, I would like to ask if there are any other questions, if anybody has a comment you would like to make. If not, I definitely want to thank Christina Kane from Catholic Health, thank you for presenting, and sharing with us, and helping moving our conversations along. Thank you to all of you for speaking up, sharing your ideas and questions with each other, we very much encourage you to do that. Keep on conversing in that group chat we will keep it open for a few more minutes. -- To keep the conversation going in that group chat. We will keep it open for a few more minutes. We thank you for your time and attention. This concludes the formal presentation. We will leave the chat open for a couple more moments just so we can finish the conversation.

Thank you. [Event concluded]