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

Please stand-by for real-time captions.

We have got open phone lines at the beginning of the session. We want to encourage some conversation as we go along. We will be doing introductions, and we will begin the session in about one more minute or so.

[Pause]

We are just past 1 o'clock. We are going to go ahead and begin the session. Want to welcome everyone. We are very happy that you joined us. This is group C, one of the breakout sessions. We're going to be having a presentation today but also having a lot of discussion, so I want to let you know that right now phone lines are all open. If you have background noise, please don't put us on hold because we will hear your music. We're going to leave the lines open so we can have some ease of conversation later on.

I do want to welcome everyone to the session and introduce you to our facilitator. This is Laura Maynard. That is my picture on the right and I and Isaac Burrows will be facilitating the session today. We have several from the CJR team that are on the webinar today and participating in the conversation as we go along.

We will cover welcome and logistics, and introduce ourselves to one another. Then we have a brief presentation from the Catholic Health. We will have very open discussion about that, and then some reminders and next steps to wind up. I do want to remind you that the phone lines are open. We want to encourage comments and reactions both by the phone and via chat. I want to familiarize you on how to find the chat function in the other functionality of this webinar platform. Across the top of the screen, on the right-hand side there are several little icons. If you would like the closed captioning, click on the media viewer and the closed captioning is available there. If you want to participate in the chat, click on the chat button, which has a cartoon speaking bubble. It will open the chat and we encourage you to chat into all participants. So send to all participants so that everyone can see your chat and we can comment and have conversation there.

If you happen to have a technical question, send it to our panelists, we'll make sure to get to assistance with that right away.

Chat to all participants. If you have technical questions, to all panelists, and let's start off by practicing with that. All the phone lines are open, so if you have any background noise or need to talk with someone on the side, please mute your own phone. At this time, let's try out the group chat. Click on the chat button and send all participants and type into the box something that you are hoping to learn better way to be talking about dashboards. That will be our primary topic. Type something you hope to learn about dashboards and it will help to identify yourself, although we will introduce ourselves verbally as well.

If you want to chat with someone in particular, use the @ symbol. If everybody can just practice that chat function, click on it, send to all participants, and type in something you hope to learn about dashboards. I hear several beeps; I'm happy to hear that we have people calling in. I will remind you that the lines are open at the present; we can first begin by introducing ourselves. I mentioned who I am and Isaac is with CMMI, he's our other facilitator. Everyone else on the call, we would like to go around and everyone say your name and organization are with and who is with you in the call today. There's a chance we will speak up at the same time so I am looking to my list. Angela Winegar, if you are called in, would you go first in introducing yourselves?

This is Angela Winegar. I am from Ascension Texas Seton Hospital down in Austin, Texas. Welcome. Who would like to go next? This is Rick and we have four of us here, Kevin Curtis, Debbie Martin, and Heather Brown.

Thank you.

This is Pam Brownfield and I'm from the Mission Health System in western North Carolina.

Thanks. Welcome.

Who else would like to introduce themselves? Let me see who else might be on. We have a fairly large group. I am looking at the list of attendees and participants. We have a good sized group of representatives from the CJR learning team, so many of the names that you'll see are from that group. Are there others from hospitals that haven't identified themselves yet? And also continue typing in that chat box to all participants. Let us know what you would like to learn about dashboards. Looking through to see, Kyle McDaniel, would you be able to identify yourself, your organization, and who is with you on the call? Your line might be muted. You might have to unmute your line. Anyone else? I suspect we have got a few others. As we go along, feel free to identify yourself, type into the chat box and feel free to speak up and participate verbally. This is how we will be able to ask questions and share our contacts with one another.

Just a reminder of some of the things that we are going to cover in the Data Affinity Group. The goals of our affinity group are to: increase CJR hospital participant interaction and mutual support with each other. So we want you to be able to talk to one another and learn from one another in these small groups. We want to identify and discuss common drivers for both low-quality and high cost, and particularly today we want to increase the use of dashboards to encourage and monitor improvements.

Here is what is going to be coming up. You are in Group C at the moment. We're meeting today. You can find the little Group C there. Webinar number two, which is this breakout session, Groups A and B will be meeting next week. A reminder that if you would like to attend more than one session and talk to other groups of hospitals, you are welcome to do that. If you have other members of your organization and want to attend a different group, that would also be fine. Our Group C next session will be January 11, and our topic for the next round is going to be physician data.

Next, I wanted to share the results of the survey that we held on October 27 when we did our initial webinar for the Data Affinity Group. We asked you all some questions that were related to this breakout session. We are going to share those with you now. Does your organization have successful practices to share with respect to using dashboards are sharing and communicating data with partners? 28% of those on that webinar said yes, 17% said maybe, and 56% said you don't have anything particular to share. Those folks are going to be in the learning mode today.

Which partners does your organization share data with? You can see almost everyone, 86%, share with clinical leadership and organizational senior leadership. Almost as many, 71%, with quality improvement and patient safety leadership, 57% share with frontline clinicians, 62% with the finance department. Far fewer, 19%, share with post-acute care providers and 24% with other partners.

How often does organization report your data or share your dashboards with your partners? About 38% said monthly or quarterly. Many ad hoc, 29%, reporting. Real-time sharing of dashboards only about 4% responded that that was what they were doing. That is a result of the polls.

At this time I went introduce our speaker for today and we are going to go ahead and mute all your phone lines. If you have a question for our speaker or comment, type that into the chat box as we go. Following the presentation, we will open the phone lines again and be able to ask the questions verbally and also discuss this as well.

At this point I wanted to introduce Chris Kane from Catholic Health System. Chris is the vice president of musculoskeletal and rehab services at Catholic Health Administrative Regional Training Center and she's going to be sharing some information with us today.

I will pass the ball to you, Chris. Okay. Thanks. As soon as I can find you on the list, just a moment. There we go. Now you should be able to advance a slide.

Catholic Health Presentation

Hello everyone and thank you for your time today. I will take about 10 to 15 minutes to speak about our experience. Full disclosure, we were not BPCI participants so really what we have developed in order to initiate dashboard reporting for CJR is really based on our experience as our service line developed in orthopedics. That is what I am going to talk to you about today. Just to acclimate you to Catholic Health, we are located in Western New York. We have four hospitals. One of our hospitals has two campuses so we start up in Niagara County and go down to the southern part of Buffalo, New York. It is not snowing here in case anyone wants to know. That's usually what we get asked, but we do have a couple of rural hospitals that affiliate with us and you could see the listing of the various services that Catholic Health provides in our community outside of hospitals, and just a note that we do have two skilled nursing facilities that are part of our system. Two of them provide sub-acute care and two of them are strictly long-term. We also do have a home healthcare agency as well as a PACE program. Just to point out, we are part of an ACO, through our affiliation with our Catholic Medical Partners. That in some ways has helped us as we move forward in CJR because our hospital systems have been in the at-risk community with our payers and obviously as an ACO we have some learnings with Medicare, but nothing really that fully prepared us for implementing CJR.

Just to give you a sense of our orthopedic volume, we have about 3600 inpatient surgeries across our systems. About half of those surgeries are performed at Kenmore Mercy Hospital, which is the northern part of our area. All of our surgeons across our entire system are independent providers. If any of you are working in that type of a system, it can lead to its own challenges but we are working through that, we are a mandated participant. Another important piece, that out of all of those 3600 cases, only about 500 are in the CJR population. That is because the majority of the patients in our community are covered by Medicare Advantage plans. We have about 60% Medicare Advantage in our community and about 40% of the Medicare population is Medicare fee-for-service. I'm curious to hear from those on the phone if they can present us with challenges as we try to implement new ways of doing things and utilize resources for CJR and how that can be challenging because it is a smaller percentage of our population. I will talk about that in a little bit.

To speak specifically about Kenmore, and the reason that put this information on the slide was to say that Kenmore has been focusing on orthopedics as a specialty for about 15 years . They have really evolved and within our system, as a best practice hospital for total joint replacements, and you can see here some of the accolades at the hospital has achieved over the years, including the joint commission specialty certified. We have our five stars and health grades. We have a good score in our Leap Frog, but the point of showing us is to say that as a service line is less mature than Kenmore is, I really try to focus on taking whatever best practices and really moving it forward. That's where our dashboard came into development and really helped us integrate best practice based on Kenmore's experience. As you all know, integrating best practices and standardization is always a work in progress and I am going to use those three words quite a bit because we are by no means expert, but we want to share our dashboard methodology with you. We communicate outcomes, because as we implement new initiatives and programs around quality or around cost savings, we really used our dashboards to report those at multiple different levels of the organization, and the dashboards are really good for that- to show changes over time as things are implemented in system. One of the other things I want to point out is that we're asked the question "so what?" So what that you have a dashboard that reports how you're doing if you're not acting on the data that you are collecting. In our mind it does not mean much. One of the things that we implemented as we started to develop our dashboards was a resource to be able to follow up on things. If we see a blip in our complications or readmissions, we need to have resource to dive into the data and understand why, so that we can then make changes. Our dashboards really help us because it gives us sort of a roadmap, a trail for us to follow to check on and monitor outcomes. The dashboard is really developed as a mechanism to streamline reporting. Everybody knows how to read our dashboards because it is a common language throughout our system, not just for my service line but for most of the clinical services that we provide, and we developed a

dashboard and a methodology that we use because we really had no national comparison database for orthopedics.

We do monitor health grade outcomes quite closely, but it is limited population because it is only the Medicare and Medicare Advantage population. We are participants in AJRR but we have been reporting level 1 data for quite some time. We did pilot the level 2 reporting. However, that has been slow to come along to really help us drive change. That is sort of how we got to the point of developing these dashboards. Because we did not and have not had a registry to compare ourselves across the country to other hospitals' outcomes, but we have had access to Midas and I don't know how many of you are familiar with Midas Datavision, but basically they collect a bucket of data, if you will, of about 800 hospitals that you can compare yourselves based on the procedures or the diagnosis of your patients. It is an all payer database. However, it is not risk-adjusted, as the slide points out. That always can be challenging to compare yourself with virtually no risk adjustment methodology with Midas Datavision, but we built our dashboards using Midas data as our comparison. This is the best that we have had up until now, where I see a lot more opportunity through AJRR and to some of the data that we are able to get from CMS to be able to compare cells and risk-adjusted methodology.

Just to move on, this is what the Midas data looks like. It takes each procedure, or each area that you want to look at and it gets into very specific information around your site percentile, the numbers, the numerators, denominators. You can kind of see- it gives you good, very detailed information about where you are compared with the rest of the participating hospitals. Again, it is not risk-adjusted and what we found with this data is that if I'm going to go to a site orthopedic steering committee to share our data, this is very cumbersome to look at. What we did was develop a dashboard using that data but put it into a much more usable format, and I know this looks busy, I found it to be quite useful and reporting to the various stakeholders that I am responsible for reporting to which I will get into in a little bit. But to acclimate you to the dashboard you can see on the left-hand side are the procedures that we monitor , so all our orthopedic procedures- these are inpatient information, fractures, hip replacements, and knee replacements, and then the measures in each of those areas include mortality, complications, average length of stay, readmissions, volume, surgical site infections. You can see that you can customize your dashboard so you can really focus on what high-level information you want to be able to communicate out to your team, and then also be able to demonstrate variances from where our targets are and also how we are doing compared with previous time frames. I'm not going to spend a lot of time going over each one of these metrics. You can see the metrics here and they are high-level data metrics, and then we ended up adding on to our dashboard, at the bottom, you can see and make sure our team members are aware how we are doing related to complications and readmissions for the CMS population, Medicare population and also our Medicare spending per beneficiary. This is not a CJR dashboard. This is our service line quality reporting dashboard. Who sees this data? This is data that we share at our quality enhancement committee of the board one time a year. I'm scheduled to bring our quality data so this dashboard has been very helpful in order to communicate that. We do have a system level governance council and each hospital has a site committee that focuses on improving at their specific site and putting in performance improvement plans as needed. Hospital and physician leadership sees these dashboards, and all of our hospitals have a quality and patient safety committee that I go to twice a year to report how we are doing in our quality metrics. The dashboards are updated monthly but there is various timing to when the dashboards are shared.
As I mentioned, QE is once a year. Governance and site committee meetings are quarterly, so it varies depending on the stakeholders I'm sharing the data with.

What has evolved out of our system and hospital level position quality reporting dashboard is a physician quality reporting. What we have developed, again, pulling from the main dashboard that communicates outcomes to the whole hospital and then rolls up to a system dashboard, we have now been able to take the data and bring it up to a physician quality reporting. You can see again, the procedures that a physician may perform at our hospital and how they are doing on those high-level quality outcomes, giving them their current quality rating, what the targets are for the hospitals that they work in, any variances, and then their baseline performance. We have been able to use is common language, if you will, to move the reporting to the individual physician level, and this kind of data can be very sensitive for any of those -- I'm sure that those on the phone with physicians, so the quality data is shared twice a year with the physicians individually. Obviously I'm aware of it, the staff person who helped

me develop and publish the dashboard is aware, but it has been very helpful because we have seen improvements in physician performance when you are able to get to them individually how they are doing and compare with the general benchmark and in working with them on: here is where you're an outlier, here's the records we reviewed and what we saw. We have just started sharing these. In the last quarter, we have seen improvements and physicians asking us questions ahead of time to understand how he or she can improve their metrics.

This has evolved into what we are here to talk about today, which is the CJR dashboard. We tried to have a common look and common language. What we've done in our CJR dashboard is to break out the quality metrics into the 50s, 40s, 10s, monitoring our 30 day readmission rate and I just spoke to our group today about adding a 60 and 90 day readmission rate and also tracking at the high-level for the hospital, discharged to home care, discharge to skilled nursing, and you can see the measurements. This is updated quarterly. We talked about updating it more frequently from our discharge information so we can keep track of that more frequently. But again, this is common for our organization, a way to use some common look to be able to communicate a variety of things related to orthopedics and now specifically CJR. This is definitely a work in progress. This dashboard is our basic dashboard but we're looking to enhance it and add more information to it as we go on.

Just in the interest of time, I know I'm already at 15 minutes. Similar people using this dashboard, but enhanced with our CJR care redesign team, similar our governance and site steering committees, we do have post-acute preferred provider networks that we meet with regularly and I am sure as I go for my annual presentation with our board, I will be reporting using this dashboard also.

The lessons learned really are data integrity. What is the source of the data, where did it come from, how do you know that it is legitimate data? As a presenter, I present data quite often in our organization. I spend lots of time making sure that I know the source and understand the methodologies for how we are tracking towards our goals, and I think most of you would agree, bad data gets questioned, but good data does not, so I try to really focus if I am presenting eight dashboard as a red area, I need to understand very specifically why it was red, what was work that we did to monitor the red and to try to move that red to yellow and green. Obviously, being sure and able to follow through and answer the "so what" question, if you're not taking steps to figure out and improve, then there is no sense in my mind on reporting data.

Our next steps are related to reporting with the dashboards is to really get more physician collaboration. We have physician leadership that is very involved understanding our dashboards. But we haven't done as much as yet that we need to do to collaborate with each individual physician. We're looking for resources to track patients more real time but it's been a challenge for us because I don't know where everyone is located but at least in our area, they don't have a lot of money laying around to add additional resources. So we really have been trying to use what we currently have to the best of our ability but recognizing that in the future and as we move forward, we're going to need more resources to help us with success in CJR and really looking at enhanced reporting to our post-acute care providers.

Thank you for your time put out that help give you a little bit of an idea of one methodology on sharing outcomes and sharing data, but certainly I'm interested in what other people are doing and how they are communicating these types of things with CJR stakeholders.

Q&A

Thank you so much Chris. I am going to ask Lauren to open the phone lines at this point and have some conversation about this presentation. This is Isaac Burrows and I just want to check in with folks and see if there are any questions based off of Chris's presentations that anyone has.

This is Angela Winegar at Seton. I had a question around the difference between the two dashboards you showed. The CJR Dashboard- is that specific to the CJR population or do you track all of that for your full population?

Right now it is specifically just for our CJR patient population. Our other dashboard is for our entire population, regardless of payer, but the CJR dashboard is specific to our Medicaid fee for service that are admitted for those procedures.

As Laura mentioned previously, feel free to go ahead and use the chat function and if you are more comfortable typing in your question, that is totally fine, but I will pose a question to Chris. I know you talked about- what are some of the challenges maybe you've experienced in doing this work and development as you come online with CJR?

For us because we have not had any experience under BPCI, we were starting from scratch as far as understanding the patient population that fits under CJR. But also I think our challenges, because it's only 500 patients, but it is difficult that are CJR and what we try to do is not have a different process for a group of patients based on a payer and payment model or anything like that. Although there is opportunity in the reconciliation payment processes as we do well to come under target price, the dollars required to add resources for 3600 patients is very high, yet the return through the CJR payment, potential payment if we come in under target price, is only based on 500 people. My challenge with the people that I need to make the case for, is that it is really the best case scenario to do what we are going to do for CJR patients for all of our total joint replacement patients and that has been a bit of a challenge for us. I'd be interested in hearing if other people had the same challenge as well. Maybe there is more concentration of Medicare fee-for-service and other communities. That is a great point. I think what we see from the CMS site, we do see variability in terms of Medicare fee-for-service versus MA penetration in different markets but there's a question from Sally.

When you're meeting with your preferred providers are you looking to discuss utilization issues like length of stay, visits per episode, and if so, have you looked at a standard pathway for your post-acute network? Yes. We definitely do discuss those things and that's one of those areas with our CJR dashboards that we're trying to enhance. Similar to what we did with our quality reporting dashboard that we brought it down to physician level, we would like to take our CJR dashboard and link in to each of our preferred providers to say "here's how you're performing in a key area like length of stay and visits" and definitely utilizing a similar reporting methodology to be able to share that information. We do have some pathways. Most of our orthopedic patients that use home care go to our Catholic Health home care which is very helpful, but as far subacute goes, we have standards around length of stay and they don't dictate specifically what happens every day in the nursing home. However, we do have expectations run length of stay and expectations on if they go beyond the prescribed length of stay, we are expecting our providers to let them know why and how many days and what was the discharge destination. That makes sense.

I'm going to throw shot in the dark and I don't know you would respond to this but in terms of using the CMS data we are providing, has it been useful at all? Fingers crossed, you will say yes , but have you been able to use that at all? Do you plan on using this in the future maybe as you were talking about in terms of establishing those relationships and giving feedback your post-acute providers?

Yes we have been able to use at a high level. We do have some resource in our finance department that is familiar with the CMS data to be able to at least from a high level, be able to help us understand trending and spending. Our challenge has been being able to spend a lot of time and effort on digging down into the Medicare data at a level we would like and that's where for us, being able to resource that to an extra contractor is our goal. At this point we haven't been able to find that without having to defund something else. If it was up to me, I would like to have a data analytics resource outside of our organization that can, when a quarter comes and get ready for us and within a couple days show it to us and help us help them with developing a dashboard. Those tools are out there but we have not been able to resource to do that. Yes, I want to be able to do that but we do it at a high level.

Thanks Chris. I will pause for a second to see if other folks on the phone have questions.

Continue to type into the chat. I will pause for a little bit longer. Laura, do you have any other questions that you may want to pose? Yes I do want to jump in and turn it back to the group just a bit. Would folks on the call be willing to share regarding their dashboards and their reporting? If any one of you would be willing to talk about how it is similar to what Chris has shared and how is different? Are your dashboards different or similar? Do you have dashboards that were developed just for CJR or using existing ones? I would love to hear from other participants on a call as to how they are doing this. Anyone willing to speak up?

This is Angela from Seton and I don't mean to monopolize and I'm happy to share what we are doing. I really enjoyed the dashboard examples that Chris put on for CJR because we have not yet incorporated any of the CMS metrics that we are getting. That is a great idea. I'm excited to incorporate that into our subsequent iteration. We've been focusing a lot on process measures that we feel, based on our conversations with our surgeons, that that is a type of data that they want to see; they are the leading indicators of hope to the success down the road in terms of making sure we are scheduling patients. We're shooting for six weeks in advance and can be seen in an optimization clinic through tele med or a physician's office. We want to give those patients an opportunity to really optimize or have the order sets in place for their postoperative care and depending on what is identified during a clinic visit, and then also looking at the percent of patients whose care follows the agreed-upon clinical pathway that we have in place for all our total joint replacements and the percent that are discharged from home health and we found that is directly related to how the surgeons prepare the patients, and whether the patients feel empowered to be discharged home health, SNF, or in-patient rehab.

We have been very active in terms of sharing that kind of data with our workgroup, and we have a BPCI program as well, to those different work groups and making sure that the surgeons see those process measures. We have readmission rates to our facilities and we haven't incorporated the CMS readmissions yet mostly because we're still working on the data that was released for Q3, so there was not really a full episode of data to know what our readmissions looked like for the April to June period that we received back in August.

That is useful to hear. Are others approaching somewhat differently or have other things to share about how you do it at your hospital?

This is Chris. I'm curious to know for those on the phone if you are using external resources to help you with the data analytics, if you are, yes or no, and if any of the things I showed today are kind of homegrown things, but curious how people are/or if you are using external resources vs. internal.

This is Angela from Seton. We have a pretty big analytics team that supports the Ascension network and we do have a subscription to Premier although we don't use it but it's not real time. But we have been building our own reports.

Are others also building your own reports or are you using an external resource for that?

This is Kyle from Michigan. We're doing a little bit of both. We're working on establishing a better dashboard for internalizing more concurrent data so we can take action and intervene on outcomes on a concurrent basis so we are not waiting for the claims data, but for our claims data, all of it ties into that and we don't quite have the structure internally to handle that we externalize that in the beginning with plans in the next couple years of bringing that also in-house as well.

Greater thank you so much for sharing that. You are welcome.

Anyone else willing to share?

This is Rick. We're affiliated with Sutter Health and so we are working with the system that they are using and they have contracted with MedBen for data analysts. We haven't done anything specifically beyond that yet but we are in the process of evaluating what they provide.

Thank you.

I would also ask to any of you, do you have questions for each other? I know we have accepted questions for Chris and for Catholic Health but do you have questions for each other, anything you were hoping to ask one another about?

This is Isaac from CMS. I have a question for Angela. I'm curious if seeing the dashboard that Chris has here with sort of more outcome measures, if you had considered maybe having those types of measures incorporated into your own dashboard, such as infection rate?

Definitely. Like I said, we were using our internal data and we have to piece it together from disparate sources right now. We don't have a great enterprise data warehouse solution that we can use as a big sandbox for data. That is on our wish list and doing a home-grown kind of complication rates so we can get more real-time visibility for complications and not have to wait for CMS data. We are actively trying to figure that out and having to prioritize that with all the other requests that are coming in, but absolutely. I really do want to incorporate more outcomes in that and preserve sort of the real-time or close to real-time delivery of the data that we are getting. It is a trade-off, of course, but I love the idea of using the CMS claims data as well and starting to sketch out some new ideas.

I think there's a common theme and others please feel free to jump in. It sounds like from what people are saying there might be some -- in terms of what you all are able to prepare, it might be a resource issue whether or not you have FTE or the funding available to have an outside data analytics or your sort of homegrown analytics, there might be resource constraints.

This is Angela. We’re sort of in a similar situation, a little different, but our ultimate CJR population is quite small because some physician practices in our region have chosen to take on BPCI programs that take them away from CJR population of work. It’s making that case to do things that are specific to CJR, so we keep the mentality of we want to have a program of excellence and be payer agnostic and reimbursement agnostic and choose the way that their care is addressed.

Anyone else have another comment or question you would like to share?

Polling

As you are thinking of that, feel free to speak up as we go forward, but we are going to move forward in the presentation and ask you to complete a poll. We are going to launch a poll, and it has two questions , and you'll see a pop-up on your screen. We would like you to answer those two questions quickly. These are questions geared toward helping us determine some of conversations we want to have in the January breakout session regarding physician data, so if you be willing to share with us if you have physician champions for your CJR model and have you had success building engagement among the physicians by using the data. You would click on the responses to those polls, that would be very helpful for us. It gives us a starting point for the next round of breakout sessions. We will give a few seconds for everybody complete that and click on those.

As I mentioned, we will not be sharing the results today. We will share the results from these polls in January at our next breakout session. I believe we can close the poll and then we can move forward to the next slide where I would like to ask you to please type into the chat box your answer to this question that is upcoming. How do you determine what metrics are valuable for your physicians? Type that into the chat box so we have that to share. And as you are doing so, we will go ahead and move on forward. If we can move to the -- here we go. We are going to continue this discussion on CJR Connect . We would like to remind you that we have your own Data Affinity Group. You can share, ask questions and talk back and forth on Connect for your Data Affinity Group. Post a comment, go to the groups tab, click on Data Affinity Group and post a comment. The directions are on the slide. If you don't have an account, there are directions on how to set that up.

We will be communicating with you between now and then, but we also want to encourage you to continue the conversation on Connect throughout December so that we don't lose any momentum on this. If you have got specific questions at any point, send those on to CJRSupport@cms.hhs.gov. Please take a few minutes at the end of this webinar to respond to the post event survey that comes up. Prior to winding up and letting you do that survey, just want to double check if we have any other questions or comments that are coming through. Anyone have a final question or comment?

All right. If not, thank you very much and ask that you please take a few minutes to respond to that survey and we will talk to you further on CJR Connect. Thank you very much.