Comprehensive Care for Joint Replacement (CJR) Webinar

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PRESENTATION

Audrey Mitchell: Good afternoon everyone, welcome to the CJR 101 webinar, "Voluntary Reporting of Total Hip and Knee Arthroplasty Patient-Reported Outcomes and Limited Risk Variable Data." This is Audrey Mitchell with the CJR model team at the CMS Innovation Center. Later in the presentation, we will hear from Dr. Lisa Suter, associate professor of rheumatology at the Yale University School of Medicine and associate director for quality measurements of the Yale Center for Outcomes Research and Evaluation (or CORE).

Before we begin a couple of reminders, first as with all the CJR 101 webinars, we will provide the slides to all the participant hospitals via email after the slides have been made 508 compliant. And second reminder, we will be collecting questions through the Q&A function on the right side of your screen throughout the presentation. After we go through all of the slides, we will take a brief break and then we will return to the line to answer.

The agenda for today's webinar is as follows: first we will briefly review the CJR quality measures and pay-for-performance methodology, then Dr. Suter will present the key points on PRO Data Collection and then we will return to the line for that Q&A session.

We adopted two hospital-level quality measures in the CJR final rule. Those measures are the Hospital-Level Risk Standardized Complication Rate, Following Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty (or as we call it the complications measure for short) and the Hospital Consumer Assessment of Healthcare Providers and Systems (or HCAHPS) Survey measure. Hospitals participating in the Hospital Inpatient Quality Rule Reporting or HIQR program) are already familiar with these measures as they are implemented in the HIQR program already.

In addition to these two quality measures, we are encouraging the voluntary reporting of THA/TKA PRO (or patient-reported outcomes) and limited risk variable data, which is the focus of today's presentation.

In the final rule we also adopted a composite quality score methodology to link quality to payment. The composite quality score for participant hospitals is determined by performance and improvement on the two quality measures per the complications measure and the HCAHPS survey measure as well as successful submission of PRO and limited risk variable data. Please note that while successful submission of patient-reported outcomes data is included in the composite quality score, performance and improvement on the PRO data elements are not. Successful submission alone will determine whether a participant hospital receives additional points for the PRO data collection. For more information regarding the composite quality score methodology, please refer to page 73363 of the final rule, or the "Methodology to Link Quality and Payment" section. And we also encourage all of you to attend next week's CJR 101 webinar, "Quality Measures and Quality Composite Score." That will be held on Thursday, March 17, from 3:00–4:00 P.M. Eastern Standard Time.

As you can see here and as described in the previous slide, the composite quality score consists of quality performance and the complications and HCAHPS survey measures, quality

improvement on the complications and HCAHPS survey measures, and successful submission of PRO and limited risk variable data. Each component is weighted in the final calculation of the composite quality score. The individual scoring values that reflect the weights of each component are shown here. We will present the quality measures and composite quality score in more detail in next week's webinar, but this week we are focusing on the successful submission of PRO and limited risk variable data, which as you can see here can contribute two points to a hospital's composite quality score. We will explain what CMS considers successful submission later on in this presentation.

Why is the composite quality score important? The composite quality score is important because it is incorporated into the CJR model's pay-per-performance methodology. This is how the composite quality score links quality to payment. Based on the composite quality score, CMS will assign CJR participant hospitals to a quality category. Depending on their quality category, hospitals may experience a different effective discount percentage at reconciliation. For more information on the relationship between the composite quality score and the effective discount percentages, please refer to tables 19–21 in the final rule or we've included them also in the following slides. The relationship between the composite quality score and the effective discount percentages is important because participant hospitals with composite quality scores that place them in the "good" or "excellent" quality categories will either receive a higher reconciliation payment or have less repayment responsibility at reconciliation. In other words, the change in effective discount percentage experienced at reconciliation will provide a potential benefit to hospitals.

And here are those tables from the final rule. Again these are tables 19–21. Again these show the relationship between the composite quality score and the effective discount percentage. Note that the effective discount percentage also varies by performance year. We will explain the quality measures and the composite quality score in more detail during next week's webinar, which will be held on Thursday, March 17, from 3:00–4:00 P.M. Now I would like to hand the presentation over to Dr. Lisa Suter who will explain PRO data and the data collection requirements for the CJR model. Thank you.

Dr. Lisa Suter: Thank you Audrey. Before we cover the details of PRO collection for the CJR model, let's take a step back and remind ourselves why PROs, patient-reported outcomes, are so important.

How did we come to this bundled payment model that's incentivizing PRO collections? Total hip and knee replacement surgery, or arthroplasty, referred to throughout this talk as THA/TKA, are two of the most effective treatments modern medicine has to offer. Nearly all patients experience reduced pain and improved function from surgery. In fact, these are the single most effective treatments for advanced arthritis regardless of the underlying cause of arthritis. I still see patients once a week as a practicing rheumatologist and there is nothing I can offer my patients with advanced arthritis as effective as these two procedures and because of this, even though they are costly procedures they are highly cost-effective even at low-volume centers. Yet despite what they offer, we know the variation in both quality and cost exist.

So in order to capture all the good these procedures can do while eliminating unnecessary variations, it's very helpful for us to measure their value. As you are familiar, value is defined by outcome divided by cost. Michael Porter, the American Academy of Orthopedic Surgeons, and others emphasize the value is best defined by the customer, in our case the patient. PROs do just that and orthopedics is fortunate to have valid instruments that reliably capture the pain and function of patients undergoing THA/TKA procedures—the very outcomes most impacted by these surgeries. PROs provide both patients and providers with objective data to help them understand the benefits of their surgery.

Because they can help with best patient status before and after surgery, PROs offer a critical tool for quality improvement. They enhance provider-patient communication and they strengthen the patient-physician relationship. By allowing identification of those practices associated with the best or worst outcomes, PROs provide important support for practice improvement. And finally, they can be used to enhance both pre-operative shared decision-making and post-operative monitoring.

Further, focusing on PRO collection now during this CJR model will help you and your hospital prepare for the future. Orthopedic and quality leaders support the integration of PROs into clinical care and performance measurement. PRO measurement and collection aligns with CMS's future direction of reporting patient-reported outcome based performance measures (or PRO-PM). Engaging with PRO collection now will give you a head start on building your PRO collection infrastructure. You will also be helping to inform development of a hospital-level, risk-adjusted PRO-PM for elective primary total hip and total knee replacement procedures—an early step towards future PRO-based Federal measurement programs in orthopedics and beyond.

And last but not least, successful PRO collection factors into hospitals' CJR composite quality score calculations. Each hospital can earn a two-point increase in composite quality score points. Plus your hospital will receive recognition on *Hospital Compare* that you submitted PRO data, a public acknowledgement of your hospital's patient-centered focus on quality.

Now that we've established that collecting PROs offers many advantages, let's review how PRO collection will impact your CJR reconciliation and repayment amounts. As Audrey noted above and as indicated by the circle triangle, the successful submission of PRO and limited risk variable data can contribute two points to a hospital's composite quality score. These two additional points can help boost your hospital's composite quality score into the "good" or "excellent" quality categories, enabling them or you to either receive a higher reconciliation payment or have less repayment responsibility at reconciliation due to quality.

Next let's review which patients are eligible for PRO collection. Eligible patients for the voluntary PRO collection are those Medicare beneficiaries aged 65 or older undergoing elective primary total hip and total knee procedures. This excludes patients with hip or pelvic fractures, bony metastases, and those undergoing revision, resurfacing procedures, or partial hip replacement procedures. Although you will not need ICD-10 codes to identify eligible procedures, we have listed them here as an additional resource for you.

Although it's hard to read on the slides, we have prepared a flow chart to help you identify eligible patients at the point of care. This flow chart walks you through each inclusion and exclusion criteria so you can easily identify elective primary hip and knee replacement procedures at your institution. This flow chart, as well as other resources on PRO collection, will be available for download at the CJR Connect website soon.

The next step needed for identifying eligible patients is to know what time periods are for the eligible procedures in each model year. This timeline shows the five years of the CJR model from top to bottom on the vertical axis. The calendar years are noted on the horizontal axis. As noted on this timeline, only elective primary hip and knee procedures performed between July 1, 2016 and August 31, 2016 (the orange line noted in the upper left-hand corner) are eligible for model Year 1 PRO collection. Eligible patients for model Years 2–5 are listed in red, blue, green, and pink respectively in each subsequent model year.

Next we'll review what data are required and when hospitals need to submit the data to CMS. Before each eligible elective primary hip and knee procedure, pre-operative PRO and risk variable data must be collected. These data include one generic PRO survey and one hip/knee-specific PRO survey. It also includes risk variables previously identified by orthopedists for PROs. After each eligible elective primary hip and knee replacement procedure, the post-operative PRO data includes just the generic and hip/knee-specific PRO survey. All of the PRO surveys that you can use for the model are non-proprietary and require no additional cost to obtain for each hospital. Further, we are asking hospitals to submit patient identifiers to be included with each data submission that will allow linking across pre-and post-operative data.

The pre-operative PRO data needs to be collected between 90 days prior to surgery and the day of surgery and consists of either the VR-12 or PROMIS-Global, these are the generic surveys. Plus, for hip patients, either the HOOS Jr. survey or the listed HOOS subscales pain and function for daily living, and for knee patients the KOOS Jr. or the listed KOOS subscales stiffness, pain, and function. This totals as few as 16 questions for hip replacement patients and 17 patient-reported questions for knee replacement patients.

We are also asking hospitals and providers to submit a few key risk variables and patient identifiers with the pre-operative data. The risk variables do not need to be collected post-operatively.

The post-operative PRO data needs to be collected between 270 and 365 days after surgery and consist of the same PRO data collected pre-operatively. For example, if PROMIS-Global and HOOS Jr. forms were collected on a patient before surgery, these must be collected 9–12 months after surgery. No additional risk variable data are required post-operatively.

Again, this timeline shows the five years of the CJR model from top to bottom and the calendar years are noted on the horizontal axis. As noted before, only elective primary hip and knee procedures performed between July 1 and August 31 of this year, 2016, are eligible for model Year 1 PRO collection. Procedures performed between September 1, 2016 and June 30, 2017 will be eligible for PRO collection in model Year 2.

The data collection period for those two months of THA/TKA procedures, meaning the pre-operative data, is April 1, 2016 to August 31, 2016. And the pre-operative data collection timeframe is shown in the double orange line on this graph. Similarly, the other double lines in red, blue, green, and pink demonstrative the pre-operative data collection timeframe for the subsequent model years.

For post-operative data collection, the data collection period for model Year 1, THA/TKA procedures, is April 1, 2017 to August 31, 2017, shown by the dotted orange line. These post-operative data will then be submitted during model Year 2 and will apply to that year's quality score.

This slide lists the PRO data submission deadlines for each model year. All PRO and risk variable data for model Year 1 must be submitted by October 31 of this year, 2016. For model Year 2, the deadline is October 31, 2017. In subsequent model years, 3–5, the deadline shift to August 31.

To fulfill successful PRO data submission for model Year 1, hospitals need to submit the data elements as finalized in the CJR final rule on at least 50% or 50 cases among all of their eligible hip and knee procedures. For example, a hospital with 20 eligible hip or knee replacements cases between July 1 and August 31 of this year would need to submit data on at least 10 cases or 50% of their patients. In contrast, a hospital with 1,000 eligible hip or knee replacements cases between July 1 and August 31 would need to submit data on at least 50 cases. They are welcome to submit more than 50 cases but the requirement is 50% for 50 cases.

Successful PRO data submission requirements for subsequent model years will increase incrementally as shown on this slide. In model Year 2, hospitals will need to submit PRO data on at least 60% or at least 75 eligible cases and so on.

The last two slides will provide an overview of how hospitals will submit their PRO data to CMS. We have created a PRO data collection template file to submit data to CMS via a QualityNet Secure Portal. This template allows hospitals to populate Excel worksheet with the required PRO and risk variable data for successful submission. The data variable names in the template are all described and defined in an accompanying data dictionary, which we will describe in a bit. The PRO data collection template will be fully customizable for each hospital and/or surgeon. You will be able to select among drop-down menus using the customization tool for procedure type, hip or knee replacement, pre-operative or post-operative collection timing, as well as the individual PRO surveys your hospital is interested in collecting.

As you can see in this screenshot of the data customization tool, you can click on each drop-down menu to customize the template for your patient. This example is a patient who underwent total hip arthroplasty and is coming in for a post-operative visit and data collection. This patient will be completing the HOOS subscales.

This is a screenshot of the actual data entry worksheet. Once the template has been customized, you will enter each patient as a separate row. Cells that are not applicable (for example, risk variable fields for a post-operative patient) will be blocked as illustrated by the gray not-applicable cells in this screenshot.

The data dictionary is a supplementary file that provides a comprehensive list of required data elements. It serves as a complementary resource to accompany the PRO data collection template. It cannot be used for data entry or submission. Its Excel worksheet tabs provide guidance on the PRO collection process, data specifications including the variable names that are listed in the template, and they can be cross-walked to the actual template. In addition, it contains hyperlinks to the relevant PRO survey instruments.

This is a screenshot of the data dictionary worksheet post-operative IDs, which details which identifiers are required at the post-operative data collection timeframe and how those post-operative data collection identifiers are defined. For example, the health insurance claim (or HIC number) is an 11-digit alphanumeric patient identifier to be collected both pre- and post-operatively.

This is a screenshot of the data dictionary worksheet HOOS Jr., which details the specific HOOS Jr. questions as well as when they are collected and how they are defined. For example, the amount of pain a patient is experiencing going up or down stairs is coded as 0 (none) to 4 (extreme pain) at both pre- and post-operative time points.

The QualityNet Secure file transfer will utilize hospitals' existing QualityNet accounts to provide a mechanism for securely exchange files containing sensitive information, including the identifying PRO data. In model Year 1, hospitals will submit data using the PRO data collection template and route the files to the Yale-CORE group on QualityNet.

In summary, collecting PROs offers both clinical and financial benefits to hospitals and patients. The requirements for model Year 1 PRO collection are lower than in any subsequent CJR model year. We are eager to support and assist hospitals interested in collecting PROs. Please stay tuned for webinars and other materials describing successful approaches to PRO data collection. I'd like to hand this microphone back to Audrey Mitchell now to wrap up. Thank you.

Audrey Mitchell: Thank you Dr. Suter. If you have any questions please refer to the following resources on the CJR website or contact the CJR participant support mailbox, which is CJRSupport@cms.hhs.gov.

In addition to the resources listed on the previous slide, CJR participants that provided CMS with points of contact received an invitation to the CJR Connect website. CJR Connect is a Web-based knowledge-management collaboration platform to help hospitals learn about the CJR model and enable their success to model through things like facilitated peer-to-peer learning, exchange of information, and sharing of promising practices. To begin using the CJR Connect site, verify your account by clicking on the link. The link should be in the invitation email you received from Salesforce.com. So again, to begin using the CJR Connect site, verify your account by clicking on the link in the invitation from Salesforce.com. We will provide additional information about the CJR Connect site, including how to use the site and how to access the resources on it in future CJR 101 webinars. The next CJR webinar, "Getting Ready for April 1st: What You Need to Know," will take place on March 15 from 3:00–4:00 P.M., and on March 17, as we mentioned before, we will be hosting the "Quality Measures and the Composite Quality Score" webinar, also from 3:00–4:00 P.M.

Thank you all very much for your attention. We will now begin the Q&A session of the webinar. Please submit questions through the Q&A function if you have not done so already. We're going to pause briefly and then return to the line. Thank you.

Q&A Session

Audrey Mitchell: Thanks, everyone, for your questions. The first one that we've gotten several questions on is how to get the slides and the registration information for those upcoming webinars. So just as a reminder, CJR hospitals must provide CMS with points of contact, and those points of contact, those email addresses, are how CMS will send you the slides and transcripts and all the registration information for the webinars via email. If you have any questions about that process, again, please send an email to the CJR support mailbox.

Another question that came in is, "How will we receive the PRO templates?" CMS will be working directly with the model participant hospitals in the coming weeks to provide those tools for the collection of the voluntary PRO and risk variable data, including the file transfer templates and the data dictionary. Those will be shared via the CJR Connect website, which I mentioned on the last slide. Just another reminder to please verify your account with Salesforce so we can access the CJR Connect site.

And I see a question: "Neoplasm is not excluded from CJR but is excluded from the PRO requirements." And they're asking for clarification. Dr. Suter, do you mind taking that question?

Dr. Lisa Suter: Audrey, I'm happy to take that question. So as people may recall from the proposed rule, there was a broader cohort proposed for the CJR model than what was finalized in the CJR final rule. In fact, hip fractures were removed from the final CJR cohort. I think it's important to recognize that when we're thinking about capturing payments and we're thinking about capturing PROs, it was really important for both groups to identify the appropriate group of patients for each of those aspects, and it's not always an identical set of patients. So, for example, the PRO collection cohort was harmonized specifically to be consistent with a complications measure to the extent possible, but it has some conditional exclusions that we think are probably legitimate for a survey that requires patients to fill them out. And so I think it's important to understand that while they're capturing a group of patients, the consistency between the quality measures and the bundled payment calculation may be slightly inconsistent to acknowledge the differences in needing to identify a particular sub-group of patients in order to do accurate quality measurements, such as with the complications measures, and the PRO data collection reflects that.

Audrey Mitchell: Thank you. And we had several questions asking for a clarification on the 50 cases versus 50%. We went through it on the slides, but Dr. Suter do you mind going over that again?

Dr. Lisa Suter: I'm happy to go through that again. We understand from hospitals that collecting PRO data is challenging, particularly for hospitals that have never collected this data before. So we wanted to incentivize data collection that would not penalize lower volume

hospitals because we think that PRO collection is valuable regardless of the number of procedures that you're doing. So we wanted to give hospitals a choice, and we gave them a choice between a percentage of their patients and an absolute number of patients. In the examples that we gave, we gave an example of a hospital that had 20 eligible patients between July and August of this year, and they need to submit a minimum of 10 cases for successful data submission. They can submit more, but to meet the successful data submission requirement, they need 50% of their patients. They don't have 50 patients, so they can only use the percentage.

We also gave an example of a hospital that has 1,000 eligible elective primary hip and knee replacements between July and August—so a very high-volume center. That center has an option of submitting, again, either 50% or 50 cases. At a minimum, they need to submit 50 cases. They're welcome to submit more, and obviously in any of these situations you are welcome to collect PRO data on any of your patients; we do not want to restrict your collection, but we're only asking you to submit data on this narrow group of eligible patients we defined earlier.

Audrey Mitchell: Thanks. So the next question we received is about how some of the BPCI participants are considering switching to CJR, and, "Can a current BPCI participant located in a CJR MSA request CJR baseline and target pricing data?" And to answer that question I'm going to turn the line over to Claire Schreiber, who is the CJR model team lead.

Claire Schreiber: Thank you, Audrey. To clarify, we've received a number of inquiries from hospitals or other healthcare providers who are currently participating in BPCI and wondering whether, given the different quality requirements between the two models, if they can access CJR data in order to inform their potential decision whether or not to stay in BPCI. We just want to clarify that under the regulations in the CJR final rule, the baseline data as well as the ongoing data, both the line level and the summary claims data, is only available to CJR participants. That means that a hospital or other organization that is currently participating in BPCI cannot have access to CJR data. However, if the hospital or other organization—in this case it would need to be a hospital—is no longer in BPCI and is located in one of the MSAs in CJR, they would be able to then request that CJR data. However, we are not able to provide the data prior to them being in the model.

Audrey Mitchell: Thanks, Claire. And then there was a question about the quality incentive differing by performance year. The quality incentive does differ by performance year depending on whether a hospital is eligible for reconciliation payment or responsible for repayment to Medicare. The effective discount varies by performance year and the quality category, which we went through briefly in this presentation and will explain in more detail on the March 17 webinar, but participant hospital with the scores that will place them in "good" or "excellent" will receive a higher reconciliation payment or will have less repayment responsibility because of the decreased effective discount percentage at reconciliation.

And the next question for Dr. Suter: "Can you please give more detail on the risk variable?"

Dr. Lisa Suter: Yes. So two things: I wanted to correct a miscommunication that I made earlier about fracture patients that we've already received Q&As [about]. The attendee is correct; fracture patients are not excluded from the Bundled Payment program model. They are assigned

a different payment. So they are included, but the payment calculation acknowledges that fracture patients are more complex and complicated patients. I apologize for that misinformation.

In regard to the risk variable, we have spent a number of years working with the orthopedic community in efforts to develop this patient-reported outcome-based performance measure that is still underdeveloped and the data from the CJR model is going to inform that measure development. And during all of those conversations, it was very clear to us that it is important to capture risk variables for patient-reported outcome base measures in orthopedics that are not necessarily captured in administrative claim data or sometimes not collected even in EHR data but might be collected by physicians in their communications or evaluations of their patients, or perhaps elements that are patient-specific and not necessarily commonly collected at all. So we spent a lot of time speaking with orthopedists and a technical expert panel and had multiple public comment periods to invite stakeholders to give us advice as to what were the most important risk variables for thinking about adjusting for patient-reported outcomes for orthopedic procedures such as these.

And the risk variables that were identified and prioritized included two musculoskeletal risk variables, one that identifies pain in the non-operative hip or knee or other hip and knee joint, so non-operative lower extremity joint pain, and the other is patient-reported back pain. And we feel that these are both important risk variables because you can imagine that their pain or function after hip or knee replacement surgery may well be impacted by arthritis in a different joint that's not being operated upon. The other risk variables that are determined and are important include body mass index, preoperative use of narcotics, a patient-reported health literacy questionnaire, race and ethnicity—we'll be collecting age, but we can use that information through the identifier, and we're also including information about how the data was collected. And that's based on the experience from the age cap survey that adjusts for the mode of data collection because in their experience, if you're collecting by telephone, or by mail, or in person, you have a different likelihood of responses. For us these were the bare minimum risk variables that orthopedists and others in the field felt were critical to collect. We did not want to burden patients and providers. As much as possible, we wanted to minimize burden.

The other thing that we are going to be doing in developing our eventual measure is we're going to be linking the data to administrative claims data. So while we're not asking you to submit comorbidity data, we'll be able to capture comorbidity data, including smoking status, history of lung disease, and any other innumerable comorbid diagnoses or prior procedures or prior hospitalization—we'll be able to capture that using administrative data, and we decided that we would prefer to capture that information using administrative claims data in order to minimize the burden on hospitals, providers, and patients. Please submit additional questions if there are further questions about risk variables, and certainly there's additional information in the final rule.

Audrey Mitchell: We received the question, "What if your hospital does not perform hip or knee replacement surgeries?" I'm going to turn it back over to Claire.

Claire Schreiber: Thanks, Audrey. So we've received a question from several hospitals that are located in the MSAs that will be in the model. And we understand that not all acute care

hospitals perform hip or knee replacements or other major leg procedures that are included in the MS DRGs 469 and 470. However, because the parameters of participation in the model are based on physical location or the location of the CCN, which is a Medicare provider number, in one of the MSAs for the model, and we've identified that all acute care hospitals that are paid under the inpatient prospective payment system, or IPPS, would be required to participate in the model. We've identified those hospitals that would be in the model, which is posted on our webpage, but we've identified those hospitals by their CCN number. So we understand that some hospitals may not do these procedures. However, we are still reaching out to those hospitals to ensure that all hospitals that would fall under the CJR regulation, or the regulations laid out in the final rule, have the necessary information and all of the necessary background information to comply with the rule.

That said, we understand that some hospitals may not be active participants in the model per se. However, should they do a lower joint replacement, that would technically be included in the model, so we do need to ensure that we have a point of contact for each one of those hospitals just in case they do change practice later on and also so that we can ensure we have a record of somebody at each hospital. And also in relation to the quality measures, we understand that for the PRO data, it would not apply to a hospital that does not do these procedures.

Audrey Mitchell: Thanks, Claire.

Dr. Lisa Suter: Hello, Audrey. This is Lisa. I have a couple questions that I'd like to answer. Is that okay?

Audrey Mitchell: That's great. Thank you.

Dr. Lisa Suter: One of the attendees asked if eligible hip and knee replacement procedures that are performed between April 1, 2016, and June 30 of 2016 need to have PRO data collected, and the answer is no. Only procedures performed between July 1 and August 31—that's the only period of time where a procedure is considered eligible. Now because a patient who undergoes a hip replacement or a knee replacement on July 1 can have PRO data collected up to 90 days before their procedure, the preoperative data collection period extends to April 1, but it's only relevant to those procedures performed during July and August, which is why there's a little bit of syncopation.

And actually we've had the request to go back to slide 27. Are we able to reverse the slides back to slide 27? Great. Thank you. Again, this is our timeline slide. We have the model year on the vertical axis and the calendar year on the horizontal axis. This is a complex slide, and it is a complex process. We're trying to make this as simple as possible, but we understand that it is not intuitive. I'll just review that the solid lines represent the time period where if a patient undergoes an eligible procedure, those are the group of patients you want to focus your data collection on.

So for Year 1 in the orange, it's July 1 through August 31; for model Year 2 it's September 1 of this year through June 30 of next year; and then starting in Year 3, it's a July 1 to June 30 12-month cycle. Because we started not on January 1 this year and we wanted to give hospitals

additional time and we needed to give you time to collect preoperative data well in advance of surgery if you wanted to, the first year of the model only has two months of eligible patients.

The next piece of information on this slide is the double yellow line. And the double yellow lines are the time periods during which you're going to be collecting preoperative data on that solid yellow (or orange) line's group of patients. So for Year 1 that's April 1 through August 31 because as I said before, if you're getting your procedure on July 1, you've got 90 days before July 1 to collect data on that patient. Many hospitals are going to collect it on the day of the surgery, but we want to give you flexibility to collect it up to 90 days in advance, and if you have a patient getting their knee replacement or their hip replacement on August 31, you can collect data up to that specific day. So the preoperative data collection time frame in that double orange line is April 1 through August 31.

Similarly, in the next years, you've got those double line time periods that show you the preoperative data collection period for the patients in the subsequent model years. And that's all that's required for this year. You are not required to collect post-operative data and submit that for Year 1 because your patients won't have had enough time after their surgery by the October 31 deadline this year to submit their data.

We had a question as well about the difference between a performance year and collection period. It works out to the same date. So the submission date for those yellow patients in that graph is October 31 of this year. Your submission date for the data in 2017 will be October 31 again. And then as we finally shift over to a 12-month July to June schedule, the data submission deadline will move up to August 31 in Years 3–5.

The final piece of information on this slide is the post-operative data. We've provided arrows connecting each model year's patients to their post-operative data collection period. So for Year 1, for those two months' worth of patients in July and August, you're going to be collecting post-operative PROs between April and August of next year, 2017. That data obviously isn't available to submit for Year 1, and it will be submitted with your Year 2 data. So next year, if you submit PRO data, you'll need to submit preoperative data on the patients in the red line, September 1 of this year through June 30 of next year, plus the post-operative data on your hip and knee patients that you collected preoperative data in model Year 1.

We know it's complicated. We are going to make these timelines available for your so you can have them available at your disposal, and we'll also make available the data submission timeline as well.

There was another question about sampling. You are welcome to sample the patients. Say the hospital that was doing 1,000 patients and that hospital decides only to submit 50 patients with PRO data, you can sample whichever patients you want to. You are not being measured on the results of the PROs. And I would encourage hospitals who are trying to collect PROs to try to engage a diverse group of patients. We want to try and understand PRO data across the type of patient, their background, their medical history—all those aspects. We encourage you to sample as diversely as possible among your patients, but we are not going to ask you to sample a specific fraction. You are able to pick the individual patients that you submit data on. Reminding

again that we are not actually measuring you on the results of those data. We are just asking you to submit the data. There's no measurement of the results of the PROs.

Audrey, are there additional questions that you would like me to field?

Audrey Mitchell: No. Thank you so much. I would like to go into just a couple questions that we'd like to answer. First is regarding support for CJR Connect. Please, if you have any questions about CJR Connect or if you are having any issues with verifying your username, please send an email to CJRSupport@cms.hhs.gov. That's the support mailbox, and we'll be able to help you with any questions that you have. In addition, just a reminder that the slides will be shared with the participants in the coming weeks after. We just have to do some processing of the slides; they have to be made 508 compliant, and then they will be shared via email. So please be on the lookout for that. That will be the slides and the transcript. And the registration links for all the upcoming webinars will come to you via email as well. Those would come from CJRSupport@cms.hhs.gov. With that, thank you all so much for your participation. We really appreciate it. And thank you so much to Yale-CORE. Have a great afternoon.