The Patient Journey Series: Strategies for Utilizing Clinical Risk Stratification to Achieve Better Outcomes for CJR Beneficiaries

Listen to the Webinar Recording Here

Isaac B: Hi! Good afternoon everyone. Welcome to our third and final part of the Patient Journey Series, Strategies for Utilizing Clinical Risk Stratification to Achieve Better Outcomes for CJR Beneficiaries. We are excited that you all have braved, especially those in the Northeast, to join in here with us in learning today. We have two CJR participant hospitals that will be talking about their different risk assessment methodologies. We are excited you have joined us for this. Myself and Alicia, who you can see our faces, will be facilitating the session. Please stay engaged with us and feel free to submit questions throughout. She will talk some about that now.

Alicia G: Thank you Isaac. Welcome everyone. I am going to spend a few seconds introducing everyone and orienting you to the platform. We have been using the Adobe Connect platform for this series. There are a lot of different windows or pods. You can use the group chat over here. It should be in the middle of your screen. That is visible to everyone. We do have that enabled and encourage you to use group chat both to talk with each other as well as to send questions to our presenters. As Isaac pointed out, you should see the video. We do have closed captioning in the lower right-hand corner. You can download the slides for today's event using the event resources window. If for any reason you cannot download the slides from the webinar platform, we did also post them to CJR Connect. Just as a reminder, the audio for today's event is available. You can stream that through your computer or dial in using the telephone number listed in the lower left-hand corner. I have already covered how we will use that chat pod today to submit questions. I do want to say, use the "@" symbol and then the presenter's name or organization. You can say "@Duke" or "@Atlantic Health". That will help us keep track of the questions. If you are typing a question that you are interested in posing to your peers that are on the webinar, type "@All" and keep your eye open for that. Next, we are going to ask you to participate in a quick poll. We are interested in having you let us know: did you attend Part 2 of the Patient Journey Series? That webinar was a few weeks ago on Strategies for Engaging CJR Beneficiaries and their Families Throughout the Episode. We are seeing those results come in. We will leave this open for just another 10 or 15 seconds and then we will move on.

Isaac B: And, we are not going to hold it against you if you did not come to Part 2 or Part 1 for that matter. We are glad you're here with us!

Alicia G: Yes, good point. Let's close that poll and we will move on. Great, we see about 50% of you were on the last webinar. As Isaac mentioned that is great, but I think it will be fine to jump right in now.

Without further ado we would like to move into our first presenter. Our first CJR participant that will be presenting today is the Atlantic Health System. And, we have two presenters. Dr. Steven Maser is the Medical Director of Orthopedic Surgery and Mina Le Fevre is the Orthopedic Central Navigator. Now, Dr. Maser, I will turn it over to you.

Dr. Maser: Good afternoon. My name is Steve Maser and I am the Medical Director of Orthopedic Surgery for Atlantic Health System. It's our pleasure to be with you here this afternoon. I would like to introduce you to Atlantic Health System. We're $2.5 billion Health System with 1747 licensed beds. We are spread over five hospitals plus a children's hospital located in northern New Jersey, right outside of New York City. Four of our five hospitals participate in the CJR program. Our largest hospital is Morristown Medical Center, where our orthopedic center is ranked 38th in the nation. They've named Morristown as the highest-ranking hospital in New Jersey. Morristown has more than 1000 CJR cases per year and 40 CJR surgeons. Our smallest hospital has 100 CJR cases and only four CJR surgeons. Two out of our 84 surgeons are employed and they do fewer than 3% of the CJR cases. The great majority of our CJR surgeons are independent. This creates hurdles to standardizing care. As you can see on slide three, we put together a structured to implement our CJR program. We report directly to Atlantic senior leadership. I am currently the physician chair and am here today with Jim Smith, our administrative lead and our CJR coordinator, Lauren Johnson. A CJR steering committee has been developed with the workgroups you see here in blue. At the far left, is the clinical guidelines group. That's the physicians. This group put together standardized order sets and the care redesign protocol. Next is the post-acute care group. This group is put together to organize patient care after hospitalization, including home healthcare and post-acute facilities. This group created post-acute provider agreements to assure quality, improve communication, and achieve length of stay in line with recommended practices. Now moving to the far right, we have the navigator group. The goal is to develop a navigation team to implement our protocols and hold the various stakeholders accountable. We worked with existing nurses from each medical center to functions at sight navigators, and we hired a system central navigator to oversee the process and work directly with our high risk patients. It's now my pleasure to introduce our outstanding system central navigator, Mina LaFevre.

Mina L: Good afternoon. My name is Mina and I am the central navigator at Atlantic Health. I manage the high risk CJR patients in Morristown, Overlook, Chilton, and Newton. This is an overview of our care navigation team. As the central navigator, I follow high risk patients across the Health System. I develop and maintain relationships with our post-acute network, currently managing 19 preferred providers, whom I work closely with. I also reinforce our best practices to achieve our recommended length of stay for our patients. I also track and evaluate patient trends. I work closely with four sight navigators who follow our low-risk patient at their specific sites, support the central navigator, and develop and provide educational materials to our patients. In year one, our goal was to increase discharge disposition to home and to decrease the length of the stay for patients going to post-acute facilities, whether that be a skilled nursing facility or an inpatient rehab. Atlantic Health uses the risk assessment and prediction tool, known as the RAPT. This tool was developed by Dr. Leona Meadow in 2001 to predict discharge destination for patients undergoing elective hip and knee surgery. These predictions are based on objective factors which provide confidence in decision-making regarding discharge destination for patients, family, and staff. On the next slide is a sample of the Atlantic Health System RAPT tool. This tool measures six factors: age, gender, how far the patient can ambulate, community support, and caregiver support after surgery. Of all these factors, caregiver after surgery carries the most weight. The purpose of this tool is: the ability to indicate before surgery the most likely discharge destination after surgery. It also allows appropriate patients to prepare themselves and their families for the return home. In addition it

assists with aligning patients' expectations about what is needed following surgery. When we first implemented the RAPT tool in April 2016, at the start CJR, our initial risk stratification identified high risk as less than or equal to six. It was followed by the central navigator, myself. This population has an increased likelihood of discharge to post-acute facilities. We considered high risk, six through nine and that was followed by the central navigator as well. Low risk was considered greater than or equal to nine and followed by the site navigator. When we performed the RAPT analysis from April to July 2016, it showed that our average score was 7.9 with a median of eight.

Why is discharged to home so important? It improves quality; it decreases the likelihood of complications, decreases the readmission rate and decreases our resource use. When we looked at our CJR 90-day readmission date from 2012 to 2014 and then again from April 1 to September 30 of 2016, it showed DRG 470 without fracture and these are uncomplicated, elective cases and that's on the left, patients who were discharged home had readmission rates of 4.2. Patients who were discharged to a facility had readmission rates twice as high as 9.8. Also, if you take a look on the right, we look to compare similar patient population with two or fewer chronic conditions and found that patients were discharged home had readmission rates of 3.6 versus patients who were discharged to a facility had readmission rates twice as high at 6.5. If you take a look at the graph on the right hand corner, we performed RAPT analysis in July 2016 and then in November 2016, which both showed that the RAPT score for patients discharged to home had a mean of 8.4. The RAPT score for patients discharged a facility had a mean of 6.4. Based on this data, it validated our risk stratification change of high risk RAPT score less than or equal to six which is tracked by the central navigator, myself, intermediate score of seven of 7 to 9, tracked by the site navigator, and low risk which is a RAPT score greater or equal to nine which was tracked by the site navigator.

By allowing this change we had allowed more time to focus on our touch points for our high risk CJR patients throughout the different changes in the level of care. As you can see, there are additional touch points for our high risk population therefore, by re-stratifying our patients, I as a central navigator, was able to provide appropriate patient tracking of the high risk population, especially in the pre-op, inpatient stay, and while the patient is in the post-acute setting. Focusing to ensure the post-acute providers adhere to our recommended guidelines for length of stay.

What are the RAPT limitations? The RAPT tool does not account for risk factors such as obesity, COPD, diabetes, neurocognitive issues, smoking or cardiovascular disease. We are evaluating a tool for readmission called the readmission risk assessment tool, also known as RRAT, which will further help us analyze these risk factors. Our team performed data analysis for 2016 data and it appeared that morbid obesity was identified as the greatest correlation to readmission. We also started with a manual paper collection process of the RAPT tool, but we have partnered with Patient Connect, a software company to document and report our care navigation process.

In summation, we recommend the use of the RAPT tool at the physician's office. It is there that the physician sets the expectation of discharged to home. Physicians are incentivized through gainsharing use this tool to identify and address discharged issues and concerns for the patients,

physician submission of the RAPT has increased from 87% from April to December 2016. Also the RAPT tool has identified intermediate patients at a score of seven to ten, and can be used to implement targeted intervention to facilitate discharge home. If a patient has no caregiver, we align them with homecare or private pay resources.

Year One Goals and Successes. We have had a 117% increase in patients going home. We've also had a 52% decrease in length of stay at our post-acute provides. We believe these successes are the direct results of implementing a care navigation team to provide oversight and identify and focus on our high risk population. In year two, our goal is to increase our focus on minimizing readmission across the system and continuing providing better and more efficient coordination of care for our CJR beneficiaries.

I would like to take this opportunity to thank CMS for inviting Atlantic Health to present our best practices for utilizing risk stratification to achieve better outcomes for our CJR patients. Thank you for listening.

Dr. Maser: So, I can address the first question I see. At what point is the RAPT tool completed? Was this done in a physician's office or the pre-anesthesia call? And, whenever possible, it is done in the physician's office. We've tied to our gainsharing that the RAPT tool and the PROs are collected in the physician's office. With the help of that, we've had a significant increase on how we can collect the data. If it's not collected in that way, it is collected during the preadmission testing or when they come for their joint class.

Alicia G: Alright. This is Alicia. Thank you to both Mina and Dr. Maser for jumping in and answering those questions. I'm seeing a few more related to that process. I may direct us so we can try to answer these. Now I see lots of questions rolling in. We will try to answer these in groups. There was another one asking about how they are reviewing that with the patient. I am seeing others. Is the RAPT score reviewed with the patient?

Dr. Maser: So, the physician would review that with the patient. Once it got to the navigator, they would put it in the correct bundle. But, the physician would review that with the patient.

Alicia G: There are a few questions about your site navigators. Can you tell us a little bit more about what is that caseload or the number of patients each site navigator is managing at once?

Mina L: It varies across our hospitals. On average, across our system, we are looking at 64 high risk patients per month and 83 low risk patients. Again, that's in a 90 day period.

Dr. Maser: We have more than 1000 cases at Morristown and only maybe 100 to 102 at our smaller hospitals. There's a factor of 10 in difference. In some degree, they share workload but for the most part we have a navigator at each facility.

Alicia G: There is another question asking about how sensitive is the RAPT tool in determining if the patient is going to go to a skilled nursing facility versus home with or without home health. Do you have insight on that?

Mina L: We use the RAPT tool as a guideline. The postsurgical team uses a tool, called the KU tool. That is done in the hospital setting by the physical therapist. It assesses the patient after surgery both at the initial and final evaluation and based on the data, it would help determine if that patient was safe or not safe to go home.

Dr. Maser: Understand the point is to identify those at are highest risk will go to a facility then have the central system navigator work with them. With the low risk, we work with them on site. It's also to take that intermediate risk and to give our best opportunity to try to allow those patients to be discharged to home. That is where those increased touch points of the navigator are effective. The whole point is to risk stratify so we know where to put our critical resources.

Alicia G: Great, now I'm going to toss it over to Isaac. We are going to try to tag team to manage these questions coming in.

Isaac B: I want to talk about the process when they are going through the RAPT tool, do the navigators reach out to those providers ahead of time to anticipate volumes, etc.?

Mina L: Yes, for high risk patients we reach out to the high risk patients before surgery then while they are in the hospital, we will reach out and touch base with case management to see what the next steps are for that patient. We will also use the KU tool to determine whether that patient will or will not go to the hospital. If that patient is not safe to go home and goes to a post-acute provider, I reach out to the facility within 24 hours to let them know they are a CJR patient and we are following them and try to improve the coordination of care for that beneficiary.

Alicia G: There is another question asking: are you using the RAPT tool for CJR beneficiaries only or for all of your joint patients?

Mina L: It strictly for our Medicare patients, our CJR beneficiaries.

Dr. Maser: We may change that going forward. The other thing we've done is that we created a group of preferred acute facilities where they have agreed to work with us and to communicate with us effectively. We have seen a significant improvement in life of stay for our patients that go to those facilities. Although we've had improvement in the number of patients that have gone home, even those that go to facilities by working with those navigators and any patient that goes to a post-acute facility, we had decreased that length of state by creating the preferred network. I will turn it back over to you Isaac to pose another question. We are going to ask our participants to do a little multitasking. We do have another poll question. We can go ahead and push that out. What type of risk clinical risk stratification are you using? Go ahead Isaac.

Isaac B: In terms of the operationalization of the tool, how are you collecting the data? Are you integrating with the EMR?

Mina L: Currently we are using a manual intervention to track that. Like I said, we have partnered with Patient Connect who is helping us streamline the process and document our data.

Alicia G: There is another question asking if you are willing to share more about that average length of stay for SNFs. You noted that it decreased by 52%. What was the baseline and what is it at now?

Mina L: We have decrease the length of stay for patients going to a post-acute setting from 23.3 days down to 11.3 days system wide. That's a 52% decrease.

Isaac B: What are the credentials and backgrounds of the site navigators?

Mina L: I'm an ortho certified nurse. They are all nurses throughout the system.

Alicia G: I know we still have questions coming in and we were not able to answer every single question. I do want to move us on to our second group. I want to thank everyone for participating in the poll. It looks like one third of the respondents are also using RAPT and the other third using a homegrown tool. If you are using a homegrown tool, feel free to use that chat to share your experience. Let us now does your homegrown tool capture the same types of data elements. We will now go ahead and transition. I will let everyone know we may have time at the end to come back to questions to the Atlantic Health team. I want to thank you guys.

Next, we will move on to the second presentation. We are pleased to have with us several presenters from the Duke University Health System. We have Joyce Kight, Dr. David Attarian, and Solomon Aronson. I will now turn it over to the Duke team. We thank them. They will join us on video as well. You can also see them. Joyce, go ahead.

Joyce K: Thank you for the opportunity to present our risk stratification from Duke University Health System. Duke University Hospital is part of our Duke Health System. We are located in Durham, North Carolina. You can see information about Duke University Hospital there on your screen. We are across Durham County. We have a sister hospital north of us, Duke Regional Hospital. Both hospitals are participating in the CJR program. Our third hospital in our Health System is Duke Raleigh Hospital. They are not participating in the CJR program. All three hospitals together have been coordinating care for several years. This just gives information about Duke Health System between the two hospitals participating in the CJR, the volume in patients we have. We are an academic medical center. I will turn it over to Dr. David Attarian who will speak to us about the history of risk stratification.

Dr. Attarian: Good afternoon. Thank you for listening and giving us the opportunity to present. At Duke we've been using risk stratification for more than 40 years. We started in the 70s and 80s with large populations of Jehovah Witnesses patients and we work diligently to work on blood conservation. That became more formalized when we developed our blood conservation center in 2005. Then within the last few years, we've been through a care redesign process at Duke called Transforming Our Future. That led us to a standardized process to rework various types of care for our patients, particularly with hip and knee since that was high volume and high cost for the university. Over the course of four months, we had orthopedic surgeons, anesthesiologists, nurses and clinical staff come together to work on the standardization process for hip and knee. During that, we worked on developing best practices and developed a playbook. Once we implemented it, we had various types of monitoring of quality of care to

make sure our costs were lower and we have continued that right along with success in terms of developing simpler orders sets and reducing implant costs and so on. The major part of that was to work on our risk stratification which we have done with our anesthesiologist.

As we got started we had to reach a consensus among the surgeons in particular to develop some hard stops, relative and absolute, for patients that would have problems with their surgery. We included all the surgeons that did the primary hips and primary knees. We also have a large population of ankle replacement doctors. Based on the literature, we came up with these indications to surgery or various types of problems that could be optimized prior to surgery. This included: BMI greater than 40 or less than 18.5, smokers who are still smoking and not in a cessation program, LBMs that were less than three, coronary stenting with or without AMI, stroke, any active infections are open wounds, uncontrolled thyroid issues, COPD and oxygen, and chronic high dose narcotic use. We have started to build a CJR dashboard that will provide pop-ups and draw out these discrete data points so we can alert the surgeons and schedulers that patients might need some optimization before surgery. With that I will introduce my colleague who has done more risk stratification than anyone I know.

Dr. Aronson: Thank you. It's a pleasure to be here and speak to the crowd. One of the things that we decided early on was that we wanted to not just identify those patients that were at high risk, as you can see with this graphic here, how we would characterize those variables that are fixed or modifiable, but we wanted to go further and implement a program to proactively address those modifiable variables to keep patients up for surgery. Optimize them the best we can to undergo surgery. So with that said, we incorporated our CJR efforts to be a part of an overarching umbrella program that we had initiated at Duke years ago. The acronym that we use to describe this program for identifying patients preoperatively with the intent of not just identifying those patients with complex medical disease and associating the risk that would go with those medical problems but to engage them to programs to address and manage more fully. POET is that acronym. We like it. It stands for Perioperative Enhancement Team. It is a term that embraces a multidisciplinary approach to addressing patients in a perioperative setting. It brings in the core competencies of surgery, anesthesia, medicine as well as the other hospital based services so we can aggressively, if you will, capture the patient population. The basic principle of POET is to stand up a way to reengineer care design. Some of the efforts that are traditionally used are to take inventory of these risk factors but to rather go forward in a proactive way to bring them into these programs we reengineered to manage their disease state.

As you can see the list of those comorbidities, the complex medical problems, that were involved in addressing is in front of you. The most mature is anemia. I will share some data about the results with respect to that program. We also have engaged in a preoperative diabetic program. This people identify with poor glycemic control. Nutrition is important. Patients with complex pain syndrome are defined as any morphine equivalent of 60 grams or greater, we have identified as a population that has significant risk. Certainly the elderly and complex medical represents a high risk group as well as some of the other things you can see. We are proud to be on the launch pad to introduce a smoking cessation program. It is elegant as it entails the involvement of pharmacotherapy as well as behavioral modification.

To give you as an example the results and motivation of those programs, we accepted the idea a long time ago that anemia is bad since it is associated with adverse outcomes, but so are transfusions. We wanted to avoid that decision in the algorithm of deciding whether or not to transfuse when we're confronted with that dilemma in the OR by identifying these people before they get to the operating room. We recognize our own internal chart review that the hemoglobin was a significant predictor of the behavior. Anemia is a morbidity that's associated with many other complex issues as well. With that said, we brought a lot of smart people to develop these algorithms on what best to manage this anemia once identified and went over to develop teaching as well as patient engagement tools to coach our patients to the benefits of having to have transfusion avoidance efforts and then we sent them to a clinic to tee them up so they could tolerate the surgery. These are examples. You can read on your own in retrospect after this conference, but it gives you an idea of the complex nature of the work that flows and scheduling connectivity that is involved for a program like this.

After a few years of being able to look back at our data and comparing to a baseline, in the specific the high-risk population that we perceive to be at risk for transfusion, so these are people who are presented with a hemoglobin level less than ten. Our inclination to transfuse the high-risk population was north of 60% before we implemented this program. We are pleased to report it is less than 15% now. This is focusing on the highest risk population. Since then, we have introduced a diabetic optimization program. This is an example of the process marker of a hemoglobin A-1 C diminution after people have gone on to have poor glycemic control and morbidity address. We are looking forward to following this up with longitudinal, hard data. In the interim, we can happily present that our hemoglobin A-1 C is significantly less than it would have been. Other mentions of programs we are introducing or have introduced. We understand in addition to obesity and high nutrition dysfunction, malnutrition is also a problem.

Here we are introducing programs where we introduce screening tools to identify this high-risk population; even overweight people can be malnourished. This is a modification of that MUST screening tool that we adapted to be more applicable to perioperative medicine and incorporated a laboratory test as well to help identify this high-risk patient with the intent of diverting this population to a care management platform where there malnutrition needs would be address. Smoking is another predictor of adverse outcomes. We have a smoking cessation program that we are engaging these people in. If I was use a metaphor, I would say this POET program is like someone sitting in air traffic control and is watching these patients to ensure that no plane lands before it's ready to land. No one should have surgery unless they are ready to have surgery. Our goal here is to ensure people who need surgery will have surgery but they won't have surgery until they are ready to have surgery. That's the goal of the program. This is a cartoon of diagrams showing how we've modified our processes from the time that a patient comes to surgery after being declared surgical and ending up in the operating room and some of the steps we implemented along the way to ensure we capture and manage the high risk population. It's now my pleasure to pass the baton on.

Dr. Seyler: Good afternoon. It's my pleasure as well to present some of the data and talk about risk assessment. I appreciate the presentation from Atlantic Health. I will talk about our experience with the tool and how we use it. It's a valuable tool and the only one that has been validated so far in the orthopedic population. It is helpful to the navigators assessing a patient

population that is inhomogeneous. If you have a patient that is less than six, it tells the navigator to contact the facility early to work on this. That is helpful in decreasing the length of stay. I think the critical information that you get out of the tool is the patients that fit in the point scale from seven to nine. I use the tool in clinic to talk to the family as well. This is where you have the patient that goes to SNF that may go home and require more resources. If you do appropriate counseling with these patients, you will be able and it's not uncommon for their children to take the first two weeks off or assist the family members at home where you reduce the number of resources required for these patients. The bang for the buck so to speak in using the RAPT tool is looking at the patients that have scores between seven and nine, classified as medium risk. For patients greater than nine, you don't have to do much because they go home and there are fewer problems and for those less than six, it's an excellent tool predictor to contact the facilities and length of stay.

More recently, I started looking at other tools that were available. The American College of Surgery has a risk calculator that appears on initial screen as a valuable tool. It gives you more information. It is a risk assessment and stratification tool. It will predict the length of stay of the patient. It can predict readmission and it is helpful for predicting this discharge disposition as well. We don't have data on that. We are working on it. We looked at multiple scoring systems to predict this and if you look at RAPT risk stratification the tool is focused on the subjective ability of the patient and the social situation around the patient. It's only helpful in determining the post discharge destination as well as the resource consumption outside the hospital. It will not be helpful with readmission and length of stay or any medical complications. That's the end of my portion. I will turn it back over to Joyce.

Joyce K: Debbie and myself use the RAPT score in conjunction with conversations we have with the patients on the phone prior to surgery. We teach a class. It's twice a month in our outlining clinic for orthopedics as well as Duke Regional Hospital several times a month. We teach a class to our patients. We also look at the PROMIS surveys that have been developed and are being used with the CJR program to help guide our conversations with patients, again, identifying patients who are high risk and who need coaching and who need to involve the families and their discharge planning. These are statistics about our total program with our joints at the two hospitals. Since implementing our global program for the joint orthopedics patients since 2013 and 2014, we've had a decrease in the number of patients going to skilled nursing facilities. Our readmission rates are there also and they have decreased as well. I will turn it back over to CMS.

Alicia G: Great! So, this is Alicia. I'll hop in here and then turn it over to Isaac. Thank you to the entire Duke team presenters and we appreciate you guys sharing your faces with us through the webcam. I think that was great. So, and there's Isaac. I will get mine started. Isaac, did you want to kick off the questions for Duke?

Isaac B: I can. I want to go back a little bit on the POET and get clarification about how it is operationalized and implemented. The graphic that you saw there- there was an air-traffic controller landing the plane or giving guidance and monitoring those. I'm wondering who in the organization that falls to and who manages that and how that works?

Dr. Aronson: It's a great question. Indeed it underscores the real essence and foundation of the success or not of this program. It's fun to talk about redesigning care and looking at data to drive in the best evidence way will we know what we need to do. The hard part is being able to do it easily and be able to connect all the dots. The short answer and we can speak to this in greater length later, is we stood up a chassis that underscores the foundation of what POET is. There is a team of people who are connected to our electronic medical record, IT Team doing integration of scheduling, best practice, and other pop ups that are important to enable that communication and connectivity within the system. If I can walk you through it, if a patient is identified in a surgical clinic, the conversation would ensue such that the surgeon and the patient decide it is appropriate at this junction to have surgery, there is willingness among the advanced practitioners within the clinic to go forward and do some of the pre-op screen to determine if they have poor glycemic control. If that is discovered to be true, then there is a smart set built into the EHR record that we have that we can connect the patient with a schedule an appointment downstream to the receiving entity. I cannot underestimate the importance of the collective effort of all of the members of the team to buy into this. A great example is we have worked with our good endocrinologist to build our pre-operative diabetic clinic program. Access is a barrier and it's a hurdle. What our endocrinologists have done is they have reserved slots in the clinic to accept these pre-operative patient referrals ad hoc. There is a one or two day pass through or fast-track without having to wait weeks to get an appointment. And, that just further greases the skids and that enables us to go forward. I could spend so much time talking about the operationalization of the program but it does involve the great team effort with a lot of dedicated time to build these programs.

Isaac B: Great, thanks.
Joyce K: This is Joyce Kight again. We saw some of the questions being posed. One of them was about a dedicated orthopedic unit. Yes, at both Duke Regional and Duke University Hospital, we have dedicated orthopedic floors. And another question we saw posed was about the participation in our pre-op class. At Duke Regional Hospital it's a regional hospital. Many patients going there are from the Durham County or regional area and they have about 50% class participation. We also have a video that is shared with patients who are unable to come to the class. At Duke University, we have patients more from the greater state area as well as Virginia and South Carolina. Sometimes we have patients from as far away as Florida coming to have surgery with us. We reach out to-- 30 to 35% patients come to our class pre-surgery and we also talk to patients on the phone who are unable to participate in class.

Alicia G: Thank you so much. I see the question. Someone is asking if you can elaborate more on how you engage your surgeons in this. Can you guys just talk a little bit about that? Is it with meetings?

Dr. Attarian: So, this is David Attarian. We are at an advantage because our surgeons are aligned with the faculty practice for Duke University. So, it is easier when you have everyone working for the same entity at both hospitals, getting together with an established process. Everyone was engaged in the committees. The workgroups shared information transparently on a regular basis. Consensus was always achieved by evidence and constructive conversation. I think it made it easier for us when you have perhaps multiple groups of independent surgeons. I could understand the culture might be a little more difficult sometimes. The other advantage we

have is that I heard someone mention gainsharing. We have a co-management program where the faculty is in a co-management program with the health system and the health system, along with our chairman come together to reach certain metrics that benefit our patients in terms of cost and quality and safety. The CJR was rolled into our co-management efforts as well.

Isaac B: That's great. I have a question for Duke and then one for Atlantic as well. There is a question about how does the RAPT tool relate to or not relate from other tools such as the frailty scale used from Hopkins. I'm wondering if you are familiar with that. Can you speak to that?

Dr. Seyler: I'm not familiar with that tool from Hopkins. We decided on the RAPT tool based on what was available in the literature that was specific to total hip and knee replacement. It does correlate with what we have seen. It predicts discharge disposition and helps our CJR navigators to tackle discharge disposition planning and also target patients that are in the gray zone. We also work in developing short educational videos for these patients and family members. It cannot be used as a risk stratification tool as it pertains to surgery, surgical complications or readmission.

Alicia G: We have time for one last question. This one's also for the Duke team. Can you talk a little bit about the process of how the RAPT and the PROMIS surveys are collected from your patients. There were some folks asking for additional information on that. Who is doing it? Is it paper, electronic? A little bit more about that.

Joyce K: With the PROMIS survey, they are administered in our clinics to our patients on paper. That started in April of last year. More recently, over the last several months, we've been experimenting ways to collect that electronically from our patients using our electronic medical record; we use Epic at the Duke Health System. We have worked with our programmers and they have developed a flowsheet where we send the questionnaires out to patients via software in conjunction with Epic, called My Chart. The patient answers those questions electronically. The information comes back to us through My Chart and it's part of their permanent record in epic. Debbie and myself can see those answers immediately and be on the phone the next day and follow-up to talk to them about that. The RAPT score is something we do by collecting information from the patient's medical record to look at that score.

Alicia G: Thank you very much. We are in the final five minutes. I am going to go ahead and move us forward into the updates and next steps. Before I do that, I do want to thank all of our presenters today. I know this was an hour filled with a lot of great information. There were questions we did not have time to get to. We will be working with both groups that presented today and may be able to provide follow-up answers to some of those questions through CJR Connect. I did want to point out- I know there were questions about the RAPT tool. We bumped the post up to the top on CJR Connect, so if you log into CJR Connect you should be able to see that. The slides are also posted and you can download the slides today. You can see a small box below the slides on your screen that says event resources. If you click there you can download. We do have one last poll question. I will ask my colleague to push that. We have now completed this three webinar series. We want to know if you would be interested in participating in an affinity group. We would envision we could dig into discussion, have

smaller groups, open the phone lines, and have peer to peer discussion about some of these topics. I'm seeing some of those results come in. Definitely quite a few saying yes, and, a lot of maybes.

Isaac B: From a CMS perspective, we want to offer the types of forums for you all, not just to learn, but to have more interactive content, where we can have that kind of discussion as Alicia was saying. From our perspective we want to make sure we offer those types of opportunities and it looks like a number of you are responding that you would be interested in. We can get more information on that.

Alicia G: Great. I do have a few other announcements. First, we would like to announce the next webinar series. This will be a three-part series focused on care coordination and management. You can mark your calendars. We will be sending registration out shortly. The first webinar in this series is scheduled for March 9. That is 2:00 to 3:00pm Eastern Time. You're the most active group on Connect. We love that. We encourage you to keep that up. If you do not have a CJR Connect account, there is a link on slide 52 and you can request that new user so you can access that. Another note- we've mentioned this on a few webinars. There is now a CJR Connect group for small hospitals. On slide 53 and 54 you can see more information on how to access that. Finally, any questions that you may have as always you can send those to CJRsupport@cms.hhs.gov. We ask everyone to take a minute or two to respond to the post event survey. We use your feedback to drive the topics for the future webinar events. Isaac, any closing comments?

Isaac B: Please, do the survey. It is quick and painless. We look forward to everyone's engagement. Thank you for your participation and we will see you next time.