Peer-Led Care Navigation Affinity Group Session Two
Listen to the Recording Here

Jacqueline Higgins: Good afternoon everyone. On behalf of the CJR model team at CMS, I would like to welcome and thank you for joining the second session of the CJR Peer-Led Care Navigation Affinity Group. Today's webinar will include a review of the Affinity Group goals, a presentation from Hackensack Meridian Health Mountainside Medical Center, and opportunities for discussion on navigating care for fracture patients. I'm now going to turn it over to Ms. Laura Maynard to walk you through additional introductions and logistics. Laura.

Laura Maynard: Thank you, Jacky. This is Laura Maynard with the CJR Learning System Team and I'll be co-facilitating today with Kathy Woods, and also with our peer leaders, Jody Harclerode from Geisinger Holy Spirit Hospital and Dawn Rakiey from University Medical Center.

Today we will cover some logistics to get you oriented to the webinar platform. Then we'll do a quick review of our Affinity Group goals. We'll talk a little bit about the Charter and Commitment Statement and then we're going to have a presentation, so we'll be looking forward to hearing from Shibani Gupta from Hackensack Meridian Health Mountainside Medical Center. She's going to be talking about managing fracture patients. Then we will have a lot of time for open discussion and reflection, so have your questions ready, have your comments ready. Be prepared to share both in the Chat pod and by speaking verbally. Currently, all the phone lines are muted, but they're going to be unmuted during discussion time. Following the presentation, we'll unmute all the lines and at that time you'll be able to speak right up and make your comments and ask any questions you have. Of course then we'll close out with our announcements and reminders at the end.

We encourage you to do that. We also encourage you to type into that Chat pod so that folks can see what you're saying and who you are with. I want to mention that the Center for Medicare & Medicaid Services, its employees, agents and staff assume no responsibility for any errors or omissions in the content of this webinar. CMS makes no guarantees of completeness, accuracy or reliability for any data contained or not contained herein. CMS shall not be held liable for any use of the information described and/or contained herein and assumes no responsibility for anyone's use of the information. CMS does not endorse any strategies, tactics, or vendors referred to in this webinar. The views and opinions expressed in this webinar are those of the participants and do not represent the official policy or position of CMS.

For participation on this webinar platform, it's very familiar to many of you, I know. Under the slides is the closed captioning. Just to the right of that are the event resources that you can download. You'll see that we have the Charter and Commitment Statement, the slides for today, different resources there in that pod, including the short bios for our peer leaders. Then to ask questions or send messages, you can use that Chat pod that says "Chat (Everyone)" at the top. If you type into the white box, click the little bubble beside it and your posts will show up and everyone will be able to see it. Dial in information is just above that.

Let's start out with a little bit of practice on using that Chat pod. Go ahead and type in your organization and something that you hope to learn from today's discussion. So something related to the management and care of fracture patients. What would you like to learn? What are you hoping to gain from this? So type into that Chat pod now, share your organization and something that you're hoping to

learn today. While you're doing that, we're also going to go to our map and see where everyone is located. So remember that to use the map, you want to kind of grab the map with your mouse and drag it over near where you are. For most of us that'll be North America, I believe. Then, you can make it larger by sliding up the bar to make the area larger to find where you are. Then, click on that little purple pin and you can drag it to your location. Take a moment and drag yourself onto the map. Once you've done that, you can go ahead and continue introducing yourselves in Chat.

Let us know your organization and what you're hoping to learn today. Okay, I see us beginning to show up all over the map. Just another moment. It's always interesting to see the distribution, there are so many from everywhere all across the United States. Just another minute.

Okay, thank you all for participating in that map feature so that we can get a look at where we all are. As we transition back to our slides I'm going to turn it over to one of our peer leaders, Jody Harclerode, to talk a bit about the goals of our group.

Jody Harclerode: Thank you, Laura. I just want to review the goals of the Affinity Group. You can download these in the resource section if you would like. Our goals are to convene once every two months to share care navigation and care coordination tools and resources. We want to discuss successful strategies, challenges and lessons learned and we want to learn from each other, learn from our peers. We want to further enhance communication and collaboration amongst care navigators and coordinators established by the CJR Care Navigation Affinity Group and communicate weekly on CJR Connect.

I'm not going to read this to you. This is something that you can download. This is our Charter and it is in the event resources section of the presentation today as well.

Laura Maynard: Thanks, Jody. Now, I'll move to a poll that's going to speak to a piece of your Charter, which is your Commitment Statement. We're going to launch a poll and we would like for you to click on all that apply. In the past two months, which of these things have you done? Does all this apply to you? Have you participated in Chat in the Affinity Group? Have you spoken up verbally in this Affinity Group? Have you shared a tool or a resource with a CJR peer? Have you communicated by email with one of your peers? Have you logged on to CJR Connect? Have you posted or commented on Connect? Or, have you not engaged yet, but you plan to in the future? Click on all the different things you've done in the last two months so we can get a sense. All of these things are sort of referenced in that Commitment Statement. That's a part of our group Charter where we just agree that we're going to communicate with one another. We're going to share ideas, ask each other questions and talk together.

Give this just another moment for everybody to click. Again, you can click as many of them as you've done.

All right looking good, looking good. Okay, so we'll go ahead and close out that poll. It looks like a good number. More than half have logged onto CJR Connect. That's wonderful to hear. That's a great place to chat with your peers, to upload resources and share those resources with your peers, and also to download resources that others have posted.

Jody Harclerode: It's my privilege to introduce our next speaker to you. Shibani Gupta is the Director of Transitional Care at Hackensack Meridian Health Mountainside Medical Center. Shibani is a licensed

occupational therapist and has 19 years of experience in the healthcare industry. In her current role, she is responsible for managing the CJR program for a 365-bed hospital. She's also responsible for managing 13 bundled payment models in which the hospital participates. Shibani has oversight of the transitional care unit within the hospital. Thank you, Shibani. Welcome.

Shibani Gupta: Thank you, Jody. It's my honor to speak at this forum. Mountainside Medical Center is a community-based hospital in Montclair, New Jersey. We're right in northern New Jersey and looking at some of our data from 2018, we were sending 90 to 95 percent of our patients to either a skilled nursing facility or to an inpatient rehab facility. The average length of stay for those patients was about 28 days. Now bear in mind, some of those patients probably stayed in the skilled nursing facility over 60 days and we had a 27 to 28 percent readmission rate. It was clear that we needed to take a different approach to managing the fracture patients.

One of the things that we looked at is, although part of the CJR program, the fracture patient is different, right? It's not a planned event so it is not an elective surgery. The patient has not had the opportunity to participate in a joint class, attend any type of prehab or the family had time to provide any type of support or line up a post-surgery plan. The social supports for the fracture patients really determine the successful outcome of the patient and the resulting success in the CJR program. Usually a patient with a fracture is somebody that has had a combination of multiple comorbidities that ultimately landed them in the hospital with a fracture.

When we pivoted our program, we took a true multidisciplinary approach to the program, engaging multiple levels of caregivers and most critically the physicians – the orthopedic doctors and the medical doctors. For the purpose of this presentation, when I think of a fracture patient I don't think of the well elderly patient that was picking up their newspaper, tripped and fell and fractured their hip. I'm really thinking of that 89-year-old patient who's living likely alone with some level of dementia and stopped perhaps feeling well, maybe varied from their medications, stopped eating, became dehydrated, fell, and now ultimately ended up in our ED. That's really the patient that I'm thinking about who requires a different level of medical management in addition to the orthopedic management. There are a lot of comorbidities associated and management of the comorbidities is almost as important as management of the orthopedic condition.

Part of our multidisciplinary team is not just the inpatient team, which includes the physician, the case manager, the ED team, the physical and occupational therapist within the hospital, the social worker, and transitions of care, but we also include the skilled nursing facilities and the home health care because their goals have to be aligned with our goals.

I'll fast forward a little bit. When a patient shows up in the ED, the ED case management team notifies the orthopedic CJR team within the hospital. That allows us to have early intervention. It allows a physical therapist to run down to the ED and meet the patient or the family, interact with the physician, with the orthopedic doctor on their approach to managing the patient. It allows the case manager to start talking with the patient and their family so that we can begin discharge planning right on admission.

After surgery, physical therapy is initiated on postop day zero or postop day one to promote early mobilization. If the patient comes up to the unit in the evening then the nurses get the patients out of bed, ambulate them or at least dangle them at edge of bed. We do try to place all of our fracture patients on the orthopedic floor so that they are managed by the CJR team there. We provide daily

physical therapy treatment, usually BID, and we try to provide occupational therapy in addition to the physical therapy treatment. Especially for that fragile fracture patient with the multiple comorbidity, it's incredibly important for them to receive not just ambulation but also their daily living skills.

One of the things that we are looking at is that inpatient length of stay typically tends to be a little bit higher for the fracture patient and we're really trying to see if that inpatient length of stay being a little bit longer may have a better outcome, ultimately because we have the opportunity to address comorbidities that the patient has. Again, that patient that fell because their blood pressure wasn't stable, the medical team might take longer to address that and ultimately have a lower risk of readmission.

Discharge planning, of course, starts as soon as the patient comes to the ED. While our preference is for homecare, for the patient to go home with homecare, and it is a discussion that we have ongoing with the patient and their family, each member of the multidisciplinary team is assessing the safety of that patient returning to their home environment. Support at home is a big major factor. If the patient is going to go home with family support then we certainly encourage going home with homecare, but in many cases we do find that the patient that comes in with a fracture and other comorbidities may require a post-acute stay. We have pivoted some of our care management in providing next site of care guidance from what I used to call a concierge model, where the family really drove where the patient was going to go based on their dynamics, to really more of a clinically-driven model. What the care team feels is going to be the best next site of care is what we recommend to the family as a team and individual departments.

We really had to keep the patient and the family at the center of managing the fracture patient. Setting realistic expectations is so critical because many times the patient may have been living in the community alone, may have actually been responsible for helping their family members with childcare and whatnot and this is a traumatic event for the family. It is unexpected and many times the family sees this as a time when their loved one needs TLC and not aggressive PT and they expect a longer length of stay. We really try to work with the family individually to set realistic expectations and say, Mom may and may not get back to her prior level of function, but we do need to start planning for her discharge.

We frequently find that a family conference is beneficial in providing families with multiple options, so beyond the hospitalization, beyond post-acute care, and beyond homecare. We also try to set length of stay expectation for post-acute care. We really try to convey to them that going to a rehab facility, to a skilled nursing facility, is not going to be the magical answer. While Mom may benefit from 10 to 14 days of intensive rehab, that's really their opportunity to plan for where Mom will ultimately benefit from being in the long term. I try to educate them to come up with options A, B and C – option A being Mom recovers really well and she is able to go home and resume her activities of daily living, but option B might be that she may need increased support at home from family or we recommend agencies that have aides to support and supplement homecare. Also, to plan for another option if Mom is not able to return home and needs to go to an alternative location.

For the patients that need to go to post-acute facilities, we utilize our preferred provider network or skilled nursing facilities. Since we are in bundles with other diagnoses, we have a strong post-acute network that we're able to utilize to communicate with them. When our patients are scheduled to go to post-acute facilities, we provide communication to the case manager, to the physical therapist, and to the social worker at the post-acute facility so that we can communicate some of the dynamics that we

have experienced and communicated with the family and they continue to hear the same message when they go to the post-acute facility.

We also set rehab expectations for continuity of treatment from the hospital to the post-acute facility. Again, if the patient was ambulating 50 feet at the hospital, we want them to continue that progress and not regress in any way. Some of the expectations we have from the skilled nursing facility is that they also, just like us, begin discharge planning on day of admission, so we have an expectation of the 72-hour meeting with the family so that they can progress towards discharge planning. Again, that does tie back to that expected length of stay.

One of the other steps we take is facilitating an early discharge from the hospital to the post-acute facility. I'm not sure about other hospitals, but for our hospital we have patients that went to skilled nursing facilities that typically went between 4:00 and 6:00 p.m. and I just really don't know what the purpose or reason for that was. But we pivoted that to getting patients to skilled nursing facilities before 11:00 a.m. and that really helped settle them into the facility and most importantly receive physical therapy on the day that they get to the facility, so that's been an initiative as well.

A quick note on our performance network. I mentioned that we have a performance network with about eight facilities. While we consider the CMS five-star rating as being important, it is not the only driver of our performance network. I really try to see which facilities have strong rehab and nursing programs because that is ultimately what leads to successful outcomes for our patients. I also look for consistency in leadership and facilities that have strong communication and collaboration initiative. From a homecare standpoint, we have onsite homecares at the hospital and we try to utilize the same homecares when the patient goes to the post-acute facilities. Again, it allows for that continuum.

A quick note on overall transitions of care for the fracture patient. Having the preferred provider network allows for a streamlined and effective transition process – our expected length of stay communication with them. The facilities have a designee that we're able to communicate with in real-time by phone or by e-mail and that's very effective if I need to send a quick note or they need to communicate back with us once the patient gets to their facility and they have questions.

Post-acute follow up, so once a patient does go to the SNF we follow the patient's progress remotely, usually on a weekly basis. I communicate with the post-acute facilities on outliers. If a patient is progressing, meeting their goals and scheduled to return to their community within the expected length of stay, that's great. But, every once in a while we do have patients that develop some sort of complication and need an extended length of stay and we talk about that by phone. I also try to get to the skilled nursing facilities within a quarter to visit.

After patients leave the post-acute facilities, we follow the patients via phone call for 30 days. For all patients that leave our hospital, we follow patients for 30 days by phone. For our hospital, we utilize a company that does 30 days follow-up for all our patients. For the patients that go to skilled nursing facilities we found that it was important to follow those patients once they leave the facilities as well. The main goal for that is to get the patients to their PCP within seven days, especially patients that have undergone surgery and again may have multiple comorbidities that need to be followed up on. It's important to get them to the PCP within seven days so that they don't return to the hospital.

Some next steps and considerations, so as we've changed this process early in 2019, some of our preliminary results show that we're sending less than 40 percent of our patients to skilled nursing facilities with a majority of them returning home with homecare. We have almost zero utilization of inpatient rehab facilities. Our average length of stay for the few patients that do go to skilled nursing facilities is 22 days and over 75 percent of our patients are going to a facility within the performance network.

Some of our considerations and areas for improvement that we're looking at is increase in OT orders in the hospital. Typically most patients have a standing order for physical therapy, but we strongly feel that adding occupational therapy to the standing order set for fracture patients will be beneficial. Also, standardizing the warm handoff from case management to the designee. We're also planning to expand and add a role for a navigator who has homecare experience so that we can really provide the patients and families with a comprehensive view of post-acute care options. Keeping that continuum in mind, we want to be able to provide the best guidance on next site of care to our patients and families by having experts from all fields available.

Palliative is a big discussion for us, as we know the mortality rate for patients with hip fracture was high within the first year. Some of the causes of readmissions we feel are probably tied to perhaps not recognizing palliative care needs early enough. So that's still in early discussions but that seems to be an emerging need. There's a lot of details that go into managing the fracture patient, but we do feel that it's worth waiting and putting all the pieces together to get it right. Thank you.

Laura Maynard: Thank you, Shibani. We appreciate that and we are going to move next to having Dawn Rakiey, one of our Peer Leaders, speak a bit about how it's handled at University Medical Center. As she is doing so, I encourage everyone to type any questions you have for either Dawn or for Shibani, go ahead and type those into the Chat pod. Dawn, would you share with us a little bit?

Dawn Rakiey: Sure. Hey everyone, this is Dawn. I'm over at the University Medical Center in Lubbock, Texas. You might have heard about our tornadoes the last couple of days. Our hospital is similar to Shibani's. We're a 500-bed hospital, and a Level I Trauma Center – the only one within a five-hour radius. We have a lot of fractures that are in our CJR program. About 40 to 45 percent of our CJR patients are fractures. Like Shibani, we do start therapy as soon as possible. We've worked with our pharmacy team and our physicians to use IV Tylenol instead of narcotics because with this elderly population, and a lot of them do have underlying dementia, between general anesthesia and narcotics it's almost impossible to start their therapy right away.

We do start education in the emergency room. I made geriatric fracture handbooks. It's not just for hemi or total for CJR, we kind of used that as a platform for the whole hospital. It has every type of fracture in there, what type of surgical fixation, and what to expect at our hospital. We also do promote going home, obviously as much as possible, but again, with this population, the majority of the time that's not feasible because sometimes these patients that live alone really probably should have already been in a facility to begin with before they fell.

We do have a narrowed preferred provider network. I was kind of chatting with Jordan, like this is what we do to be in compliance with CMS. You are allowed to give a list of and state that you have a preferred network, but you also have to give a full list or include a full list of all the skilled nursing facilities in that area so that you're not swaying or pushing patients to go to your preferred network and not giving them the choices of other places.

Again, it is patient choice. If they want to go to a facility that's on the next page that isn't in our preferred network, well they have every right to do so. But we do provide the front list, it is our preferred network, and then the other two lists are other facilities. In Lubbock we have 16 facilities. Only two of them are a four-star and one is a three star. The rest of them are one- or two-stars. It's a challenge.

We decided we wanted to do the preferred network to get our patients to go to higher quality and higher outcome facilities. Our goal is two weeks or less for length of stay and before CJR, we averaged about 40 days length of stay. Then, after we started our preferred network, we're at about 20 to 22. I meet with them monthly, go over every single patient, not just CJR. Then I call weekly to see where the patient is as far as their progress. If they're going to be past the 14 days, 10 to 14 days, then they're supposed to notify me and I go over to the therapy notes, and see what we can do about getting this patient back home. Like Shibani said with hers, before CJR 88 percent of our fracture patients went to SNF – 88 percent, that's outrageous to me. Now we average about 55 percent to a skilled nursing facility. We're trying to optimize – getting patients up early, front loading home health if we can get them to home health, getting them seen every day – to avoid a SNF stay.

We also work with the Emergency Room. If we have a patient that went to a skilled nursing facility and had to go back to the ER for something, whether it's they fell again or they need fluids, we work with that skilled nursing facility and the EC physicians to see if we can mitigate them from becoming a readmission and just taking care of them in the EC and then sending them back to the skilled nursing facility if they don't require a readmission. A lot of it is just education regarding post-discharge from the hospital.

As far as managing patients with dementia, I mean the hardest part is being able to get them to participate in therapy. They can be combative or sleepy, but like I said, we try to change their medications. We would much rather have a patient stay longer in the hospital than to go to a skilled nursing facility if we can help it. It's just managing those dementia patients. I mean it can be challenging but those are ones that we do try to keep a little bit longer to see if extra therapy can keep them from going to a skilled nursing facility. That in a nutshell is kind of what we do here at our hospital. I encourage y'all to ask questions. I think they can open the phone lines if you guys want to speak and ask questions or chat. We would really encourage that and would love to answer your questions.

Kathy Woods: Yes, Dawn. Hi, Kathy Woods here from The Lewin Group. We would love to now hear from all of you. We've had some great conversations by Chat, but we're going to unmute the lines. For those of you that aren't planning to ask any questions by phone, we ask that you go ahead and mute your line locally so we don't get background noise. Let me pause here for a minute and see if we have anybody on the phone who would like to pose a question verbally to any one of our speakers.

Jody Harclerode: I'll start with a question. How did you develop your preferred network and what do you give to the patients or the families on your paper?

Kathy Woods: Thanks for that question. Shibani or Dawn or Jody, any of you like to offer some comments?

Shibani Gupta: Hey, this Shibani, I can take the question. So when we looked at -- so we're in northern New Jersey, we have probably 70 skilled nursing facilities within 10 or 15 miles. It was certainly

challenging to determine which facilities we were going to work with. In our process I looked at their CMS five-star rating. I looked at their CASPER report, which is a facility-generated report that outlines some of the performance of the skilled nursing facility, including length of stay, hospital readmissions, and ED readmissions. I then completed an onsite visit to, say, about 25 facilities. I met with their care team. Again, it's really important to me that not just the corporate team or the leadership team, but really the Director of Rehab, the Director of Nursing, the administrator, I like to go in and see how they function as a team. Then based on that and some of our volume, we also looked at what volume of patients are going to these facilities. If you're in a community where a skilled nursing facility is just, I'm going to call them the popular place, it's better to develop strategies to work with those facilities than try to send patients to other facilities. Those were some of the determining factors.

We narrowed it down to about nine facilities, which we review every quarter. I also do a Town Hall Meeting with all the skilled nursing facilities quarterly so that everybody stays on pace with performance, some of the goals that we're working towards, so that we all stay on the same page. Your second part of the question was how we share the information. We developed a performance network sheet, which has preferred facilities and we have a listing of all the other SNFs in the area attached to it.

Jody Harclerode: Thank you.

Shibani Gupta: You're welcome.

Kathy Woods: Shibani, thank you. And while we're waiting on other thoughts from that, if anyone else on the phone who would like to pose some questions, likewise, folks if you're not able to speak by phone, please don't hesitate to ask additional questions in the Chat and we'll get to those. I'll pause here for any more questions by phone please. All right. I wonder if -- Dawn spoke to her approach at her organization for managing patients with fractured hips and dementia. Shibani or Jody, I wonder if any of you have additional comments of your perspectives on working with your patients with fractures and dementia.

Jody Harclerode: Challenging – the most challenging population, I'll start with that. You know, I think a lot of what Shibani said is on point. You do your best with those folks. We're moving forward with a lot of multimodal pain management, just as Shibani was saying, to decrease those medications that will affect their cognitive function afterward. We have the hospitalist manage them with an orthopedic consult. There are lot of medical management on board. But I'm actually going to speak and ask a question at the same time because Shibani, when you were talking about these complicated patients, you mentioned the family conference, so can you speak a little bit about who initiates that and who's involved in that because I think that sounds like, especially for these patients with dementia, I think it's a great idea.

Shibani Gupta: Yeah. You know, and just, you're absolutely right. It's a very challenging population and many times because patients are living in our community anyway, they're frequently living alone still. It's a big revelation to the family and they -- in their mind, Mom was fine because they spoke to her two days ago and she was fine, so many times the dementia is really a new discovery when they come to the hospital. That's where we really feel like there's a -- it's not really a disconnect, but just a discovery for the family. It really poses as new news because they're oftentimes in different states. They might not even be living in New Jersey. When we are able, we try to have a family conference. We invite whoever the caregiver is, whether they're a designated caregiver or frequently the siblings involved. We try to have, if it's the hospitalist team, whoever the hospitalist or the other resident or whoever the physician

is, we try to have a physician involved. The social worker, the case manager, myself and the physical therapists are integral to that family conference because what we find is the family needs to hear it not once, but multiple times and then in a group because it really helps to sink that in because my concern is not just that the patient is going to go to skilled nursing facility or that they came here with a fracture. My bigger concern is that that patient is probably not safe to return back home alone and that message takes multiple education opportunities to get through.

I think just repeated messaging from different people at different points of the hospitalization and post-hospitalization is so important. We try to give them options of -- if we can predict and see that it's somebody with a lot of confusion and it's not just post-op confusion, we try to tell them to look at options, look at companies that are able to provide home health services or assisted living facilities or even medical day cares. We try to give them those resources ahead of time so that they're not waiting until 30, 40 or 50 days in the skilled nursing facility to then start looking at options.

The other point I did want to make was with the multiple comorbidities, and even with dementia, that's something that we communicate to the skilled nursing facility also because frequently when the diagnosis is fractured hip, the focus and the care plans and goals of care in the SNF become rehab-centered goals of care, but the medical component and the medical management are just as critically important for these patients. We do try to make sure that we underline that in our communication to the skilled nursing facility.

Kathy Woods: Shibani and Jody, it's Kathy, thank you so much for your comments, and as we're talking a little bit more about the skilled nursing facilities and that collaboration, Randy Thomas, I wonder if you could share a little bit? We have some questions from Christina Kane about particularly that coordination and communication with post-acute providers and for folks that maybe can't see the chat on the webinar, Randy, I wonder if you could, again, speak a little bit, paraphrase some of your suggestions for how you coordinate and collaborate with your post-acute providers.

Randy Thomas: Sure, I'd be happy to. I'm calling from a sister hospital from Shibani, also from Hackensack Meridian Health, the Hackensack University Medical Center. I think that one of the key things discussed here is the communication that we have with our post-acute providers – that we do have preferred providers like most people do, but we do have to present everything to the patients because of patient choice. But no matter where our patients go, it behooves us to look at our patient in their entirety with their cycle of care, and for us to really communicate on how they're doing and to really follow them for a bit afterwards to see are they continuing in the recovery from what we started with them. This is certainly a much more complex patient, as we've discussed.

But in order for us to follow through, we need to build relationships. This is something that clearly takes us out of our silos, which we've been doing for quite a while now with CJR and our elective patients. It really just follows suit with that and establishing relationships with our post-acute providers, whether they are preferred providers or not. I really did a lot of outreach, like many of us have, to find the right person to speak to in the facilities. Sometimes it's someone that heads up rehab, sometimes it's the administrator, sometimes it's a collective sum, but we find out what's their best way to communicate. My important goal is to communicate. If they want to do a weekly phone call or if they want to have do this via some type of web-based or e-mail type of situation, I kind of defer that to them because I just want to communicate. I will be happy to work around what's easier for them. Sometimes it's a team approach of nursing and therapy to them, but we can discuss what our goals are with progressing the

patient, understanding that each patient is more complex than our elective line and I established those communication goals.

I follow up on every single patient that leaves us, whether elective or a trauma or hip fracture patient, and so a relationship gets established and therefore a great kind of conversing back and forth. I have found that they are more apt to move the patient along, to move up the family meetings to really pay attention to our patients. Not that they didn't before, but to really kind of have that be upfront and center because they know that I'm going to be communicating with them, so we get a good professional dialogue.

Kathy Woods: Randy, thank you so much for sharing. Christina, is that helping? Are there are any additional follow-up questions you might have for Randy or any of our other speakers today?

Christina Kane: No, that was helpful. I was asking for the process related to what -- were you making phone calls, which it sounds like that's what you're doing, and just whether anyone's engaged with any online or web-based programs. But I know with the fracture population that is obviously really difficult because there's a lot more going on than just a surgery. I was curious if anyone was using anything other than the outreach by phone call, but I appreciate that. Thank you.

Randy Thomas: I also want to, if I can, branch off to something a little bit different than this level of communication from the professional standpoint and go back to what Shibani and Dawn were talking about before and having to do with the expectation of the correct plan for the patient when they go to a SNF, if they do go to one, and the length of time there. It is as vital in this group to educate the family as it is for elective surgery. It's not planned education. It's not the gift we have with that with elective surgery, but when that patient ends up in the ER, whether their family members are nearby or afar, it's a shock to everybody. It really is important for us to educate the patient and the family members on the type of the fracture, the plan for it, what the recovery might look like, and what the options are right from the get-go. We start education with the patient and their family when they're in the ER before surgery. That kind of sets their mindset to prepare for the recovery and what it might look like. It's kind of coming from the back-end to do education at that standpoint, but it's as important in the recovery time for the patient and the family.

Kathy Woods: Again, such helpful feedback everyone. Again, Kathy Woods here, great feedback. I think for sake of time here, if you have additional questions, please don't hesitate to put them in Chat and we can follow up after this session to continue the dialogue, certainly on Connect. I'd like to segue us. In preparation for our next learning event together, we have prepared a few polls to help us get some additional information here, and there's a total of four of them. We're trying to look at some ideas around patient optimization and how you're using risk assessments. We'd love for you to tell us a little bit more.

The first question here is whether you modify your care protocols to enhance patient care based on the risk assessments. Then, whether you do or you don't, we'd love to hear more and if you'd be willing to share your strategies for enhancing patient care based on risk assessments, it's so helpful. We love hearing from all the ideas from all of our participants in the CJR model and appreciate those of you who are willing to volunteer on events like this to share your experiences.

I'm going to just give one more minute. Oh, and the question here, Christina, now this is a general question regardless of whether you're talking CJR elective patients or patients with hip fractures. We're asking all of these poll questions broadly. All right. Okay.

We're going to, then, we've got two more questions for you folks. As we are switching to the next two polls, they're coming onto your screen now. As I mentioned, we're also -- besides risk assessments, we're curious at what's happening out there as far as optimizing your patients prior to surgeries, and what some of those specific strategies are and if you'd be willing to share those with us on these future peer-led learning events. Thank you all so much for responding here. We're going to give it just another moment for those of you to respond to the polls.

While we're doing that, certainly it's been a great presentation for me to listen to. I think we've heard a lot of very common themes from all our peer speakers. Some of the key concepts that maybe you want to think about a little bit more – we heard a lot of ideas about how critical education of the patient and the family is from the very, very beginning of, they're entering the emergency department with a fracture, apprising them of all their various choices along the way and engaging the family and as Shibani was talking about, giving them a few different options that may not just be one option that they can look at.

Another key concept that was shared by many of you is the value of the team collaboration and the consistent messaging, the importance of that to the patients and families. Again, starting that discharge planning in the emergency department, and certainly a key part of our question and answer session was how invaluable it is to have that close coordination and collaboration between folks in the acute care setting and in the post-acute setting. Again, we thank you all for your participation today.

As we are wrapping up, let's talk about what you've learned, and we'd love for you to share in Chat today. What are you doing? What will you plan to do to leave in action based on the information you've heard today? Maybe you'll enhance your approach of your communication with your post-acute providers. Maybe you'll change some of your approach when you're first meeting your patients with fractures in the emergency department. We'd love to hear from you and tell us in Chat. Maybe some of the information you learned today you'll also apply to your elective patients. We'd love to hear a little bit more about how these learnings here, how you might apply those otherwise. Let's take one more moment and see what you're all thinking about to leave in action here from the great discussion that we've had together.

While you're all telling us what you'll be doing in the coming months, I'm just going to wrap us up here with a few reminders. Of course, not only today, we'd love you to continue to engage with your peers here on this topic. We've got a Care Navigation Group on CJR Connect where you can continue this conversation. Of course, here on the slides, which you can download right now from the Event Resource pod, it also gives you the link. If you don't yet have a CJR Connect account, we'd love for you to get further engaged with us and those details are on the slide here for you.

Likewise, it's really important that we remind you of upcoming events and reminders. A little later on this month we have the "CJR Model Final Performance Year Two and Initial Performance Year 3 Reconciliation" webinar. We've got in the beginning of June, the "CJR Hospital Monitoring Report: Preview and Opportunity for Hospitals to Provide Feedback" webinar. Then of course, this group, our Peer-Led Care Navigation Affinity Group, we'll get back together again on the 9th of July.

I think let's see here, what else am I missing that I want to remind you of. I think one other thing that we are working on for those of you that will be joining this event, accessing it on-demand, we are asking that you please also submit the on-demand viewing worksheet that you'll see there in Connect along with this on-demand event. We are working to obtain your feedback as well on your experiences with fracture patients and so we'd love to hear from you, whether you joined the live event with us or not for those of you that are accessing this on-demand. Again, I'd like to thank again Shibani Gupta and all of our peer navigators here today, Dawn Rakiey, Jody Harclerode and my apologies, I know I am missing someone and I'm missing it right now. But again, special thanks to all of our facilitators today. We hope you finally will give us your feedback on the post-event survey so we can continue to enhance and refine and make these events valuable. Thank you so much all for joining today and we look forward to your participation at our next session on July 9. Thank you and have a great afternoon.