Developing and Enhancing Relationships with Independent Surgeons
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Operator: Hello and welcome to today's teleconference at this time we're currently waiting for all the participants to arrive. Thank you for your patience and please continue to hold.

Isaac Burrows: Hi, good afternoon everyone and welcome to the CJR learning system event Developing and Enhancing Relationships with Independent Surgeons. My name is Isaac Burrows here at the CMS Innovation Center, we're glad you joined us today – excuse me. This topic actually came out of some surveys we did some information, it seemed like there were some folks that had some questions and we know that it's a sort of a unique challenge and many CJR hospitals in terms of laying out the CJR model and sort of getting the engagement with surgeons that are maybe outside of your control. So, we wanted to kind of present some ideas and views on that today.

Monitoring the session today will be both myself and my colleague Laura Maynard and just to go through the agenda we'll start up by some – Laura will go through some logistics, then we'll have a few different folks kind of share some ideas. Laura will introduce them and then we will have some Q&As kind of standard format and at the end will kind of wrap up. So, with that I'll turn it over to my colleague Laura, to go through with logistics.

Laura Maynard: Alright, thank you so much Isaac appreciated. I just want to orient everyone to the Adobe Connect platform so that you can participate fully. Closed captioning is available just under the slides and the text alternative is available in the event resources pod that's right beside that. The slides are also there in event resources if you would like to download the slides at this point. You'll notice up at the top of the slides if you want to make those slides larger there is a small box made of four arrows pointing outward, if you click on that you can expand the size of the slides in your view. To view the video click on the video pod and access audio by telephone the dial in information is there. The chat pod is below the dial in information and we're hoping that you will use that chat panel a lot today to converse with one another and also to ask questions of the panelists. If you are going to be asking a specific panelist a question or one of your colleagues who also chats in a question, if you could use the "@" symbol then that will help us know who to direct that question toward. You can submit your question or comment by typing into the white box that's at the bottom of the chat pod and then click the little bubble icon beside it.

So, we are going to begin as you start out here with a poll. So we would like to ask you to please click on the poll response that best represents your organization as to what percentage of your surgeons are not employed by your hospital, what's the rough percentage of surgeons in your hospital that are not employed by the hospital or health system.

Isaac Burrows: And I would just one quick clarification, well this is Isaac, I think that I would say that your CJR surgeons specifically I think we'll say it that way.

Laura Maynard: Yeah that's much more useful thank you. We will give folks a moment we have some more responses coming in and some interesting results on that and this will help us have a sense of sort of the feel of who is on the call today. So, yes let's close out that poll and share the results. Give just a moment and we will give you a chance so that you can see the results, and merely an even split between those who have 100% of your CJR surgeons that are not employed and 99%. So clearly the majority of you have at least half of your CJR surgeons that are not employed by the hospital. So, relevant topic and we're hoping that since so many of you that are on the call, on the webinar today are in that situation you will have some strategies to share as well, about how you engage with those particular surgeons.

So, given that most of you are working with engaging independent surgeons type into the chat box what's been your most successful strategy so far, for engaging those surgeons what's been working at your hospital for that? So, go ahead and start typing that right on into the chat pod so that everybody can see it, so what's been your most successful strategy? And as you are typing those strategies into chat, I'll begin introducing our panel for today.

We're going to have two different panel presentations and then our panelists will participate in some conversation and dialogue with you, we've got Jacqueline Strinden who is the Director of Organizational Quality at CHI St. Alexius Health in Bismarck. We've got Denise Addis and Amy Sailor – Denise is the director of value based quality at Excela Health, and Amy is the Director of Rehabilitation and Joint Works at Excela Health. So, we're going to begin this panel presentation and as we're doing so continue chatting your strategies into the chat pod and we'll call on Jacqueline to tell us a little bit about the strategies that they used for engaging their positions their at St. Alexius. Jacqueline?

Jacqueline Strinden: Thank you Laura and good afternoon, I'm excited to present and share with you all a little bit of the work that we've been doing at Catholic Health Initiatives specifically at St. Alexius Health in Bismarck, North Dakota. So, I'm going to pause for just a moment and wait until I can bring up my video live and then I'll begin the presentation. You would be able to see me here in just a second so I'll get started just giving you a little bit of background as stated I am the Director of Organizational Quality and Education here at the medical center. And I'm going to share a little bit on the next slides of what that really means within our organization. It had a specific impact on how we intentionally designed our CJR program within the first year. So, looking at our hospital I've included some statistics for all of you so that you have a little feel for who we are. This is the picture of our hospital, we were founded 130 years ago by the Benedictine Sisters proudly and provide healthcare in the region in a very

competitive market. We do have one additional tertiary Medical Center within our city. So, we are aligned with the system, our system has 104 hospitals within Catholic Health Initiatives in 18 states, we have four academic health care centers, 30 critical access hospitals, 22 long-term care hospitals, 55 home care facilities and 12 clinically integrated networks. So, a pretty robust system. And fortunately we can pull a lot of information actually and best practice from within our own health care system.

At St. Alexius we are part of the west region within North Dakota consisting of 7 hospitals that are aligned as in Alexius system of Catholic Health Care Initiatives. You can see we're ER trauma 2, we're joint commission accredited, we recently did receive our comprehensive total joint certified status through the joint commission and that actually was a joint effort with bringing up our CJR program we defined that we wanted to also look at comprehensive total joint certification. We were the first facility in the US that was granted a comprehensive status without having to first go through the primary certification. So, we're very proud of that and we've done a lot of work here at the medical center in very much so a team perspective. So, here at the medical center we on – when I pulled up our stats in 2016 just to give you an idea kind of where we're sitting on our total volume we had 379 total hip procedures and we had 638 total knee procedures. For our hip just to give you an understanding we had really began with hip and knee improvement actually slightly before about a year and a half prior to being selected for the CJR program. So we'd really focused on our outcome based measures looking at driving down our geometric mean length of stays. So, our hips typically now in the year of 2016 are seeing a 2.1 day average length of stay and a 1 day length of stay for our knee procedures. So much work was done there both on driving down our metrics and improving our patient care outcomes, and I'll speak to that throughout the presentation.

Next slide please. So I did include this picture just to give you an understanding of our quality team here at St. Alexius. This is our team and then I also gave you an understanding because I think that's important when we talk about how we're going to build a team and how we're going to drive integration especially from a surgeon perspective. So, these are the different areas and departments that report to me. I did include and I'm hoping to go through all of them but I did include in bold in red the departments that really had an impact on why quality was selected. We pulled together the first initiative for CJR and why we were so involved. I know that there are many hospitals that didn't have as much involvement from their quality team, from an infection prevention perspective we really look at the complication rates and how important that is for our surgeons to understand our teams to understand what information we are collecting in a performance outcome perspective. We also included our OPD and our CPE physician management that was another driver. We currently conduct all of the OPP and SPPE initiative so it gave us a methodology to further link our surgeons with performance and with outcomes in driving the importance of management in bundles. We also of course for the quality of review perspective and data analytics included our performance analytics on our quality review team and

certainly our decision support as we continue to build our organization and restructure to meet the rigors of the CJR bundle program.

In addition to that a huge piece of our design was really involving lean six sigma and that was really the glue that held our program together and you will hear more of that in the slides to come. Our entire process and project was really designed around lean six initiatives and continuous performance improvement. We also have a very strong department that manages our accreditation regulatory services as you've seen, we have multiple certified programs as well as team status with our joint commission. So, really understanding the regulatory requirements of bundled practice and then making that come alive in a way that our surgeons could embrace what we were attempting to drive within the organization and to integrate into our care, and redesign from a care management perspective. And then data governance of course a piece that's you know very important to all quality endeavors and then we then brought out the bundled payment and ACO are our clinically integrated network relationship into this having already had experience within the health care arena and managing patients and navigation.

Next slide please. So another good reason and I want to give some background on this. Our quality communication structure was another reason why our quality really is at the center of the work that's been done for our performance year 1. We have a very strong structure that involves physicians at every level. So, at the very bottom of this slide you are going to see that we have multiple project teams. Within the accreditation regulatory team we have reports that occur at that level which involves physician involvement and you will hear more of that in slides to come. That is brought up all of that information is shared at our performance effectiveness committee at the leadership level again involving a larger group of physicians multidisciplinary in approach and representing multiple chairs of medicine that occur here within the facility as well as then bringing that information up to the governing board level at our quality and value committee which we also have representation from physicians as well as multidisciplinary. And this actually is the focus that now we've taken on a west region structure representing seven hospitals at the table. So, really a very robust reporting structure which helps drive the importance of bundled payments and oversight management of that program.

Next slide please. So, one of the key elements when we really talked about what is successful in involvement of individual surgeons as well as really the multidisciplinary team here at St. Alexius was really doing it right from the very start. We were very fortunate to have a tremendous resource her name is Tamara Kull she came to us from the National Structure and helped lead us through a three-day workshop, really we felt starting off on the right foot is the most critical defining success factor, really getting good engagement, strong understanding and involving the right people from the very onset of the program was critical for our performance and really in driving this endeavor. So, we had multiple sessions, we started it at a very high level 100,000 foot

level of really pulling together our executives, pulling together individual leadership sessions, break-up sessions that were multidisciplinary and embedding our physicians of which we have 7 physicians that are all independent in various levels of those workshops, really making sure everyone had a concrete understanding of the task at hand. And to do that we really had to define some goals. Our lean six sigma department really coordinated that work and 5 of the primary goals that we defined very early on in this endeavor was number (1) we needed to provide education, those stakeholders were critical in getting the right people at the table. Secondly, making sure they really understood the program in a very rapid way. Secondly, we looked at the finding deliverables, what did we need to define as our to do list so to speak are actionable over the next 13 weeks which was the time period we defined as bringing up the CJR program.

We then had to look at how do we build highly effective teams and we really put a great amount of time into determining what position should serve on various committees throughout the medical center and did just that. Looking at goal 4, we encompassed the TJC comprehensive joint accreditation. As I mentioned we felt CJR and TJC really are pretty comparable in terms of really driving systems and care we design. We felt one would overlap nicely into the other, we did skip the primary certification and moved directly to that comprehensive and it was very successful for us. The really leveraging economies of scale and essentially completing two tasks with one initiative. And then the fifth goal was leveraging existing strengths and technology. We knew that we had quite a few strengths within the organization both with our physician involvement at the ACO level they are clinically integrate network. We were managing about 15,000 lives at that time and looking at how could we benefit from what we've already learned in nurse navigation and then apply that to the CJR program as well as leveraging existing technology within our MIDAS system as well as purchasing additional software systems to assist with patient navigation through web-based application.

Next slide. So, one of the things that you will notice, earlier I showed you a diagram that really covered the project team levels of leadership level as well as our administrative level. So, we replicated that exact structure and you will see more of how we reported out in future slides, but it was very important for us to intentionally silo all of our teams so that we could execute the work that needed to be carried out over the course of the next 13 weeks. So, what that looks like? At our 3-day workshop we pulled together all of the best practices that we believed we needed to evaluate. The evaluation of those practices was carried out in three separate teams, the pre-acute care, the acute care, and the post-acute care team. Each one of these teams have surgeons that are independent surgeons embedded within the team. At times we had multiple surgeons, we had multiple representation for example on the acute team we had representation from the hospitalist team, from our surgeons that were operating, we also had representation from MDAs. So, we had multiple groups of physicians as well as the multidisciplinary team represented. We wanted to make sure they were at the heart of the work that's being done as well as the decisions that are being made.

So we looked from the pre acute care team, at our physicians that were involved heavily within our accountable care organization and really learning from what they had already developed within their system and how could that be overlaid to being successful in the CJR team. Again I mentioned those individuals we shared ownership at the acute care team and then our post-acute care team we had a representative as well from our independent surgery group. How many would they understood to be their routine practice on post-acute discharge management and where they frequently discharge these patients and the reasons behind why they discharged two specific facilities.

So a number of really great decisions were made, I have to say that was one of them. We really wanted to intentionally silo the work that needed to be accomplished, gain valuable information insight from our surgeons as well as the multi-disciplinary team and evaluate practices we had in place and determine what practices we still needed to evaluate and define workflows for. Looking to the next level of leadership that became our steering committee, our steering committee again had physician, independent surgeon involvement at that level. It really was the group that made day to day decisions on what best practices were to be implemented designing specific software, looking at our data management and reviewing the progress of the work that had been completed on an ongoing basis. Administratively we had a monthly meeting which is the third run, and that was our CJR executive counsel. They really looked at evaluating all of the practices reviewing the work that had been completed and managing any resourcing or challenging situations that we were unable to solve for between the three teams that were working on these focus project team level.

Next slide please. I am giving you a small snapshot just so that you understand how we manage these groups. As you can imagine I believe when we pulled together all of the best practices we have between 30 and 50 best practices defined for each of those project team, our independent docs were very involved they were encouraged to attend and did attend those meetings, had frontline involvement and input shared with the group on what practices we needed to focus on. This is one of the tools we use to do that you can see there is timelines kind of in the middle of this a document and on the far left you will see there are a number of strategies that we wish to drive throughout the course of our 13 weeks.

The teams strategize, they evaluate it and they determine the priority of each of those items. Fitting them into the 13 week timeline. So that is the information that then was presented to the steering team with ongoing updates of their progress. So independently, they were all working on best practice and yet there was quite a bit of cross over that occurred at the steering committee level. So we will move from this slide to the next please.

And this is one specific tile that I just wanted to mention. This is the tile for our nurse navigation, as you can imagine we picked a 13 week timeline for a few really important

reasons one of them was we knew that we needed to have the process in place by January 1 at that time, program had not yet been delayed to April but beyond that very important was we were going live with Epic in 13 weeks. So we really had a very short time frame to fit all of our, our other priorities kind of into this. So what we ended up doing with nurse navigation we did not have nurse navigation online for this program when we began with the planning stages, so we did end up looking at how can we onboard hire integrate and train an individual so to speak to be ready to nurse navigate within our facility. So that became primarily a very important as we looked forward to managing patients both pre hospitalization, acute stay and then post hospitalization. So there was quite a bit of heavy lifting that occurred to bring that individual but we were very successful. And then looking at how do we integrate their work with our physicians understanding of nurse navigation and communication of ongoing concerns from patients.

Moving on to the next slide please. Now I have to pause for just one second I am now having trouble seeing the slide but I will see if I can bring it back up, and I'll continue to move on as I am doing that. So looking at the process map our lean six sigma group as I mentioned was very involved. Each one of those silos are really created and project teams created their own mapping, their own workflows, each of those were individually created and then we held a large group session this is one process within many that were defined. We then created one large group session to review a full day from beginning to end how a patient would be navigated and what our care redesign model was. So you can see that on the slide it did take us a full day to get through that. We were very fortunate I think in that view the final rule pushed back the go live of this program, which then gave us a window of time, we actually performed a soft go live in the month of March and from March 1 to March 31 we put in place our complete program and ran with that program for a month to determine what things needed to be reworked. So we felt that was valuable time gained for us to really put to test the work that we were doing. And this is one example of that. if you would see the entire process map it spanned a wall that was about 40 feet in length with every process mapped out.

Next slide please. And then just to give you an understanding our physicians were really very entrenched in the work that was being done as for our multidisciplinary team members and stakeholders. This is an example of what went to the student team as well as the executive team. So nonetheless you are just seeing a very small snapshot of all the different processes that needed to be accomplished, and then at the very bottom we gave them an understanding of what is pending, what is in progress, what has been completed, what we have cancelled? There were some things that we defined became less important or took a lesser priority or simply weren't needed. And then those things that required an update and what was not yet started. So you can see just a quick snapshot of how that was communicated in a very efficient way up to our steering team.

Next slide. And then this is kind of a roll out, we did follow one basic template. Every team presented one slide and this encompassed everything that they needed to

communicate to the steering team, it enabled us to be a little bit more flexible in getting through a larger volume of data so to speak ongoing. And so this is what we shared with them I just wanted you to get a taste of how we communicated. This information was shared and put together with that project level team so very heavily this was involved with our physicians and communication. So both our joint committee team and then it was also shared at our independent surgeon's board meetings ongoing so that they were very much so understanding the direction that we were heading.

Next slide please. And I believe this is my final slide. So just to kind of speak we talked a little bit about software and some of the integration. We were very heavily entrenched with the MIDAS system this gives you an understanding of all of the different opportunities that we have within MIDAS one of which is that all of our nurse navigation all of our patient integrated discussions, our phone calls out to patients, their phone calls and to clarify pieces of the care are we have a joint academy training session, couple hour long class that all of our replacement candidates attend all of that information was stored within the MIDAS system. It gave us a very robust database to understand and to better navigate patient, understanding frequency with which calls were made, what types of calls were made using that information to better our joint academy training. All of that really was encompassed with the MIDAS system we used the community management tool within MIDAS. It consisted of well over 300 questions, that over a nine month timeframe we would use from pre-hospital to post hospital 90 days and beyond. In addition to that we turn that information into metrics within the data the data called system called Stata essentially using that data to feedback to our surgeons into our teams, our charter team to really understand what our performance was that was critical. And then how to better our performance. Well that consisted of dashboard individuals were given access to that dashboard they received daily emails to tell them what our performance level was and to drive performance in an ongoing continuous basis.

Now right now we manage in total about 18,000 metrics within our MIDAS system of which we really narrowed it down to about let's say 50 different metrics that we monitored within MIDAS ongoing. So there is a component of data sharing that really is very rich within our organization, feeds back into that process improvement cycle. In addition to that we held a number of root cause analysis events that involved our positions. We did eventually pull together all three of our teams as well. So our pre acute, our acute, and our post-acute teams eventually after our go live became one solidifying team but then looked at improvement across the continuum and really driving the cohesiveness of the program as well as defining outcomes for patients.

So I hope that gives you an understanding of how we really task ourselves of how do we integrate our independent surgeons. Certainly I am not saying every day and every endeavor that we had was easy or simple or very straight forward it took a lot of hard work but we really had I think a nice platform early on that defined how important this

process was for St. Alexius and most importantly for the patients that we serve. With that I will open it up to any questions that you might have.

Laura Maynard: Thank you Jacqueline we've had some questions come in and in the interest of time we are also going to move ahead and launch our next poll while we post some questions so we'll multi task a little bit. So we've had someone ask who led your steering committee was that a physician or someone from administration?

Jacqueline Strinden: Sure. Great question with every team that we had, we had dual ownership of the team. So on the steering committee I facilitated that team with our main sigma department however it was chaired by a physician as was our administrative team our executive team, and all of our project teams also had a physician that was aligned to sharing that committee but it was facilitated by another administrative partner.

Laura Maynard: Right, great thank you and folks continue jumping into the poll we're asking about the level of integration of your surgeons into your quality improvement processes and structure, how fully they participate in that. So go ahead and continue clicking on the poll options as we go through a few more questions. Someone also had asked about your nurse navigator that you mentioned and how often that nurse navigator communicates with the 600 patients and is that 600 patients a year or is that defined some other way?

Jacqueline Strinden: Sure. Yes we had multiple nurse navigators, we started with one we eventually ended up adding two that seemed very manageable at that point. We had a number of ways actually at that time that they were working with our patients. So across the continuum they met with them multiple times. There were pre-hospital calls that occurred one month prior when we knew of those patients one month prior. Also two week prior to surgery one week prior to surgery interval the one week prior to surgery interval and they called out the day before surgery as well to clarify any questions that they might have. On the acute side there were multiple bed side visits and then post-acute we had defined multiple intervals that we were interfacing with those individuals who was a very defined so we would follow up with them at the 1, 3, 7 day, two week, 30 days, 60 day and I believe 90 day, and then to say we're at a SNF or skilled nursing facility or nursing home we actually had a completely different methodology for following up with them. All embedded within the MIDAS system so we could define where our patient was going and it would pop up on our list based on that timeframe defined. We also had a system built within MIDAS that we could actually when patients arrived in the ER it would page our nurse navigator to let her know that one of our CJR patients that was flagged in the system had just arrived and it was a potential readmission.

Although we very much so encouraged them to call our hotline which was staffed by our nurse navigators Monday through Friday, and then we purchased in partnership with

another CHI facility services from them to cover our nurse navigation after hours and weekends so we could benefit from not having huge high volume of calls but still having someone available that understood the rigors of the program that could answer a question. So I hope that answers your question but we had multiple timeframes like I said over 300 questions that were defined for each one of those intervals all customized and certainly that's information I will be happy to share if there is someone that has a specific interest in that. I think that's part of the benefit of us all working together. We are all driving the same pieces that's the heart of what quality does is improving care and outcomes I mean certainly I feel CMS is really from an innovations perspective taken that same approach. So if there are specific requests I could certainly share some of that information.

Laura Maynard: Thank you. And in our poll results we see that the majority of participants don't have their surgeons well integrated into their quality improvement processes and structure but some do. So those of you that answered that poll would like to -- we would like for you to type in to chat at this point if your surgeons are well integrated into your processes and structure for quality improvement. Type in how they participate and if not type in some ideas that you may have as to why they are not participating as fully. We have had a few other questions come in but I think in the interest of time to make sure we have enough time for all of them we are going to move on along as folks are typing into chat, let's move on to our next panelist and then we can all discuss together once they have finished as well.

So continue typing questions and thoughts into chat, we will come back for additional questions we are capturing these. We will have more time for discussion but let's move on and have our folks from Excela Health, Denise Addis and Amy Sailor are going to share with us a little bit about how they approach engaging their independent surgeons.

Denise Addis: Thank you very much, this is Denise, and I am the Director for Value Based Quality at the health system and we are going to very much focus our presentation around engaging the physicians in the program. And our program for orthopedic and electric joints we have labeled as joint works, so when we speak about that, that's the program and structure we put in place for electric joint replacement. Next slide please.

Excela Health is a three hospital health system, we are located in the Pittsburgh Pennsylvania area and we are the only health system in our county or in our community, the next closest is in the Pittsburgh area. So, we work very, very hard to keep our patients engaged and close to home that is our mission in order to provide community based care within our facility. We are about 300, about 700 beds amongst 300 hospitals all within a 30 mile triangle, each other and we have approximately 500 employee physicians and allied health being nurse practitioners PAs and CRNAs that our Excela Health Medical Group employees with all specialties.

The next slide. In the orthopedic joint works program we are really, really started this program, we were conducting and performing total joint replacement at three hospitals with three cultures even though we were one health system that had been previously competitors. And many of us have all been through that, so that in of itself proposes a lot of challenges, but when we started the program officially in 2012, we also had seven orthopedic office physicians performing these surgeries, five of them at the time were employed and they were performing about 85% of our volume at the time when we in 2012 when we started really aggressively exploring this program. And we at that point did have two independent surgeons that were doing 15% of our volume primarily at our larger health system, and you can see that volume represented. But obviously our role was to be bigger and better than that and to capture the majority of our clients and our patients in our county within our program. I'll let Amy take it from here.

Amy Sailor: Okay next slide. So we do have to go back a few years about five years to look at our initial idea to streamline this process, with the goal of attaining a center of excellence distinctions for our hip and knee replacement. So Denise will be back a little bit later to talk about what fast forwarding five years 2017 and what that impacts CJR. So we had an issue in 2012 a lean process as well it's not lean six sigma but in our lean process we follow the Toyota model and basically what we did was what's called VSM or Value Stream Map. Basically you gather all of the parties representations together multi-disciplinary from everybody from dietary who serves the meals to the nurses, therapist, physicians, and we all map out current state. So what current state does happen with the patients and what do we want to see it to be. So we all sit down and as I said they are all represented across the continuum while we wanted to look at preadmission acute and post-acute so we had our physicians and their office staff become part of this. And initially I will tell you they did not see the efficacy in this approach, really did not wanted to get there but wasn't -- they weren't really buying into the lean process at first. So we had the representation from both owned and non-owned practices.

So what we did was we targeted, we came and we mapped out what we wanted to see. So we created standard work between those offices and our pre-admission, basically we have a Joint Works Coordinator who is an RN and we streamline that work. As Denise said, we had different heath systems come together, hospitals to form our health systems. So even though those physicians were owned at the time they all brought staff that had their own way of doing things. So we were working with them as well as working with our independent physicians' office. So I think that definitely had a buy-in for process change by including those office staffs. So we wanted to – we established better intake communication, we had so many forums, everybody had their own idea of how to do things, it was so redundant so we really streamline things and created electronic intake and barcoded that forum.

Now I will tell you in the next slide about the challenges that we had with kind of tweaking our standard work to help the independent surgeons' office and we'll talk a

little bit about that. We wanted to improve our Joint Works Class attendance that's our first step class, that's our education class, multi-disciplinary format, patients come to. We had links on the Internet, book and reference materials. So we all got together and decided what exactly we wanted to educate and make sure that we scripted everybody from physician to the staff making sure in each department we are telling them the same thing. So then we had meetings with the surgeons and we included them all on these meetings creation of standardized pre-op ordered sets making sure that everything is as streamline as we can make it - implementing the infection control, CHG pre-op scrub, MRSA screening - making sure that's standardized.

We had a meeting to review and have surgeons approve shared decision making tools and then we actually went a step further and everyone had to be tested to make sure that everybody knew what those standard – those shared decision making tools were and how to give them not only in the hospitals but in the office. So the office staff and the surgeons actually went through this exercise. The offices agreed to take on the LEFS that we were using as a quality outcomes indicator at all visits points in the office which was very, very huge because you know that is not an easy task to take on. So we had also agreed to doing follow up phone calls, discharge phone calls by our nursing staff to ensure that patient satisfaction and follow up were key. So the physicians ask were doing this time making sure we had staff stability, they didn't want the nurses pulled, they wanted them to be educated to orthopedics. And actually our independent surgeon and our representative on the employed surgeon came and educated all of our staff and signed them off. They wanted communication board, they wanted collaborative care rounding with ancillary disciplines and we made sure we do that. We come in early and we round with them at 7:00 and 7:30 to make sure that everybody is on the same page.

And bringing all of this home was establishing that Joint Works Committee with both the non-owned and owned physician representation and we meet – we at the time met every other month, and we all agreed on metrics and we all reviewed it at the meeting. So I see on chat that a lot of you have both the relationships, know about the communication and also understand that's being an ensuring that data is key because if they see what's getting back to them they want to move forward. So to accomplish this with the surgeons, we had numerous meetings, we attended all the orthopedics physician department meetings and had our own agenda. I still continually go and have my own agenda standing so I update them on everything which includes non-owned and owned. I met with them individually myself just to understand where they were at the process and what their individual issues were. And then as again, I can't stress enough having that staff that office staff buy-in was key because when they go back to their staff as the staff is happy and willing to do it the surgeon probably is going to do as well.

So, as I said, you can move to the next slide. There were some challenges with the incoming surgeon because they didn't have EMR but they were still pay-for charge. So we were willing to develop pay-for practice processes for administrative and operations

functions for them in the interim. They didn't even have staff email accounts so we designed an UltraNet Communication Process where our coordinator would reach out to them in specific times and make sure that everybody was up-to-date on everything that needed to be done. You know it was very protective of staff timing resource and which I can certainly understand so we understood that all of our surgeons we expected to schedule patients for classes where they left, but he felt that that was really a string. So we came to a compromise and he would give the information to the patients and then they would call for class to our scheduling department and our coordinator would follow up. And then he was really not really supportive of our best practice SSI Bundle so we would deliver the CHG to the office and just repetitively talk to him about best practice and outcomes and things like that and he did finally agree to the standardized best practice. So communication and all of that was very key. So next Denise is going to go through the next slide about how that happens five years later when it was in the advent of CJR. Denise?

Denise Addis: Yes, next slide please. So, this is a journey as we have all been on with CJR let alone our original journey showing in 2012. I think truly the key to success here is we treated the independent physicians no different than we treated the employee physicians. So they were part of the workgroup, they were part of the lean process, they were part of 5S and designing and cleaning up the existing process and doing workflow design. So sometimes kicking and screaming he came along with us, sometimes he didn't, and Amy shared with you some of the strategies and things that had to put in place particularly as it related to not having an EMR in the office setting, up until most recently. As of April of this year that individual is now employed by Excela still is in the process of installing an EMR but we have again continued to engage him and his office staff in all of the work that we do, again treating everyone the same is equal stakeholders has really been key.

The orthopedic surgeons definitely continue to participate in the Joint Works Committee and program. They have been very integral decision makers through this process all of them again independent or employed, and we have been very transparent with the data. And CJR has certainly made us all look at the data potentially differently than we looked at it in the past, but – and the sheer nature of physicians they have become very competitive to see where they stack against each other. I think now that our one independent physician is not employed he would even be more tightly aligned with looking at those initiatives, but even when he was independent he did not and ever want to see his numbers at the bottom of any data we presented. But the program continues to evolve and grow, most recently as of December of '17 when I become more involved in it we have are in the process of hiring nurse navigators, two of them to manage our case log-in, and what we have done is we have located these nurse navigators in the doctors' offices, not in the hospital. We believe that they need to be in the office to have that touch point with the patients once they make the shared decision to have surgery. It also allows that nurse navigator to become the right-hand of the surgeon in the moment. In our office setting too, they have ironic I am a nurse so what I

learned is they are some of the first nurses to be in these orthopedic practices so they are also bringing that advantage to that office setting. But they have started to navigate all of our orthopedic patients and again be that right-hand of physician, and one of those is actually three out of five days in what was the prior independent physician office practice.

We are currently selecting navigation software. I would love to hear what other people are using to allow them to manage the volume and communicate. We also are looking at how we do our classes and when we do our classes as a result of that. We have involved our physicians regardless again of their status in pain management protocols and in-patient, out-patient order sets, we have also reached for home care pathway and skilled care pathways. Our goal is that over 90% of our elective hips and knees go home most with home care, very few go home independently, and that has been a challenge as we have worked with our community and with our physicians. You know physicians at the discharge end would hear for their patients that well my neighbor went to a nursing home for couple of days, can I go to rehab for a couple of days? I think I will do better and encouraging with the doctor and the navigator that the patients will do better and have better outcomes if they go to their home setting, have less UTI, less VET, be more safe, and has been a cultural change for us in our organization and we have again brought all the physicians along together in that journey with us. And we have seen a drastic reduction in patients get centered skilled care. That skilled care I think is filling the pain of those reduced admissions.

Next slide please. So as we plan for 2017, our budgeted goal for this current fiscal year, we used to do 1,300 procedures. We are only doing those surgeries in two of our three hospitals now, it's better allowed us to align our resources and our manpower and reduce our cost. We have six physician offices and five now owned orthopedic surgeons that are working together with us through this journey not independent or separate. It will be an experience as we move through and I am sure there will be bumps on the road as we continue to work on improving the quality of care for these patients. I really want to thank everyone for the opportunity for Amy and I to present and I would be happy to answer any questions.

Laura Maynard: Thanks so much Denise and Amy. And we have had quite a few questions come in. I am going to address the one as the most common and it's been in chat and we appreciate you all participating in chat and answering some of those questions. Can you talk a little bit more about the shared decision making tools and how those are used? There has been a fair bit of interest in chat as to whether you develop those, whether you ave found them somewhere, whether you can share them, and we are hoping you will be able to share them on the Connect site. And you mentioned Amy the option grids, could you talk just a little bit more about that for those that are so interested?

Denise Addis: Amy, I'll let you take the shared decision making.

Amy Sailor: I was on mute. So we found this option grid shared decision making tool back in 2012 when we obviously were looking for something to deal with our patients. They have served us well, they are online, but when we went in 2017 to update them we had some trouble finding them so we can certainly and therefore use for anyone's use so we can certainly try to find them for you and post them on Connect. But they are very simplified options for the patients whether you are going to have injections or follow pain control or are you a candidate for surgery, and it's just the tool that helps to facilitate that conversation with the surgeon in order to come to the conclusion or the steps that they want to take. So we like it, we get good feedback, the surgeons like them as well.

Laura Maynard: Great, thank you so much. Thanks for sharing that and we will try to get the links and the options there onto the Connect site for folks to see. One other question has come in that we wanted to ask you as well, having to do with the metrics, you mentioned sharing your measures with your surgeons, do you have any surgeon specific metrics, and if so, what are those?

Denise Addis: We are – this is Denise. We are not producing surgeon specific metrics at this time, we are truly producing problematic specific. We have the surgeon, but we have not broadly shared that this time. But yeah.

Laura Maynard: I think – go ahead.

Denise Addis: We'd be willing to share our dashboard as the client ---

Laura Maynard: Oh that would be great. I know there is going to be a lot of interest in that as well so.

Denise Addis: Great.

Amy Sailor: We do have – the only specific surgeon metrics that we had and we've had since the beginning where how many patients went to class because we had some surgeons that were very engaged in having their patients attend and some did not, and unfortunately, our independent surgeon was one that did not see the need to send everyone. However, his participation almost doubled over the past five years in working with him and his patients in all of the other aspects that go into it. So we do share that with them but that's really the only patient specific one we have now, yeah.

Laura Maynard: Yeah and I am seeing in chat that Margaret is also saying that for them class attendance is a surgeon specific metric as well. So we can see if others have another surgeon specific metric that you do share with your surgeons feel free to type that into the chat box at this time and share that. And as we are sharing – yeah some requirements for the class, I am seeing some different comments come through,

another surgeon specific metric that is mentioned in chat is readmissions, any others feel free to put them in there. And as you are doing that I see that several are typing so yes as you are doing that we can share with that, we are going to move on and next, we are going to talk a little bit – we have mentioned that we are going to ask folks from Excela Health to share on CJR Connect and to put some of these tools that they have mentioned there on Connect for you to see and to find, and so at this point, Isaac is going to tell you a little bit about how to do that and how to find that.

Isaac Burrows: Yeah absolutely, thanks Laura. So I am actually going to jump on here and sometimes we think it's a good thing for us to actually get on and sort of walk folks through log-in into Connect and I will start doing that in one second. I think it's useful for folks to have an idea of – it's just – it's useful for a reminnder sometimes I do this for myself. So when you – since when you log-in to Connect as you will see you come in here, this is the home sort of chatter page, it's useful and you can see folks had been chatting even today on here and you can setup notifications. And I think one thing just to highlight for folks sort of the default you will notice here is posting to my followers. So for most people they have very few followers actually. So it's probably most useful to always sort of post to a group and then the group probably have – that you should probably be posting to a CJR if you wanted to go to everybody and we can all sort of jump on and chat about things and share it. So I just wanted the chance that kind of walk folks through that in terms of just posting that, and Laura, I will pass back you.

Laura Maynard: Thanks Isaac. And we do want to also show how you can get started on Connect if you don't have a Connect account and now you want to come and see these tools that are going to be posted from today's webinar. To request an account, go to the link that's posted on that slide, click New User and we will get you hooked up with a CJR Connect account so that you can see these resources as they are posted and carry on ongoing conversations with folks that are participants in CJR on not only this topic, but multiple other topics as well. I want to share some information about some upcoming events, we have some webinars coming up that you are going to want to mark your calendar and be sure to attend. Quality Office Hours next Thursday, the 27th at 2:00 and this is going to be a step-by-step guidance on the CJR's pay-for performance methodology. So we will be walking through the complications measure, the hospital consumer assessment of healthcare providers and systems, survey measure, patient reported outcomes, risk variable data, how the composite quality score influences participant hospitals net payment reconciliation amount, lot of great information will be gone through on this webinar. And there is an opportunity to ask questions, so you can submit questions in advance of the webinar by emailing LS-CJR@lewin.com and that will be on the next slide coming up or as you register there is an opportunity to submit questions for that webinar as well.

Then coming up on September 13th, we will be having a webinar on CJR patient reported outcomes and risk variable data submission for performance year two. So both of those will likely be of interest to your CJR team and we want to make you aware of them.

Here is that support address if you have any particular questions related to the model you can send them to that link and there will be a post-event survey popping up right now and will also be sent to you following this webinar and we would really appreciate your honest feedback on this survey. We use that information to improve these webinar sessions as we go forward. So we are right at the top of the hour. At this point, I will thank everyone for participating. Thanks all of you who participated in chat who asked good questions. Many thanks to our panelists who shared today, we appreciate your sharing from your hospital perspectives and we thank everyone for your attendance.