The Patient Journey Series: Strategies for Engaging Beneficiaries and Their Families Throughout the Episode

Isaac B: Good afternoon, everyone and welcome to our next CJR learning event in the patient journey series, strategies for engaging CJR participants and beneficiaries and their families throughout the episode. We're excited that you are here with us today. We want to welcome you. My name is Isaac Burrows. I am with the CJR team here at the CMS Innovation Center. We will facilitate the event along with Laura Maynard who is with the Lewin Group and a part of our Learning System team here. With that, I will turn it over to Laura to give some basics, and we are excited you are here with us.

Laura M: Thank you Isaac. We want to welcome everyone and just give a quick run through on our agenda. We will be having presentations from three CJR hospitals, the University Medical Center of Princeton at Plainsboro, Major Health Partners Medical Center, and Indian River Medical Center. We will have lots of discussion throughout the webinar and plenty of opportunities to ask questions of the presenters, and we will wind up with some updates and next steps.

Just a quick refresher on how to use this webinar platform and what you'll find here. To access your audio by phone, there is a box at the bottom of your screen that says dial-in information. That tells you how to telephone in. If you need closed captioning, that is at the bottom of your screen on the right side. The event resources are in the center column at the bottom of your screen. The slides are there, it says webinar slides. There are also currently posted on CJR Connect. We will be using group chat today for our questions and answers, as well as an opportunity for you to converse with one another and interact. I encourage you to find the chat panel that is to the right of your slide. It says chat at the top. You want to make sure says 'to everyone'. Type in the little box the bottom, whatever comments or questions you have. Then click the little bubble that looks like a chat bubble to send your chat comments. If you want to ask a question of a particular presenter, use the "@" symbol in front of their name, or their hospital's name and we will triage that question to the correct presenter.

We will launch a poll. We want to ask you, did you attend part 1 of this patient journey series following the beneficiary throughout the episode. All you need to do to answer that poll is click on the answer that best represents your hospital. You do not need to click anything further. It automatically submits. You can see the poll responses updating as we go. We will give that just a moment so more of you can respond. As you are responding, there are the results of the poll. As you respond to the poll, I want to remind you that those slides from the first webinar identifying and following your beneficiaries throughout the CJR episode, those are posted on CJR Connect. If you missed it, if you were not able to attend it, you can find it on CJR Connect and watch the archive. If you did attend it, you will find that this webinar will be a follow-up to that and will build on what we discussed and what we learned in the first webinar.

I believe that is the end of our poll. I am going to post the results. Here we go. Now, we will move to our presentation. The initial presentation is by Vickie Ribsam. Vicki is the nurse navigator at the Jim Craigie Center for Joint Replacement at the University Medical Center of Princeton at Plainsboro. At this point, I will turn it over to Vickie.

Vickie R: I want to thank you for the opportunity to share some of our experiences. We will go over a little bit about what we do around patient engagement. Our hospital has been in existence for over 100 years. We opened a new hospital at a new location in May 2012. The efforts around the new hospital was centered on patient comfort and efficiency. We are located in central New Jersey. Our hospital is in a tight market. There are a lot of hospitals around us that also provide some the same services we provide. We like to think that we do things differently. We have 319 licensed beds.

Our Jim Craigie Center opened a little over three years ago. It started with a gift from a grateful patient. The patient had a hip replacement here. He really liked the care and thought we were doing great things and wanted to see it grow. With that, we decided to open the Jim Craigie Center for Joint Replacement. We started with a patient-centered approach for the creation of the center. We met with patients. We had multiple focus groups to make sure that we would really get an understanding of the patient point of view and how we could best make the center work for them. We used meaningful data collection and management. We started collecting data on all kinds of patient sensitive indicators that helped us understand where we needed to go and where we were and how we could get there. We used an interdisciplinary team of approach. We have a very engaged group of surgeons, anesthesiologists, administrators, nurses. We engage nurses from previous testing departments through the operating room, through the inpatient unit, and beyond into our home care services. We have a lot of people that are involved in the program and have been for more than three years now. We develop a lot of printed materials. We have books that are edited by some of our patients to make them user-friendly. We have newsletters that we give to patients to help them understand what they can expect for their inpatient stay and what to expect with the side effects of medications and different things that they might have questions about. With all of that, we opened three years ago. We had our opening of the center in November. Four days after that, we got the certification from the joint commission of total hip and total knee. We did it all at once. Some of the key features of our program here, it is me. I am the nurse navigator. I am responsible for the patient experience. I represent their voice throughout the process. When we have meetings and we are designing processes are implementing new tools, it is my job to make sure that those patients, if they are not with us at that time are represented and then I reach out to them so we can make sure we are doing everything we can to include them in all of the processes. I am also responsible for data collection and interpretation. I coordinate with the interdisciplinary team and I want to make sure everybody is on board with everything that is going on. I do a lot of patient and staff education, community outreach. I do lectures in the community. Once a month, I go out with our community education folks and give lectures on total hip and total knee and what to expect if you are planning on having surgery. Sometimes, just general joint pain. I am responsible for contacting patients before surgery and I will get into how we work with our high-risk patients. We definitely keep an eye on those patients before surgery and I keep track of them after surgery.

Patient optimization is one of the central features of what it is that I do here at the hospital. Some of the patients that are high risk may be identified in pre-admission testing. We record data about what it is that makes them a high-risk patient. I put a snapshot of our database, right on the screen so you can see what it is that we fill in. That report is run every two weeks or so.

We look for high risk patients and I follow up with those patients. Some of the things we look at, we do action items. For example, we identify patients that have a BMI over 50. Those patients transfer into the bariatric center for evaluation. After speaking to them, we refer them over to the coordinator for bariatrics who calls them. She identifies ones that might be appropriate for medical weight loss, and after that process is complete, we may transfer them back into the joint center. We have had a couple of success stories. We had a bunch but there is one patient that when we first started the program, we worked with her. She had a bariatric surgery. She came back and had both knees replaced. Since then, she became a real part of our center. Even this December we had her speak at our nursing education day. She came back and got to meet with the staff. She talked about her experiences and how she was managed through her high risk and what that meant for her. It was nice to close the loop. The nurses were really excited to see her back and to hear about her experience. Some of the other things we looked at, anticoagulation stop dates. Those are the things that kind of get in the way sometimes of the surgery going through, especially when we are using our final anesthetics; we like to make sure that patients know when their stop dates are. We like to make sure we are coordinating with the doctors involved.

Another feature is the preoperative class. It is a two-hour session. It is knee or hip specific. We have a need class and we have a hip class once a week. The class features a former patient who was a volunteer. Usually, in the beginning of class, I will introduce myself and get everybody settle but then we start talking about patient goals. We talk about what it is they are hoping to achieve with the joint replacement and John, our volunteer will come to the front. I will step aside and let him talk about his experience. He is pretty candid and he talks about the good the bad and the ugly. Patients really appreciate that candid conversation. He is also available to them after class for questions. He also is available over the phone. We have had patients who may be struggling with feeling like they are progressing slowly or feeling a little blue after surgery and they may call him, just to talk about what his experiences were and what it is that he went through to make sure that their feelings are normal. He is very good at talking to our patients. After that, we have a physical therapist. Patients are encouraged to join the volunteer department so they can come to class and speak with patients. We have other former patients who volunteer on the inpatient unit and visit patients during the stay here so we can make sure that feelings are validated in the hospital and they have somebody to talk to in the hospital that has been through the process before. Again, that class is where we make sure they have their education books. Those books were developed by the interdisciplinary team including a group of patients who I still keep in touch with you still edit that book on occasion. We make sure that it makes sense for everyone.

We have a hotel experience, which is really about admitting our patients directly into the room after registration. We register them on the ground for and then we take them to the room they are going to stay in the whole time they are here. That allows the patient to be oriented to the room preoperatively. They feel like they are putting their things away and the family has privacy with them so they can ask questions that they may want to ask so they feel like they are sort of at home. Family usually waits in the room while the patient is in surgery. They appreciate it quite a bit. The hotel experience makes a big difference in terms of their admission experience. Also, we had a continuity of care. That joint replacement nurse that is doing their admission is likely the same nurse that will see the patient postoperatively. The communication

between the patient, family, and inpatient nurse is smooth because they have that contact already made.

We have group therapy. Our physical therapy department is active with our program. They teach with me. They build the program with me. They are excellent. They meet with patients within 4-6 hours after surgery. All of our patients are up walking within 4-6 hours. They meet with them the next morning for individual therapy sessions to make sure they have tested out on their goals for going home. We have them in a group therapy session in the afternoon. The patients enjoy that session where they can talk to each other. Sometimes the families participate, but it is definitely a good time to reinforce that what they are going through, others are going through it and they enjoy that. The goals for therapy are discussed with patients. We talk to patients about personal goals. In the preoperative class, we asked them to write down a good reason why they are having the surgery. It is a personal reason so I tell them it can be anything from wanting to go back to work or go on vacation or I would want to go back to shopping at the mall but whatever it is that they have given up due to their joint pain, we will write that the white board when they come in for surgery. The physical therapist takes the responsibility to put that goal on whiteboard in the room so everybody coming in and out of the patient room is mentioning to them, for example, Mrs. Smith, I see you want to go on vacation, where is it that you are wanting to go? Let's see how we can get you walking today and taking your first couple of steps towards your trip to Florida. There is a lot of different ways that we incorporate personal goals and into what it is that we do here.

We also do a discharge class. The day after surgery at 10 AM, we bring everybody together into a conference room right on the unit. We do a little champagne toast which is actually sparkling cider. They enjoy their sparkling cider, so while they are doing that, we do our discharge teaching. Originally, we had found that there were a lot of phone calls back to the inpatient unit after discharge. As our discharge gets closer and closer to the admission and the length of stay gets shorter, we found that patients are going home and having a lot of similar questions. We spent time collecting the questions and putting them together in an education session that is now our discharge class. We try to anticipate what the needs are going home in terms of education, and we review that in the class. We have also incorporated that in the written materials that they get and the nurse reinforces quite a bit of that at the discharge as well. They hear it a couple times while they are here in the hospital. That is a nice time when they're together, and they get to answer questions together. Some of the topics that we include are pain management and use of pain medicines, side effects of pain medicine, swelling, activity incision care, and when to call the surgeon.

Our patient reunion is another thing that is specific to our processes here. Every September, we have a five mile race and a one mile walk to benefit the Joint Center. I know a lot of people asking, how do you get your patients to race five miles? They do not race. We have had one of the patients, the first we did accommodate did pass one of the surgeons and he was not proud. We tell them, they are there to cheer everybody on. They are encouraged to the one-mile walk if they are up to it that we have a tent set up in the field. They can have breakfast and the staff enjoys it also. Everybody can be together and talk about recovery. We like to talk to them about the goals they've achieved since we last saw them. We have been doing this for three years.

There are patients who come every year and it is such a joy to see them. We also use it as a fundraiser for the Craigie Center. And help sustain the programs that we put in place.

Some of the outcomes, this is a couple of things that I thought might be interesting. The volume in 2013, you can see for knee and hip, it was 460 for knee, and 317 for hip. We increased that quite a bit. Some of the struggles that we have now are related to the increased volume. We are adjusting to that. We encourage the preoperative class. It is mandatory. We tried to get everybody in there. It is a live class on-site at the hospital and we have increased that up to 82%. It is doing well. The length of stay has gone down from 2.8 to 2.2. It is moving closer to a one night stay. It does provide challenges in terms of putting the features into a shorter length of stay. The discharge home, we went from 50% to around 80% for hip and knee. We are doing well getting everybody at home. The next step for us, a couple of things we're working on is a fragility and fracture program. We have the fracture program and site right now. We're looking to formalize that and do something extra and try to mirror some of the things that we are doing with the elective joints and fractures. We're working on outpatient joint replacement surgery. We have done a couple outpatient joints. We have not made -- done a full thing for that. We will work on that program. We're working on a joint registry – we currently do not currently belong to a joint registry, so that's something we are going to be doing. We have a partnership with the University of Pennsylvania. We will do a merger and new electronic medical records. We are have a grant to start prehab. I know that is something that people have been working on. We have not started that but it is something we will do this month and next. We will try to take some of the high risk patients and patients that maybe think they can't go home but we think they can go home and try to do some training with them about transfers and meeting challenges at home. We are going to be working on prehab and possible looking at some of our patients who may be a little bit nervous to go home with home health aides. We are looking at health aide services to see if those might be appropriate for some of our patients. That is a snapshot of what we are up to at the University Medical Center of Princeton. I am happy to answer any questions.

Isaac B: Thank you. That was a great presentation. Thank you. I will go ahead and start posing a few questions. The first is having to do with the additional parties who you engage. I guess the question would be, do families and caregivers attend the discharge class and how do you incorporate the families and ancillary care members within a patient's network?

Vickie R: We call them coaches. Every patient is encouraged to designate a coach. We include them in our classes. In the prep class, we tell them that they should be present at the discharge class the day after surgery. We encourage them. They participate fully in all of the processes here. We have the coach with the patient all the time that we have contact with them.

Isaac B: Great. That is useful. Thank you. I also want to ask about engagement with other providers. Obviously surgeons are probably engaged. Can you chat about that? How do you engage with primary care physicians pre-op when you are optimizing those high-risk patients? What does that look like?

Vickie R: You know, that was one of the struggles in the beginning is how to reach out to the primary care doctors. You know, the patients come here and we're dealing with a different

primary care doctor for almost every patient we see. We do not have one group. We have a hospital advisor on the committee who helps us figure out what it is that we should best do to communicate with the doctors. We have developed a few forms and things like that. For example, patients that come in with pacemakers are a challenge at the beginning. We did not always have the information we needed to care for a patient undergoing a total hip or knee replacement with a pacemaker. We developed a form that we sent out to the cardiologist. We make sure that whatever cardiologist or interventionist the patient is seeing, they get the piece of paper. We have a standardized format, we have in it information we need. We include the cardiology department in our work. We do have medical advisors on the committee also.

Isaac B: Sure. A couple of high-level statistics related to your facility. How many joint replacements do you do per year? How many are those elected versus traumatic fractures?

Vickie R: The numbers I showed you were all elective. We are anticipating that last year, it is going to be 1300 elective total joint. Our fracture volume is smaller than that, because like I said we are sandwiched between lots of other hospitals. You know, the fracture patients, I anticipate that volume is going to be a couple hundred for the year but our elective volume is up around 1300 for last year, 2016.

Isaac B: Great. Thank you. In terms of -- this was a more of an operational question. It seems that you are doing a lot in terms of outreach were you coordinate pre-and post-op. How does that work? Do you have backup? I'm just curious as to how you're operationalizing this.

Vickie R: I know it sounds like it is a lot. I work with a really great team. There is a lot of people that help me do what I do. I have volunteers that help me. I have nurses that I work with. There is a clinical nurse leader who does about half of the classes that I teach. Right now, I am the only navigator. I think with the increasing volume, we are looking at getting a second navigator but right now, it is me. I rely heavily on our data system, which are fantastic. We have a great team of people that pitch in to do the work.

Isaac B: Yes. That is great. Thank you. The post-acute portion of the episodes, a couple of questions, do you have preferred providers or folks that are discharging to SNFs that you have relationships with, and if so, what are those relationships like working with those post-acute care providers, understanding that it is only about 20% of your discharges?

Vickie R: You know, like you said, we do not have a lot of patients going to SNFs. We are working on developing some of those relationships. We have a preferred provider list that we developed. We also have met with them to talk about their clinical outcomes and their length of stay and what they are doing with our patients and when, and trying to develop some type of protocol with our SNF providers. The main objective is to try to get patients home safely if we can. The SNF providers, I think we will do more with that this upcoming year. We will do some more work on their length of stay.

Isaac B: That make sense. Do you have any does one question? Do you have financial arrangements set up with the post-acute providers or the surgeons?

Vickie R: The surgeons, yes soon, and the post-providers, no.

Isaac B: Great, thanks so much. Laura, did you have any questions?

Laura M: Looking at the other questions that are coming in, some of them have been about culture change and using a patient-centered approach. How did you design this patient-centered approach? How did you get everyone on board with that? Can you talk about that?

Vickie R: think it was a number of things in the beginning when they first opened the center. That was when the culture shifted. The patient that donated the program to us, I think that really triggered people's minds. We had an open group of people to that. They also had some consultants come in and say, I think you can start doing things this way. We worked with outside people to try to develop some of our resources. It was not always easy. It is not like everybody woke up and decided to do everything differently. It was a process and we continue to work on that process. You know, part of my role is making sure that the patients are at the table and that is the point of being represented we do that. I am lucky because the team here has been patient-focused and we have always been able to say what is best for the patient and move in that direction. We have had supportive leadership. They also, they are open when we think this direction is best for the patients. They have given us the okay with that. We have been lucky.

Laura M: Great. Thank you so much. Some other questions that are coming through in the chat and the question panel, it has to do -- when patients go home, are you using automated systems to continue patient follow-up post-discharge?

Vickie R: No. We are in the process of developing a web-based application for that purpose, but right now, we have an access database that houses our information. That is where we run our reports from. We have most of our patients go home with one of two home care agencies that we are in constant contact with. We can keep track of almost all of the patients that leave the hospital. I follow up with nations who are going home without home care. They do not see a provider the next day. They get a call from me.

Laura M: Wonderful. Thank you so much for that. In the interest of time, I am going to cut short the questions. We have many other questions for Vickie that have come in. We will have another question and answer time later in the webinar. We make it to those at that point. We will have a process to answer questions on CJR Connect. We will continue the discussion there and get to more of your questions that we haven't had time to answer here. Vicki, thank you so much. We may call on you later to answer a few more questions if we have time.

Vickie R: I am here. Thank you.

Laura M: The second poll question, one of the things that Vicki mentioned is that they use patient volunteers in the program. That helps with the entire development of the program. Does your hospital use patient volunteers to help engage in patients and families in any way? We will launch the poll and click on the button. You do not need to click anything else. Click yes or no our I do not know. We will get a sense of whether others are using patient volunteers. I

will say if you are using patient volunteers and you want to share about that in the chat panel, you can share that as well about how you use patient volunteers in your hospital. We will give just another minute. Some people are still clicking on the polls. Getting a good response rate. Think we can go ahead and close this out. We will show you what the results are. The majority of people are not using patient volunteers yet in away a few of you are not sure whether you are or not. If you are, if you are and would be willing to share about that, in the chat panel, feel free to share your experiences there.

We will move on to the next presenter. We will introduce Kelly White. Kelly is the director of orthopedics at Major Health Partners Medical Center. I will turn it over to Kelly.

Kelly W: Thank you for having me. Major Hospital is located in Indiana. We are accredited for 89 beds. We do approximately 130-150 beds total joints per year between two surgeons. On the elective side, we primarily have a surgeon that does 90% of these cases. About a year and a half ago, we implemented a nurse navigator program for our total joints. We have worked on development of patient engagement throughout the process. I will share a little bit about what we have done over the last year and a half to engage the patient. In our surgeon's office, when a patient decides to have surgery, the get their surgery day and preadmission testing date before they leave the office. The preadmission testing is scheduled to two to three weeks prior to the surgery date. The hospital will do their medical clearance at the time at the joint camp day. Any known clearances are initiated before they leave the surgeons office by the physician assistant or medical assistant. The physician assistant will briefly meet with the patient and get the orthopedic information they need to complete their H&P for the surgery. They are provided a rack card at the time which has a picture of the nurse navigator and her contact information. It indicates to them that they should expect a phone call from her within the next 48 hours so she can schedule a home visit with them prior to preadmission testing. This home visit occurs one week prior. They will also receive detailed joint education binders and a calendar with the upcoming appointments. At the home visit, the nurse navigator will do medicine reconciliation and she will enter these meds into the hospital EHR and primary care practice EHR. These are two different ones at this point. She would do a home safety assessment and look at adaptive equipment needs they may need prior to surgery. And for the safety of home, how many pets they have and the general cleanliness of the home. And she will educate the patient if there are any concerns in any of these areas.

She will go over the joint binder one on one and she will include the patient family and 95% of the time, the patient's family is with the patient during this education. She will go over everything from how to use the wipes, the nasal creams, etc. She will go over the surgical procedure using joint models. Again, she will talk about safety concerns. They will establish a discharge plan and try to have a plan A and a Plan B. They report this back to the surgeon's office afterwards. She goes over risks and benefits of the surgery the patient. They discuss nutritional things they need to do before or after surgery. The anticoagulation expectations and pain medications that they will have postoperatively. She goes over what to expect on the day of surgery and where to go and any other questions or concerns the patient or family may have. She teaches them the pre-operative range of motion exercises and how to use an assistive device if they are not already using one.

She fills out a communication form that gets returned to the surgeon's office with concerns she might have for the patient prior to surgery. This home assessment usually takes on average about two hours. On joint camp day which is about two to three weeks before surgery. They will come to the hospital and get a chest x-ray, their labs, and get a tour the inpatient room they will be in by the nurse navigator. They will then see the hospitalist for their medical clearance and if there are other clearances that need to be initiated, then they will do so. If there is medication adjustments that need these are done at that time, the preadmission testing nurse will communicate the changes back to the primary care office and the surgeon office. A final communication sheet will be sent back to the surgeon's office along with the H&P by the hospitalist to the physician assistant to put in the order sets for the surgery ahead of time. These are finalized the day of surgery. The day of surgery, the nurse navigator will meet with the patient and the family after surgery in the room along with case management. If they are a partial knee replacement, those leave the same day at the facility. She will talk with them and schedule a time to meet with them the next morning at their home so she can pull their drain. If they are a total knee or hip patient, she will follow up with them in the home one time. If they are going to an ECF or homecare first, she waits until they have been discharged from all of those services before she has a visit in their home. She make sure that medications are filled and they are taking them as prescribed and making sure they have what the need and there are not any concerns and reports that back to the surgeon's office as needed. If it is a CJR patient, she will chart them as appropriate. If they have been discharged to an ECF for skilled therapy, she will go out to the skilled facility once a week and check on the patient and talk to the nursing staff and the therapy staff to find out how they are doing and their discharge expectations at that point. She started the home assessments in February 2016. There has been one patient that has not allowed her to come into their home for education. There have been seven CJR visits in the home and four of them she was able to identify problems. Examples, one patient was not wearing their TED hose and the other example was the patient did not have their blood thinners to take. We have had five inpatient readmissions for knee and hip for 2016 at 4.3 readmission rate. That is compared to 2016, we were at 4.6 with hip and knee. We are seeing a benefit of her going into the home gradually and seeing that readmission rate decrease. She has picked up on several potential readmission issues that have prevented others from entering the hospital system. Thank you very much.

Laura M: Thank you. We appreciate that. We have had several good questions come in for you. Hang on with us. We are going to move to the third presentation and then we will take questions on both of those all at once. All of you participating, keep the questions rolling in and we will have another segment of time to ask questions of Kelly or Sarah who is our next speaker. Sarah Mondano is the director of musculoskeletal services at the Indian River Medical Center.

Sarah M: Thank you. I am happy to be here this afternoon. Don't take this the wrong way, but I am in sunny Florida. We are a 335 bed not-for-profit hospital located on the East Coast. We perform about 1200 joint replacements annually. I want to preface my talk in that the service line really came together during the early part of 2016. We've been doing orthopedic surgery for a long time. Ortho was not a big focus. It was not a formal service line. Everything I present today comes together since about May 2016. A lot of this happened in a very short period of time. The implementation of really bundling under CJR was the impetus for us to examine the

service line not only for patients included in CJR and but for any patient choosing elective joint replacement at our hospital. We knew that one of the largest drivers of a patient dissatisfaction with joint replacement surgery is the uncertainty as to what to expect at all points along the care pathway.

One of the first initiatives earlier this year was to promote Maria, who you see. She is our joint program coordinator. She was a seasoned charge nurse on our orthopedic unit. It was a natural move for her to go into this position. Her responsibilities are to ensure that each patient was engaged from the date their surgery was scheduled up to six months after surgery. When we began the redesign of our service line, we realized that our weekly joint class's attendance was minimal. What I mean minimal, I mean maybe one patient or two patients without any family members with them. We began collaborating with our surgeons and the staff also in the offices through a lot of different mechanisms but the attendance I'm going to say it is probably up to a little over 80% now. The joint class is not mandatory but our surgeons will tell the patients that we expect you will attend the joint class as it is part of the care I am providing you on this journey of elective surgery. We encourage patients to bring care partners with them. We usually have 100% of the patients who bring a care partner. That care partner might be a daughter or a spouse or neighbor. It could be a paid live-in caregiver. We do not call them coaches. They are care partners and they have expectations as well. We have been pleased with a percentage of patients who come with a care partner. We think that is probably one of the things that has contributed to the success of that. The other thing about our joint class it is a multidisciplinary team approach. Like the other ladies have presented, we cover all aspects of the surgery. It includes preop preparation such as the prehab exercises and what to expect after surgery through discharge. It is generally run by Maria and our director of therapy. We also have someone from case management as well to address questions that they may have preoperatively, depending on the insurance they have, and postop as far as community resources. We have had anesthesia come in but pretty much, it has been a multidisciplinary approach to bring the class to the level that we wanted it. What was interesting, what emerged from our classes were the, like the other ladies mention, we have joint camp ambassadors. Our ambassadors are former patients. They attend the weekly classes and they offer additional patient support, promoting positive awareness and positive perception of our joint replacement program. Really, most importantly, they reduce the pre-procedure uncertainty and even cancellation of the surgery by addressing fears and concerns that they may have.

In the short period time, we started from zero with the educational materials. The communication vehicles convey and reinforce the consistent messages about the joint replacement experience from prehab to recovery. What they are hearing in class, we have replicated in our joint replacement handbook which you see on the slide. The new handbook that just came from print, it is about 40 pages long. It covers everything a patient and a care partner needs to know before, during, and after joint replacement surgery. As you are aware, after surgery, the patients are receiving pain medication and they do not often remember what the nurse said five minutes ago in the room or what the physical therapist said or the navigator. We developed what we call the hip times and the knee news They are laminated. Each room has a set of hip times and knee news. It goes from postop day 1 and recovery day 2, post op day 3 and it is the care plan, the roadmap for the day. If we have just medicated them, and they do not remember what they are doing that day or the family member was not there and didn't hear

what the plan for the day was going to be, it is a written reminder of what the plan of care is for the day. Again, it helps further educate our patients and families what they can expect beginning with the day of surgery. It reinforces expectations postoperatively and it serves as an itinerary out what the patient can expect each day.

The last tool that we have added to our program to this date, and I will say probably most integral to the success under the bundling is the implementation of a web-based patient navigation platform, specifically built for bundled payments that engages the patients before surgery and spans the 90 day episode of care. We chose to enroll everyone in this platform, not just our CJR patients but any patient is having an elective joint replacement at our hospital, as well as those patients that come through our emergency department with a fracture, that end up with a hip replacement. They are enrolled into this platform after surgery once we know they have had a hip replacement. We decided that every patient, including the bundled patients, follow the same journey, so why not have them follow the navigation on this web-based platform. We look at a lot of different systems. The system that we chose not only continued with the preoperative patient engagement that we have been talking about but it allows the hospital and my team to manage the post-acute care and hold those providers accountable for the care that was provided following evidence-based pathways.

Since May, some of the things that we are really proud about, if we looked at our HCAHPS through August of this year, you can see in the slide, we have a good communication with nurses and responsiveness of hospital staff. The pain management is not a huge increase. It is not where we want to be. We feel the patient understands the new medications and they are reporting pain is under control. We are proud of the fact that we have gone from the low 70s to 100% of our patients are likely to recommend us to their friends and family for surgery. We are happy to monitor our readmission within 30 days. We have stayed at 4% consistently through the year and through December. We are early on in our journey of putting together and achieving the success with the service line that we want. I guess that is why added the quote that it is progress and not perfection. I am sure that a lot of hospitals on the call have had a service line for many years but I am happy to be to share with everybody what we have done as a team in a short period of time. That is all for me. I am happy to answer questions as well.

Isaac B: Great. Thank you so much. These have been some excellent presentations. I do want to pose a couple of questions. First, I want to go back to Kelly. I think a unique aspect of what you are doing are these pre-op home visits. How much time does it take to do the home visits? How much one on one education and how much time does it take for the individual visitations?

Kelly W: She is in the home two hours, but the actual education piece of it is 90 minutes.

Isaac B: Great. Thank you. Sarah, did the admission rate change recently? You just showed previously, you talked about 2016 was 4%. I wondered if it changed.

Sarah M: Actually, you know, the average has been 4%. It has been lower and higher. We have months where we have zero rehospitalization rate. The average is 4% or the last 12 months.

Isaac B: Great. Thank you. We are running short on time. I will turn it over to Laura.

Laura M: Thank you Isaac. I appreciate that. We do have several other questions that have come in for Kelly and Sarah. I will ask one more quick one for Kelly. Do you have a schedule and a script for those postop calls and follow-up criteria? Is that scripted and scheduled?

Kelly W: She calls within a day or two of them being home and she will tell them before the discharge from hospital that she will follow care before the doctor discharges them. There is not a specific script. The patient is expecting it.

Laura M: Thank you. One quick one for Sarah. There has been interest in what system you are using for the web-based follow-up. Can you speak about that?

Sarah M: I would be happy to. Am I allowed to tell the name of it?

Laura M: As long as we're not promoting a particular vendor, yes.

Sarah M: If anyone would like to contact me directly, I will give them the specific vendor. I will say we did a thorough request for proposal. We looked at about eight different vendors. Most of the vendors out there have robust preoperative education alerts. They have emails and various ways of contacting patients who may be do not have technology. Everybody has that. Very few of the platforms have a robust mechanism to engage the post-acute providers. That is for us to hold them accountable. The other piece is we needed to make sure we met the requirements with the patient reported outcomes as well. The reason we chose the vendor that we did, I will say the biggest reason was holding our post-acute providers accountable. I mean very accountable. I would be more than happy to address that with anyone. My email is on the screen. I am happy to save everybody the three months it took me to go through different vendors.

Laura M: Thank you. There was a great deal of interest in that. Moving along, we will deal with the other questions we have on CJR Connect. We have another poll and it ties in with the idea that we have a lot of good conversation happening in chat and good questions coming in. I am seeing some interest in a group that might be able to continue these types of discussions with one another following this webinar series. This is your opportunity to say would you would be interested in an affinity group to share more about patient engagement across the CJR episode. Touch on the yes or the no or maybe. It depends on your response. As you are doing at, go ahead and click and we will let the responses roll in. As you are doing that, in the interest of time I am going to thank our speakers. I appreciate everyone speaking, Kelly and Sarah and Vicki. Thank you for sharing with us. I am going to close the poll. We will close it out and get a look at the results. It looks like people are interested in having an affinity group. We will follow up on that and see if we can find ways to convene you so that we can continue these conversations. Also, the next webinar in the series is going to happen on Thursday, February 9. It will be about utilizing risk stratification to achieve better outcomes. That will address some of your questions that came up around the type of risk assessment being use and the opportunity for you to talk to one another about that. Also, a quick reminder, you can continue this discussion on CJR Connect. There are instructions on how to do that on the slide. If you're not a member on CJR Connect and able to chat with us and access the resources that are there, the

instructions are here on how to go about doing that. Updates and the next steps, also a reminder that we have a chat group for small hospitals. If you represent a smaller hospital, there is a specific group on Connect for that. The information is in the slide on how to do that. If you have any program related questions, you can send those to CJRSupport@cms.hhs.gov. There is going to be a post-event survey pop up. When you leave the webinar, you will be directed to a survey. It is a pop-up window. If you're pop-up blockers on, you will not get the survey. We will send it to you by email a few minutes after the webinar. We will send you the survey. If you're pop-up blocker stops you from getting it immediately, it will come to you in an email. Either way that you take the survey, we appreciate that information. It helps us to plan learning events that may be more meaningful for you. Thank you for your participation. Do you have any final comments? Is there anything you want to say to close out?

Isaac B: Yes. Again, we appreciate everyone's engagement. We're looking forward, it seems like there is a lot of interest in the affinity group. We will do work on that. We are looking forward to seeing you on the next session for risk assessment in February. We want to put a plug-in for January 24. You should've seen an invite go out today on the participant monitoring report that are coming out soon. We look forward to seeing you. On behalf of everyone in the room from the CJR team, thank you.

Laura M: Thank you.

[Event Concluded]