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

Please standby for real time captions.

Thank you for joining today. We will get started in a couple of minutes.

We are ready to get started. This is Isaac Burrows from CMS. Welcome, as part of this group, hopefully we can Get some good learning here today. I think you can see my face. Welcome to the group. Myself and Laura from Lewin will be monitoring this group. We are looking forward to you joining us. We're excited that you're with us today. We have Catholic Health giving us a presentation on what they are doing with dashboards with some of their analytics. We think it will be useful. We want this to be an open discussion. Towards the end we will get reminders and next steps. A couple of housekeeping items and some logistics. The phone lines are open. If you are not speaking, go ahead and mute your line. We encourage you to comment throughout the presentation. Please use the chat function and be sure to chat to all participants. If the slides do not refresh, please use F5 on your keyboard or Apple + R if you are using a Macintosh. Closed captioning is available if you need it. It would be great if you could chat amongst yourselves. One of our Lewin folks is monitoring the chat. Nicolas is a provider and will help facilitate the chat as we go through this. So again when you're using the chat, go ahead and send to all participants and we can all talk amongst ourselves.

So let's go ahead and test the group chat now. Something you hope to accomplish or learn about dashboards. Please type it into the chat. If you are talking to someone in particular, use the @ symbol like the example on your screen. In the spirit of calling on people, Laura, do you want to do some further introductions?

Laura M: Absolutely. Everyone continue to type into the chat box as we go along. While we are doing verbal instructions click on the arrow beside the chat and click on where it says send to all participants and that will send it to everybody something you want to learn about dashboards. While we are doing that we're going to introduce ourselves. If you have a technical question or having problems with how the webinar is working, send that to all panelists not all participants and we will deal with it right away. We're going to go through some introductions so that we know who we are talking to today. This is Laura Maynard. I am a part of the CJR Learning System team. I'm joined by a host of Lewin Learning System folks. We have Nicolas on the chat and Lauren who will push slides. We have Kristian, Lora, Alicia, Sheila, Elizabeth, Chris, Jennifer, and Brandy.
Many folks are with you are with Lewin and part of the Learning System team. We also have CMMI part of the Learning System team as well. Isaac could you share who is in the room with you today?

Isaac B: Sure Laura. Like I said, my name is Isaac Burrows, I am from the CMS Innovation Center and a part of the CJR team and the Learning System lead. In the room with me we have the CJR project officers, Maria Agresta Workman and David O'Reilly here in the room with me. We are here to facilitate and answer questions. We are excited to learn today.

David O: Good afternoon.

Maria A: Good afternoon.

Laura M: Now it's your turn participants. We want all participants to introduce themselves. We will unmute the phone lines. If you have any background noise, please mute your line. We are going to do a roll call for participants who are part of Group B. If you are not a registered participant of Group B, that is fine. It is fine to attend any or all of these breakout sessions. To begin, Dale, I see you are here and I know there is a group from Robert Wood Johnson University Hospital that is with you, would you be willing to introduce who is with you today?

Dale: With me today is me Dale, former gainsharing coordinator for BPCI Model 1, which ended March 31 so now I am involved with this. Ann Marie is our Vice President of nursing and Barbara is the Director of Rehabilitation Services.

Laura M: Thank you. Denise from Sacred Heart, are you on the call? I am not seeing your name on the list but you may be here. Ok. We did not mention that our speaker Christina Kane is from Catholic Health who is part of Group B. Anyone else from Catholic Health on the call today?

Christine: I think it is just me today Laura.

Laura M: Ok Chris thanks so much for representing. Anyone from Dignity Health on the call?

David: Hi this is David I'm a business analyst with Dignity Health.

Laura: Thank you for being with us.

How about Baycare? Anyone from Baycare with us?

I know earlier Jean from Bronx Lebanon was with us have you been able to rejoin the call? Anyone else from Bronx Lebanon? How about Covenant Medical Center?

Pat: Yes this is Pat, VP of Finance at Covenant Health.

Laura M.: Great thank you for introducing yourself. Thanks for joining us.

Anyone from St. Francis Health Center? Is Sharon or anyone else with us today? How about Mercy Hospitals? Stephanie or anyone else from Mercy?

Sue are you there from Naples Community Hospital or anyone else from Naples Community Hospital with us? Let's see Tom from Maimonides Medical Center in Brooklyn.

Tom: Maimonides Medical Center in Brooklyn. Senior Vice President for Value Based Contracting and I am not sure if he got on yet but Charles our Administrator of Orthopedics is also going to join.

Laura M: Wonderful thank you all so much for being with us.

Kristen from the University of Missouri Healthcare?

Kristin: Hi this is Kristin. I am the coordinator from the accountable care operation and with me I have one of our administrative fellows.

Laura M: Thank you so much, we appreciate it.

Isaac: Hi Laura I see Ed Lee from Indiana University and other folks from IU are on the line.

Laura M: How many from Indiana University?

Ed L: Hi this is Ed from IU Health. I believe Alex from my team is on the call also. I am calling in separately from a Starbucks actually I believe Alex is at our base camp.

Alex: Hi this is Alex I am with the orthopedic service line with IU Health and I am at base camp.

Isaac: Not at Starbucks, got it.

Alex: I wish I was at the Starbucks.

Ed L: I will be taking orders.

[laughter]

Laura M: For the entire 25 people on the call and deliveries. Also wanted to check Haley Hill from St. Francis? Anyone else from St. Francis?

Are there others? Pamela do you have anybody with you today?

Pamela: No it is just me. This is Pamela from Milliman Actuarial.

Laura M: Thanks Pam.

Is there anyone we have not called? Anyone hasn't yet introduced themselves?
Thank you all for participating in the exercise. I know it took a little while. I'm hoping by knowing who is with us today you will know who you want to ask questions of and want to share things with. And by having already spoken out loud, you understand how easy it is to unmute your phone and speak up. As we go along there will be opportunities to have discussion and to ask each other questions and share things with each other.

To review the goals of the Data Affinity Group, the goals are to increase CJR Hospital participant interaction and mutual support. That is what this is about is helping you support each other and interact with each other and giving a forum for that. Another goal is to identify and discuss common drivers of both low quality and high cost. What is driving that and what have you learned that you can share with others? Also to increase the use of dashboards to encourage and monitor improvement. So here is the overview of what is coming up in the data affinity group. This is currently Group B. You all meet on the second Tuesdays of every month, and that will happen in January and February. But anyone is welcome to attend any or all of the breakout sessions. And our next ones will be in January and Group B you will be on January 17.

I want to share some results from a poll that we did in our October 27 learning session. We asked these questions that were relevant to this webinar. We want to show you what folks said and what they thought so you have a sense of the whole affinity group not just the breakout group. How did others respond to these questions? The first one is does your organization have successful practices to share with respect to using dashboards or sharing or communicating data with partners. 56% said we have nothing. I hope those folks are here to learn from others and ask questions. We had 17% that said maybe and 28% that said yes. You were the ones that we are hoping will speak up and share.

We also asked with which partners does your organization share data. We asked you to select all that apply. The majority share with clinical leadership and with organizational senior leadership. That is followed closely by sharing with quality improvement patient safety leadership. Frontline clinicians not so much drops all the way down to 57%. Finance department 62%, postacute care providers only 19% share and other partners as well. Is interesting to see if you fall in there a little differently we will have the opportunities to talk about that.

How often does your organization report data or share dashboards with your partners? Mostly monthly and quarterly. A third ad hoc and a few in the realtime or weekly category. At this point we're going to move into our presentation. We are going to be muting the phone lines right now. We will unmute again after the presentation so that we can chat. If you think of questions or comments for Chris Kane or others on the call, keep chatting those in while Chris is talking with us.

Catholic Health Presentation

Chris is with Catholic Health Systems. She is the vice president of musculoskeletal and rehab services at Catholic Health Regional Training Center. Chris I'm going to pass the ball to you so that you can advance your slides.

Christina K: Thank you, everyone. I'm going to take 10 minutes or so to review will we have been doing here at Catholic Health. We're going to share how we use dashboards to report our outcomes. As Laura said I am in Buffalo, New York. We are part of the region mandated in the CJR initiative. Catholic Health is located throughout Western New York not just the city of Buffalo throughout the Western New York area with four hospitals and five campuses. You can see here the different types of services our system offers. In particular importance for CJR we do have a couple of nursing homes in our group as well as a home care agency. Our hospital system is affiliated with our Catholic Medical Partners ACO. We have been able to benefit from some of the experiences that our ACO has had as they are looking towards reducing the overall cost of healthcare. However what we did find and any of you who are participating in CJR and also part of an ACO, we found that our ACO population is not the same as our CJR population. Only 32% of our patients in CJR are also part of the ACO and that patient population. Some of the capabilities we have in monitoring outcomes through our ACO are not as effective when talking about dealing with the CJR population. We do have some support as part of our system that does help with CJR. We do about 3600 inpatient orthopedic surgeries across all five hospitals.

The majority of those are done and what we call our campus of excellence or our hospital of excellence for Kenmore Mercy Hospital. We'll talk a little bit about how Kenmore evolved and how a lot of our programming around CJR has evolved from some of the expert learning we've had through Kenmore. Of note all of our surgeons that work in our hospitals are independent providers. We do not have any employed orthopedic surgeons which can sometimes be challenging when you start to talk about physician engagement. We are working on that. The dashboards definitely help with communicating as quickly as possible how we are performing under CJR. The other thing to note as one of the challenges in our system is we have a high population of Medicare Advantage patients. We have a small portion of our total joint replacement patients that actually fall under CJR. One of the challenges we have found and I would be interested to hear from other people about this is how you resource for CJR when the population of total joint patients overall and CJR is just a small portion of that. Kenmore started focusing on total joint replacements probably about 15 years ago. Over the 15 years they have achieved a lot of excellent quality ratings throughout the time period they have been developing their program, a few of which are listed there.

With Kenmore starting up about 15 years ago the orthopedic and musculoskeletal service line probably started five years ago. What we were trying to do as a service line was integrate as practices at all hospitals and try to work towards standardization using Kenmore as our model because they had success in quality, patient satisfaction, and standardization. My term there always a work in progress obviously is challenging. We will take steps forward to standardize work and it feels as though you take two steps forward one step back. That ties into using dashboards to help us keep ourselves on track with achieving goals. As we were developing the service line, we needed to have some common tools to communicate outcomes with a variety of stakeholders. For example, we have system level governance council which is made up of leadership across all five hospitals, as well as our home care and nursing homes. Each hospital has a site steering committee that is more interdisciplinary based on the team at that hospital that influences orthopedics. We also have an RN that helps us with reviewing medical charts when patient is flagged for complication we try to make sure we take a look at those charts to see if there are opportunities for improvement. So one of the things I would say as we move forward and look at the dashboards, keep in mind when you are reporting you want to be able to take actions are what you are reporting. Just looking for trending on complications or actual patient satisfaction without actionable takeaways is not helpful. So we really try to make sure as we have a dashboard, we have actions we can take to improve where we note that we are not doing well.

The dashboard is developed as a streamlined reporting mechanism to communicate with all of stakeholders how we are doing and performing in orthopedics. Because we had not been participating in a registry we had been participating in AJRR but up until now they have really only had level I reporting which is basically implant data

and demographics. No specific quality reporting up until recently through AJRR so what we did is we have a system called Midas. Not sure how many of you are familiar with Midas. It is a database that allows you to compare your outcomes to other hospitals across the country. It is all payer data however it is not risk adjustment. Which is always been a thorn in the side of physicians because as we report compared to other Midas hospitals it is always best to have risk adjusted data. It is really the best we have at the time that we started the service line.

The next slide shows you what the Midas data look like. It is very cumbersome. You can see lots of numbers and lots of percentages. They give us quite a bit of data related to confidence intervals statistically significant information, but this in itself was very confusing and people were having a hard time following it. But we did was started to take the data and put it into this dashboard format.

From this dashboard I wanted to give you context as to how we got the data to the dashboard and if anyone is looking for a way to communicate some of the high level goals of the service line, I have found this dashboard to be quite helpful. Over on the left hand column you can see the different procedures that we monitor, hip replacements, knee replacements. The next column over are the different metrics we monitor such as complications, length of stay, readmissions high-level quality outcomes we want to keep our eye on. The reporting period for the dashboard and where we are currently and what our current rates are in these quality metrics and what our target is. This variance column gives us the opportunity to show how we're doing. Obviously, green is better in yellow means we are improving but we haven't hit target yet. If they are reds that means we are not doing as well as we did the year before and then at the bottom we have our CMS current ratings and complications readmissions, and the Medicare spending per beneficiary. This is a tool that can be shared with a variety of stakeholders.

We have dashboard for the whole system that rolls into one. Each hospital site has its own dashboard and what we have been able to do is take this information to a physician specific reporting dashboard. Who sees the high level dashboard goes to our quality enhancement committee, governance and site committee meetings, hospital physician leadership meetings, QPS meetings. It is a great tool and people are very familiar with the format so it doesn't take a long time to focus on areas that require improvement through using the dashboard. That larger dashboard then has evolved into our physician quality reporting.

Each physician orthopedic surgeon practicing with us we give out twice a year. We give them information on how they are doing related to those higher level quality outcomes we're monitoring for the system. This is always helpful because physicians want to know how they are doing. They will come back and want to know which patients and what the complications were and how to make it better. Obviously, it helps to drive and improve performance overall for the hospital. This is a nice tool to work on improvement. We don't share the physician specific dashboard with many, it goes to the physician we are looking at. I am aware of it, I see it and my staff member who helps me to develop and prepare them. But we have used to in times where it appears the physician is an outlier in a certain area and we will use the dashboard to help them understand performance compared to a larger group.

As I mentioned, we send it out twice a year. The first time he sent it out I had lots of questions. You have to be prepared to meet with the physician in person and review their outcomes with them rather than just distribute and reading it out it is much better to meet with them in person and share the dashboard with them to answer questions and then move to more of a 'here's your dashboard, let me know if you have any questions'. So from that we have evolved to use the similar format to report on CJR performance. This is a work in progress.

One thing I like to add is the composite quality slower rather each individual item for quality. Just to meet you to the dashboard we have the weight of the composite quality score rather than each individual item for quality. We have the weight of the quality scores here. Each of the measures that tie into the CJR quality reporting as well as measurement periods. We track our readmissions rates; we track our discharges to homecare and discharges to skilled nursing facility. So again this is not the CMS data this is data that we have internally. It is not real time. It obviously takes time to get the information out of separate databases. At this point, this is our best data and

the most timely we can get it. You see it follows a similar format to what other dashboards look so it is easy for people to understand and follow along. It uses the same yellow, green, and red metrics. We will be adding in the number of patients we were able to collect pre-op PRO.

And this will go to care redesign team, governance and site steering committees. We have a post-acute preferred network that we share the information with. The hospital leadership and I'm sure when I'm scheduled to report to the board I will give a service line update and this will be included. We will be updating these CJR dashboards quarterly maybe more frequently based on getting resources to help us monitor our CJR population. For now, we have been updating it quarterly, which has only been two times.

As we have been developing these dashboards, some of the lessons learned had been around data integrity. As a presenter sharing the information and knowing the source of the data and methodologies of determining statistical significance, the more you know about the data you are presenting the better it is. As the third bullet points out when there are yellows and reds it gets questions quite a bit. No one questions the green areas but when they are yellow or red we definitely get I have to speak to where the data to came from. You want to have the ability to follow through on what you find. It is answering the question of so what. Reporting quality outcomes without having the ability to take action what you find is not necessarily helpful.

Our next step is to use the dashboard and their information and get that CJR dashboard to a physician-specific dashboard. We have not had a lot of physician collaboration on the CJR side other than to leadership. We would like to get into real time collection of data but it does take resources we do not necessarily have available. Trying to make sure we are reporting and collaborating with post-acute providers, as that is where opportunities in savings are in CJR.

Q&A

Questions? I see there is a question about calculating complication rate given the lack of risk adjustments. The complication rates really just are the numerator and denominator calculations because they are not risk adjusted. It is a simple division of rates per 100 just how we calculate the complication. I see another question about is it automated.

We built a tool inside the Midas database so when different DRGs are recognized by Midas, automatically populates into a database that one of our quality analysts takes inputs into the dashboard. We did have to create a tool to collect the information. Once that tool is in there it does it fairly automatically. We still have to take it from the Midas format and put into the dashboard format.

Isaac B: Chris, there is a question about have you begun to look, are you tracking length of stay in the post-acute setting like with SNFs? Are you tracking the post-acute portion of the episodes?

Christina K: What we're doing now is manually reaching out to the nursing home that patients are discharging to. We are able to keep track of our CJR patients and discharge destination. Unfortunately now it is still a very manual process. I reach out mostly to the nursing homes receiving CJR patients and ask them to back to me on the length of stay and what their discharge plan was, to outpatient rehab. It is resource intensive at this point. My hope is within the next certain amount of time period we would be able to look at some resources to help us with that tracking. More using technology versus having to use human time.

Isaac B: That makes sense. Ed Lee has a question.

Ed L: When we try to create a real time monitoring of the complications measure, an issue that evolved starting last October was that ICD10 came out and the people at Yale hadn't published the official definition. My question is, have you guys found an official definition in ICD10, or did you guys do what we did, looking up the ICD9 definition to try to guess what ICD10 would look like.

Christina K: My understanding and I am not the data expert I am the reporter, but Midas was able to crosswalk ICD9 and ICD10 so that were able to monitor it. We probably did not have a dashboard we could use for the first five or six months of 2016 until Midas built those crosswalks for we do have them in Midas as far as I know

Ed L: There are some post philosophical issues translating or cross walking ICD10.

Pam: Hi this is Pam. We have had some challenges with that as well just with using the preliminary crosswalk they have made public. It has a totally different effect. If you just look at what percentage of CJR procedures are eligible for the complications measure, it has gone down to 10% based on the preliminary ICD10. We have not been using it. We've had a lot of challenges with not having a finalized list. You can obviously make your own, but there is a philosophical challenge, I agree.

Ed L: What we did was ignored the ICD 9 definition and just looked at ICD 10 and the diagnosis codes associated with the complications and inserted those hoping when the official definition comes out our guessing would match, so that's how we accomplished that.

Isaac B: Great thanks. Laura we will turn it back over to you for group discussion.

Laura M: Thank you and we appreciate the questions that have come in for Catholic Health. If you have other questions feel free to chat them in or speak up. We also wanted to hear from you to understand how you are using your dashboards, what's working, and what might be able to go better.

Alex: Hi this is Alex with IU Health. My first question is it looks like that report is an Excel report that they key in from the Midas data extract or your analyst does. Are you looking into an automated style of reporting such that on a weekly basis, maybe utilizing a SS RS reporting suite or Tableau? How are you doing your end goal on your dashboard? We've done that kind of push on our end at IU health where we do have certain reports or dashboards that we send out on a weekly or daily basis and sometimes we have a monthly reporting dashboard that we send that is a PDF format and now we are looking into exploring on Tableau. I didn't know if anyone was going that route or is everyone sticking with Excel and manually doing dashboards.

Charles: Hi this is Charles from Maimonides Medical Center in Brooklyn, we do everything manually. We track everything manually. I have a question for the previous presenter at Catholic Health. Does your organization participate in gainsharing?

Christina K: We do not today but we are trying to work with our legal team to get that together but as of right this minute we do not.

Charles: And what percentage of your patients is discharged to home?

Christina K: We probably have about 35% going to home but that is our best performance. I would say we range. Kenmore has the best performance related to most orthopedics including CJR is 35%. Some hospitals are as low as 20%.

Charles: Thank you.

Tom: This is Tom. Are you looking to get that percentage up to a certain level? Is there a target you would like to achieve with discharge to home?

Christina K: I cannot say specifically that we have set a target. We just had our care redesign workgroup meeting this morning. My comment was even if we could get all of our hospitals up to our best performing hospital at 35% as a first step and trying to integrate what they are working on and what they do on a daily basis with their patients. A lot of that has to come from the surgeon's office. Our community is used to going to subacute. I don't know who else, I am sure a lot of you have the same experience. Changing that community expectation around

going to subacute is challenging. Because we do not have gainsharing and collaborative agreements with surgeons yet, we have not have a lot of engagement to help with that I don't know if that is others experience.

Tom: That was second part of my questions following up on what Charles asked about the gainsharing. Is that the reason you're looking at that to try to get the surgeons lined up to try to move people into the home upon discharge?

Christina K: The comments we get from our surgeon partners, they feel it is more work for them when you send a patient home because they get phone calls and get questions and those kinds of things. I think they have to see a little bit of the benefit themselves to offset increased office resources or whatever help they may need with more patients going home.

Laura M: Thank you for asking those questions. Tom and others do you all have a target of patients discharged to home at your place?

Charles: We can make the target whatever we like. We have been successful in decreasing length of stay with our preferred postacute providers. We have not had much success with decreasing the percentage of discharge of Medicare patients home. Right now we are hovering between 10 and 20% trying to push that to 50%. 50% is our goal.

Tom: We did recently have a discussion about gainsharing with administrative folks here. It is a discussion and will continue as we move along.

Laura M: Thank you for sharing. We had a comment come into the chat box from Kristin and was wondering if you would be willing to talk about how you are using Tableau and what you're doing with your data.

Kristin: Sure, actually it just replying to Alex that we're currently doing manual monitoring and our goal is working on importing the data into an EDW from the quarterly data we get from CMS. We will be using Tableau as the product we purchase. We are not there yet but that is our target.

Laura M: Great. It's sounding like most folks are doing this manually. Is there anyone that has something in place that pulls the reports automatically?

Alex: This is Alex with IU Health again. We first went out and leveraged the Microsoft Power BI desktop version. That allows you to bring in the data set and start doing some modeling and then bringing in some internal information we have within our enterprise data warehouse at IU Health. We have a fairly developed enterprise data warehouse which will bring in our EHR as well as our costing data, HR, supply costs etc. into one data source we can leverage. We first went out with Microsoft Power BI. We ran into some difficulties as far as when we use the desktop version, we don't have the Power BI site, so when you use the desktop version you cannot necessarily present those dashboards we have been creating that are really nifty and awesome. You cannot print them from the Power BI desktop you have to deploy them to Microsoft Power BI. We as an enterprise do have a Tableau license and we have as a service line leveraged Tableau multiple times. So now we are shifting what we have built in Microsoft Power BI and pushing that into our Tableau reporting. We have had great success with Tableau. It seems to be a great dash boarding tool. It's when you get into the lower granularity that Tableau seems to kind of chug along. So Microsoft Power BI seems to be doing a lot better in terms of taking raw data and drawing it out so people can see, whereas Tableau is better with high level aggregations. That's where we've kind of figured out we have some vulnerabilities with Tableau. We are doing a lot of sequel processing on our end before we push it out to a Tableau front end. Does that make sense?

Laura M: Yes. What other comments, thoughts, suggestions. Anybody doing your dashboards any differently or anybody really wishing you could be doing something better and you want to ask someone who is on this call how they do it?

Alex: I have a question, this is Alex again. I have noticed that the data feeds that we get we work closely with our data management team to take the CMS claims file and load them into the EDW and columns continue to change with every extract and this obviously has been a pain point for our data management team. If anyone has struggled kind of figuring out why columns change or last month we had this, this month we don't, now we have two new columns that we are trying to figure out, if anyone has kind of struggled with those kind of situations, at least you will when you push it onto an enterprise data warehouse.
Pamela: Yes, this is Pamela from Milliman. Yes, I agree. I think we have an automated solution but it can only be automated to the extent that we know what to expect from the data every month, right? And it changes every month. Columns change some of them are populated in one month but not populated the next and we have also struggled with that we have not come up with a good solution. I can agree with you. We use a click view which is like Tableau as a platform for our reporting at this point.

Laura M: Does anyone else want to share that pain point or more specifically share suggested approaches to dealing with that?

Isaac B: That is great feedback to hear we will circle back with our team here as CMS and see if there is something we can do about it. No promises but we will at least circle back on the issue.

Pamela: I will say that my feedback is, again this is Pamela and thank you Isaac we appreciate that, is that CMS also doesn't want to do manual work is my assumption and so I assume once they figure out how to automate this process and get it on a schedule on their side, that this problem will fix itself. Which is what we have seen in the BPCI program. Which is that at the beginning of the program the files changed constantly and that stopped essentially.

Alex: Well that will definitely improve load times into the enterprise warehouse.
I have a question for the group. When you speak with your preferred post-acute providers, do you set target length of stays for your total joint patients, and if so what are those targets?

Christina: This is Chris from Catholic Health. We've shared protocols driven by one of the physiatrists that works with us in our total joint program. We tried to work on seven or eight day length of stay depending on the hip or knee. When I reach out to the nursing homes retrospectively and I see that their length of stays are higher and I do ask them to provide an explanation again it is all manual right now, but I do reach out to them for accountability. But generally it is seven to eight days is what we are looking for. We don't always get it, but that's what we are looking for.

Ed L: This is Ed at IU Health. What our physicians are telling their preferred providers is that, and the physicians have different numbers, some say seven, some say ten, one says twelve, that if the patient needs to stay longer than that, then they expect a phone call. We're not telling the preferred provider that the patient cannot stay any longer, because that wouldn't be right, but we expect a phone call. And really, honestly, that phone call is more of a speed bump to make the nursing home really ponder does that patient really need to stay longer. That is how we've accomplished that.

Polling

Laura M: Very helpful discussion and kind of will lead us into the next point because these topics about engaging the physicians and engaging the postacute care providers in meaningful ways are exactly the topics we will be talking about on our next two breakout sessions. So we are leading right into that, those are some really good thoughts. To help us gather more discussion points on that, would like to push out a poll to you now and we will not share the results of this poll today. We would do so in January so we can gather up some talking points and conversation ideas for the January session which will be focused on physician data and how you share your data with physicians, does that help you build engagements and how does that work, that's the topic in January. If you would not mind taking a few seconds to click on that poll. Do you have a physician champion or physician

champions for your CJR model and have you had success in building engagement among physicians by using data. You could let us know yes no or I don't know. That will help us as we plan towards the next session.

Another thing that will help us is something we will ask you to type into the chat box. So as we finish up the poll, take a few more minutes to click, please type in the chat box for us how do you determine what metrics are valuable for your physicians? How do you determine which metrics are valuable for your physicians? Please type your responses into the chat box. This will give us some talking points and ideas to build on for our January breakout sessions.

Continue typing that into chat as we move forward. We encourage you to continue this good discussion on CJR Connect. You have your own private data affinity group, so those that are a part of this group and not just breakout Group B but the entire data affinity group, you have a private group on CJR Connect where you can talk to the same people you have talked to today as well as a slightly larger group of people interested in these topics. To post a comment or share a resource go to the groups tab and click on data affinity group and post your comments or questions right there or you can just respond to others who are talking.

Since we are not having a breakout session in December, we really encourage you to go on to Connect, get into that data affinity group ask your questions and share your comments. If for some reason, you do not have a CJR Connect account the link is on the slide. Our next data affinity group webinars are going to be in January. Group B will be on January 17 from 1 – 2 PM ET. At that time we will talk about identifying and communicating high cost lowquality drivers: a deep dive on physician data. And know that you are welcome to attend any or all of the breakout sessions. If you have questions about which group or anything about that, send those to LSCJR@lewin.com and we will get you sorted into the right group or let you know the links for other groups. If you have technical or program questions we encourage you to send those to CJRsupport@cms.hhs.gov. As we conclude, we want you to respond to the postevent survey that will come up. I'm going to open the chat again because I see we are beginning to type in – I hope you are answering that question about what types of data engage your physician. Type that in there so we know how you determine that. I want to thank Chris from Catholic Health for presenting today. Thank all of you for your great participation. Folks have just been speaking up really well and interacting with one another. That is how you learn and connect and get the mutual support that you might need in this project. So I appreciate your participation and want to thank everyone for being with us. I encourage you to take a few minutes to respond to the postevent survey. Any announcements or final thoughts?

Isaac: This is Isaac at CMS again, I want to thank everyone. Again I appreciate Laura for facilitating this. Clearly the yellow wall behind you has an impact on your personality. So again, thanks to everyone for participating. Jump on Connect. Anything you would like CJR comment on, send to CJR Support, and everything go ahead and engage with each other on the Connect data affinity group. It is there for your good, and we will chat with you all again in January.

Thank you.