Care Navigation Affinity Group Session Three

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Harold Bailey: Welcome this is Harold Bailey from CMS and I want to thank you for joining our third session of the Care Navigator Affinity Group. We look forward to hearing from you as you exchange promising practices, exciting innovations and lessons learned. We look forward to an open discussion to discuss strategies that you have found successful. Alicia.

Alicia Goroski: Thank you Harold, and again, I echo Harold's welcome. This is Alicia Goroski with the CJR learning system team. I will be one of your facilitators during today's event. So I quickly would like to review today's agenda. We will have a few minutes here in the beginning after the welcome reviewing the logistics of our webinar platform, then I'll review the overview of the Affinity Group goals, and we are very excited today, we have four great presentations for you. So, we will be hearing from four of your CJR peer hospitals, all sharing their strategies for care navigation around, specifically around the fracture population. And then following the presentations we will do a group discussion, we've got a poll for you guys, and again we will wrap things up with some announcements and reminders. So, I am now going to turn it over to my colleague Lauren Nir who will review some meeting logistics for today's call. Lauren.

Lauren Nir: Thanks Alicia. As a reminder all telephone lines are muted and will be unmuted during the discussion session later. Please dial-in using a telephone in order to enable that open discussion. We encourage comments, questions and reactions throughout the presentation during our – in our chat pod and we encourage you to participate using the chat, through the poll later, through that open discussion on the telephone, and then at the end of our event using a post event survey.

This is just a brief introduction to the platform, I know many of you have seen this before, but as a reminder the top left side of your screen will show the slides. Then to the right of that we have the dial-in information for today's event. Many of you are already on the audio, but if you ever lose connection you can dial-in using that information right there. Below that dial-in information we have the chat pod you'll see a message from my colleague Laura Maynard welcoming everyone. Then next to the chat on the bottom we have our event resources. In that pod you can download the slides for today's event and the text alternatives as well as an updated version of our driver diagram for this Affinity Group, and then you'll also see the closed captioning to the left of that.

Following that I just wanted to do a brief introduction via the chat. So if everyone could please share in the chat now your organization and one success or challenge you've had that's related to care navigation this week. You can use the @ symbol later on during our presentation if your question is directed to a specific presenter or participant and you just submit your question by clicking on that chat bubble icon. I'm going to turn it over to Alicia right now, so that we can test out a new feature that we are planning on using while you are welcoming and doing some introductions in the chat. Alicia.

Alicia Goroski: Great, thanks Lauren. And great- welcome we're already seeing some chats, the chat did just disappear because we are inviting you all to join us in testing out a new feature and I'll start by saying this came as a suggestion from one of you on the post event survey from the last session. Someone had said it would be great to see where we are all located on a map. So I

invite you right now to add yourself to the map and let me start by saying one of the first things you are going to want to do you should see in your upper left-hand part of your screen kind of a grey legend, if you hover your mouse on that pull that down, just a little bit otherwise there is a top bar that gets in the place of that. Then you can zoom in on that map to the United States and then we invite you, what you want to do is click your mouse over on that purple pin that you should see drag it to where you are located and I'm starting to see a few folks. I'm dragging my own and just a note that you want that the point of that map to be where you're located. Oh this is great we are seeing people pop up all over the country although I feel like I'm alone in Colorado here, but we have great representation all the way from California up and down the east coast. And just a reminder that you can zoom in and out on the map either by using your mouse or there should be also a legend to the very right.

Alright, this is great, so we will leave this up just another minute here, and if you need to – if you want to zoom in on your area especially you have the east coast you guys are – have quite a few you can see what colleagues from your area are also on. Okay alright, I think we can move on back to our- to see in the slides in full view. While we're doing that I will go ahead and review just the group goals. So the Care Navigation Affinity Group was convened a couple of months ago, primarily to bring together care navigators on a webinar monthly to share care navigation and coordination tools and resources. Also to have open and great discussions, sharing successful strategies, also talking about challenges and lessons learned and really to learn from one another. So we, for those of you who may not have joined our last two sessions we did develop a driver diagram at the beginning of the webinar, we don't have slides to go over that today, but you can download that in the event resources. It's the second resource listed. Click on that resource, then you should be able to click the download file button. And great thanks to everybody for hopping right back into the chat and introducing yourselves. And thank you to those who are sharing successes and challenges.

Okay, we're going to do a quick -- now we're going to transition. The topic for today's session is really around working with the fracture patient population. So we're going to do a quick live poll where we're going to ask you to raise your hand. Just above the slide you should see an icon with a man raising his hand, and so raise your hand if you have a process currently that is working well to identify your fracture patients. All right great, we're seeing a few hands raised here we go all right, okay I am seeing, I'm going to say fewer than 10 hands raised, and we've got at least, it looks like about probably 60 people on the phone today. So hopefully today's series of presentations that we have today for you will provide some great information for others to take back.

So without any further ado, we are now going to transition into the presentation portion of today's event and our first presenter is with Overlook Medical Center and I'm pleased to introduce Nanci Smith. Nanci is the orthopedic nurse navigator at Overlook. And Nanci the floor is all yours.

Nanci Smith: Thanks Alicia. Hi everyone. Okay, so as we know there's often a challenge caring for the elderly people, the fracture patients here at Overlook that one of the key indicators about two years ago was that these patients were not addressed expeditiously or so in medicine often didn't know who should take the lead. So after on the next slide we shall see the algorithm that got us to where we currently are but just for right now the fracture -- fragility fracture here at Overlook includes all fracture patients. I know CJR is concerned for 69-70 plus fracture, but we

deal with all fractures because that, at the time two years ago, was what they identified where the need was. And of course the CJR's fall under that.

Our fracture team includes doctors for medicine and orthopedic surgeons. We have available fracture block time available every day at 1 pm for the doctor that took call the previous night. He knows that, you know, there's going to be an OR available for him at 1 o'clock should the need arise. We have expedited the cardiology department with the echo, they moved to the top of the list to be done in time for surgery. We have a pain management protocol which is on a future slide and a flow map that we utilize for fracture patients. The things that I am responsible for keeping the data for at fragility fracture committees triaged to OR we identified 48 hours as our cutoff, our length of stay, the readmissions and the mortalities.

This looks a little scary, this is the fracture patient flow map and there are many steps in getting to where we are now, and this was kind of an overview, this is where we started, and have pretty much adhered to all of these steps. This is the ideal scenario of a patient coming at in 5:00 in the afternoon and who is responsible for what and getting to the OR the next day at 1 o'clock. This is ideal coming in at 5:00 pm, but we have been fortunate that if they come in later or in earlier in the morning we often have success with getting them to the OR at 1 o'clock the next day or the same day if it's the early morning hours. And this is just a look at the first three quarters of the year, our 2 OR in under 48 hours and again I say at our meetings you know just because they didn't get there it doesn't mean that the care plan did not work, it means that these folks as you all know come in with many comorbidities and then they do take a little longer oftentimes.

This is the Overlook pain management protocol for fracture patients as I said earlier and you all know they are elderly, frail, often dementia, so pre-op orders are written by medicine post-op initially written by orthopedics and then medicine follows. They try to keep an eye obviously oxycodone at the minimum. So they do use things like Neurontin, Tylenol and IV Tylenol and that was a challenge with pharmacy it is costly, but we prevailed.

The benefits for the patients are pretty obvious, they are obviously able to have their surgery sooner. They -- so this is team members communicate early in the care of the continuum of the patient and regularly all the way through discharge and the standard process flows and defined roles and responsibilities reduce the ambiguity and helps nursing know who to contact regarding the clinical issues- you know who owns which item in the care of the patient. And you know if that's addressed that it's sooner – it's addressed sooner and the patient of course benefits. Of course the physician benefits it's an efficient way for the medicine practitioners to care for these patients, orthopedic has a shared responsibility in the pre-optimization of the patients, and there's a predictability due to the standard OR availability at 1 pm every day. And of course anesthesia is involved and the dreaded cancellation and holding area has been greatly reduced is practically nil due to the great team effort. And this is my contact information. Please feel free to call or contact me if you have any questions about what we do here at Overlook. Thank you.

Alicia Goroski: Thank you Nanci. So this is Alicia and I'll just kind of transition up and I also want to remind all the participants if you have questions for our presenters go ahead and put those into the group chat. We are going to hold and do a group Q&A and discussion after they've all presented, but just so you don't lose those questions go ahead and put those in the group chat.

And we do ask particularly since we have four different presentations today use the @Nanci if you have questions specifically to Nanci. And I just wanted to kind of reflect on the slide your graph showing the data that you have been, I just wanted to comment on the impressive improvement in your time to OR statistics and comment on your, you know, it's great to see you know, you using data to assess your improvement activities. Fantastic.

And then I'll also just tie back into -- I noticed in the group chat that someone had indicated one of their current challenges- Sandy, with the University of Kansas health system- had indicated a particular challenge around undiagnosed dementia and you kind of touched on that. So that may be a topic that we come back to as well during discussion. So, thank you very much, Nanci.

So next I'm going to move us along to our second presentation in today's webinar and with that we are pleased to welcome Hackensack Meridian and we have two presenters with us today we have Randy Thomas, the manager of the Orthopedic Special Projects and Samantha Rodgers the nurse practitioner in orthopedics with us. Randy and Samantha, yep.

Samantha Rodgers: So, hi everyone my name is Samantha, I am the nurse practitioner here at Hackensack University Medical Center. We actually have joint commission visiting us right now for our hospital wide survey, so Randy did have to scoot out, but she apologizes, but she was very excited to be sharing our program with all of you. So, welcome again, thank you for taking the time out of your day to join us.

So why we're all here: we identified a need for the program and as you know hip fractures are a public health problem nationally and even worldwide. So what our plan was to have our surgical treatment which is indicated despite the high complication rate and the mortality rate and the readmission rate, we needed to come up with a program to help optimize these patients and get them into the operating room as soon as possible. We know that there was a need to operate so we knew that there was a need to bring together a program here at the hospital. So, our mission and our objectives we're focusing on the patient, patient always remains at the center with everything that we do with all of our programs and through that we created two different patient pathways which I will discuss in a little bit and with the pathways we wanted to create preoperative optimization.

So when our patients arrive into the emergency department, we had a little bit of a battle going back and forth between who admits the patient, is the patient admitted to medicine or is the patient admitted to orthopedics and we actually decided that we need to have the patient admitted to medicine, and orthopedic should be called in as a consult. Ultimately we needed to address patient safety, we needed to improve quality of care, while also minimizing the risk of complications. So, I'm just going to focus a little bit more on our program goals and standardization is key to everything that you want to do. So first, we identified the three types of fractures to focus on. So we limited, we didn't include femur fractures in our groups and we focus on intratrochanteric, subtroch and femoral neck. Secondly, we created the patient pathway like I talked about, so when the patients come in if they're a medical fall; for instance, if they had had a syncopal episode, an MI, some other medical reason that caused them to fall these patients are automatically out of our fast-track program.

If the patient is, "help I've fallen, I can't get up" and just a mechanical fall right off the bat this patient qualifies for our fast-track program. Our fast-track program was designed to have our

patients go from the identification of the fracture, whether that was through x-ray, MRI or CT scan, so that time of confirmation to the operating room within 36 hours. If the patient is a medical fall, we do have cardiac algorithm. We did decided as a group that we didn't need to have patients worked up with an echo and stress test and all that if it wasn't medically necessary. We came up with standardized orders which start in the emergency department, follow through to admission pre-op, and then also a post-op order set.

We created hip fracture block time in the operating room Monday through Friday. This block time follows after the normally scheduled OR times for our elective joint replacement patient. So most of our patients for hip fractures are going to the operating room sometime between 2:30 and on through the evening depending on the day of the OR. We also created patient and family education which I am going to talk about a little bit later. And then we did achieve DSC Certification. We are the first hospital in New Jersey to receive this DSC Certification which we achieved last October.

Our teams, we have two primary teams both of them are multidisciplinary. Again, you see the patient right there in the middle smiley face, very happy, and our first committee that we put together was the Steering Committee. This is comprised of leadership and management from all touch points starting in the emergency department all the way through pre-op, post-op, physical therapy, and then the practice council which is our front-line staff which includes registered nurses, physical therapists, case management and discharge planning as well as a representative from our health program. Both of these committees are led by myself. This is our Fast-Track Protocol, might be a little bit tough for you to see, but if you can zoom in you can see that we have fast-track and non-fast so just like I discussed.

100% of our patients when they come in with a suspected hip fracture, we put them through the patient pathway. Our goal is to get them optimized within 36 hours. When a patient seems fast-track there is a banner that does show up in our electronic medical record. So every person who opens up the patient chart knows that the patient is in fact a fast-track patient and knows that we are all working towards these goals, again, standardized orders and then our Patient and Family Education.

So for our DSC, like I mentioned, we were the first hospital and our four metrics that we are keeping track of in our data is to the OR under 36 hours. So again, it's just for those three fracture types and this can be confirmed via x-ray, CT scan, or MRI. Our second goal is to have our Fast-Track hip fracture patients out of that post-op day one. They don't necessarily have to take a couple of steps, that's great if they do, we just want them at least standing completely away from the bed. Our third one is discharge on or before post-op day three, and then to address dementia, we are keeping track of the CAM negative patients when CAM is assessed in the emergency department, we want to make sure that the CAM negative remains CAM negative throughout the hospital admission.

We created a hip fracture handbook. This is given to all hip fracture patients on arrival to the emergency department. We also do keep them up on the orthopedic unit. We have a great guidebook for our total knee and total hip elective patients and we decided there was a need to also educate the patients who didn't plan for this fall. So they didn't get in the education prior to coming to the hospital, but we created a 16-page book that does carry them and their families from pre-op through immediate post-op and then even when they are discharged and talk

about prevention of future fracture falls and prevention of delirium.

In conclusion, I do wanted to just remind you, that you are already advocate for the hip fracture population- be creative. We meet monthly with our teams, sometimes every other month depending on issues that are arising, so we come up with ways to be creative and make sure that the staff has all their needs met, the patient, the family has all their needs met. We don't want to lose sight of all the individuality of the patient. Yes, we have these goals and these metrics that we follow, but we do, do drill downs just to see what are the specific reasons why our patients fall out of our metrics. And then always keeping the communication doors open. Again multidisciplinary team, everyone has great ideas, and we also want to make sure that when our patients leave the hospital go either home or to subacute rehab that wherever the destination is any questions have been answered for them.

So thank you again for taking the time out to listen to this webinar. Here is our contact information, so please feel free to reach out to us if there is any question that you think of in the future.

Alicia Goroski: All right. Thank you so much Samantha, and I do just want to kind of again just pause for a moment and reflect on your presentation, and you know what really struck me is that I think the two pathways that you highlight – that you shared and discussed really, really just highlight exactly how complex this population is. You know there can be many, many comorbidities. You also mentioned dementia, so I definitely see a recurring theme here during today's event and you know that need to coordinate across so many different medical, ortho, pre-op, post-op. So again I think it was great your pathways. Thank you so much for sharing that.

Samantha Rodgers: You are welcome.

Alicia Goroski: Yeah and I will just give two quick reminders to the audience. First, again, share your questions, we will be doing all the questions at the end. And second, I saw a few requests for the slides just wanted to- Laura had put this in the group chat- but in case you're not seeing group chat you can download a PDF of today's slides right here from the webinar platform. Look for that Event Resources box, click on to where it says webinar slides then you have to click the Download File button just below that. If you have any issues downloading the slides just let us know, and we can get those over to you. Sometimes pop-up blockers don't allow that. All right thanks for keeping the questions on coming. And now I am going to move on to our third presentation, and with that, I am pleased to welcome David Broussard. David is the Senior Director of Care Management Services at East Jefferson General Hospital in Louisiana and so David.

David Broussard: Hi, welcome from South Louisiana. My name is David Broussard. I am a Senior Director of Care Management Services here at East Jefferson General Hospital. We are in a suburb of New Orleans. We are a full service acute-care facility and we got together some time ago because we knew the CJR bundle project was coming, and we also knew that it would be just a short time that we'd have to do something for other bundle projects as well as our fractures were deemed of utmost importance. So we got together, we built the Steering Committee, we put this whole project under a performance improvement team and then once we got the project going then of course physician alignment was key.

We had each discipline review their best practices for their particular service. We had of course several meetings later and we came up with our fracture plan. And of course, we can apply this fracture plan not just to our Medicare beneficiaries, but to all patients who come with fractures. We coordinated with our emergency department, so they jumped on with both feet. Our orthopedic surgeons are on call 24/7, we have anesthesia available. Once it's determined that a fracture patient can go to surgery it was our intent to reduce their length of stay between presentation in the ED and into the surgical suite. So what we did was once they are in the ED and the team gets together then they can declare whether the patient is appropriate for surgery, and we don't have to worry about cardiology clearance, pulmonary clearance because the anesthesiologists will get called in, and they volunteered to do this program and they come in and clear the patients.

We established a revised pre-anesthesia clearance protocol just for this particular purpose. Our surgical team gets called out, they come in, we can start the case at around 6 a.m. and our goal was also not to affect our surgery scheduled for the entire day. So we can do our – perform our surgery and our patients come out of surgery, recover, and usually get to the unit early morning just after surgery. We have dedicated service line beds for our orthopedic patients and of course on that unit is trained and educated nurses, all the ancillary staff, respiratory, very well trained, physical and occupational therapists who see the patient same day. And we had great success with our multimodal pain management during surgery instead of using narcotics we have a cocktail that surgeons use and then post, we try to avoid narcotics at all costs. Our intent was to make hospital day one our post-op day one. We do utilize minimum narcotic use. Our Regimental Therapy Program they see twice a day if upon tolerance. We have a dedicated care -- orthopedic care manager as well as a dedicated CJR bundle navigator and those two individuals coordinate and make sure we have a Plan A and a Plan B. Our goal is to make sure that our discharge plans are in place so that when our CDI nurses review it we get a confirmation of the DRG and then we proceed with discharge depending upon the length – patients' satisfaction, patient abilities to ambulate, where they're going. We do have our own skilled unit here, so we have a high utilization of skilled services.

We do also have post-acute provider networks here in our community, and one thing that we really did well was there is a ton of home health licenses in our area. So we did an RFP, passed it through compliance, and we narrowed it down to four providers for our home health services, and they understand their responsibilities in this program, also they communicate with us quite well. Continuum of care, our navigators follow obviously through it – the hospital stay here. Our goal is post update to discharge to a safe disposition, and we have follow up calls by our navigators at day three, seven, 14 so on. Orthopedic surgeons are kept in the loop, primary care doctors are kept in the loop, and if they by chance have to go to the post-acute provider, we do weekly conference calls with the therapy staff at the facility to make sure that our patients are moving and progressing the way they should. That's what we do at East Jefferson and thank you very much.

Alicia Goroski: All right, thank you David. And I think you shared a lot of information. I know we've already got a few questions coming in so like I said we will be getting into those. I think there is definitely some interest in hearing a little bit about the pain management, and it piqued my interest as well instead of narcotics. I definitely think the opioid crisis is front in center these days. So we will ask you to follow up a little bit on that after we hear from our fourth presenter. So we are -- and again the questions coming, we will have kind of time at the end for some Q&A

as well as open discussion. But now, we will move on to our fourth and final presenter during today's webinar and with that, we are pleased to have Joyce Kight, the CJR Program Manager and Deborah Silverman, the Hip and Femur Fracture Program Manager- sorry that's a tongue twister- from Duke University and Duke Regional Hospitals. So with that, I am -- I believe Deborah, you are going to kick things off.

Joyce Kight: I am just going. This is Joyce Kight. I'm just sending greetings from Durham, North Carolina and I'm very happy and pleased to introduce Deborah Silverman who joined our team this fall as part of the bundled payment project. Take it away Deborah.

Deborah Silverman: Thank you Joyce. Well hello from Duke University Health System. Joyce and I are here representing today two of our three Duke Hospitals. The first is Duke University Hospital located in Durham, North Carolina which is our major medical center and second is Duke Regional Hospital also located in Durham, North Carolina which is one of our two community hospitals. From the map, you can see that we get patients even though we are a major medical health system we get patients from all over and very many of them come from very rural areas. And our demographic for our hip fracture patients, they are mostly female, the average age is 81 years old, the average length of stays for the two hospitals is 8.2 days, of course you can see there is a huge range there from 3.1 days to 16 days depending on how sick they are. Being in a major medical center here in Durham, we do get the sickest of the sick at times. 40% of our hip fractures are in the CJR program, 60% of them are not in the CJR program, and as you can see, a lot of our patients do get discharged to skilled nursing facilities.

So in 2012, we started our Hip Fracture Steering Committee and case management was invited to join in 2013, and since then we have incorporated many of the same initiatives that have been mentioned in other presentations today. We worked on early optimization for OR, we used the standardized pre-op order set, we worked on multimodal pain management, our anesthesiologists respond to hip fracture call from the ED within an hour of the call, and then they show in the ER and put the blocks – get the blocks to the patients right then and there in the ED, so they get pain management as soon as possible onboard. And we also greatly use the Cotylenol in addition to the block to try to minimize narcotic use. And the ultimate goal is to get our patients to the OR in less than 36 hours and many times less than 24 when it at all possible and appropriate. We also have standard post-op orders including DVT Prophylaxis and calcium and Vitamin D and we do initiate early mobilization with PT initial evaluation starting on post-op day one.

We have also increased our efforts for Patient and Family Education. We start upon admission with a packet, we continue to educate them throughout their stay and then again upon discharge, and we have also worked on provider scripting for osteoporosis follow up. In 2016, our CJR program manager positions were created and that's when we had Joyce here and our other CJR Program Manager Debbie came on board. And then just recently in September of this year just couple of months ago they created the hip fracture program manager position and then I came onboard. And you can see that our team is very multidisciplinary. We have all levels as part of our team, it's a very, very invested team all the way from floor staff through administrative leadership. And our current state here at the Duke Health System at Duke Regional being the community hospital we have narrowed our attendings for our hip fracture patients down to three select internal medicine hospitalists. They do great job taking care of our hip fractures so if anybody comes in with a hip fracture they will get one of those three

attendings. And as great as they are at handling our hip fracture patients and making everything good for them, they also still make geriatric consults as needed for those cases like severe dementia, delirium and such.

Duke University Hospital being quite a bit bigger and that model did not work for Duke University. So what we use over there is we have internal medicine hospitalists as the attending and orthopedics is consulting but we've also instilled a HOPE consult which is like a geriatric consult for every hip fracture patient. The HOPE consult is part of the order set, so it gets ordered on every patient that comes in with the hip fracture and then therefore the HOPE geriatric nurse practitioner can come in and do an assessment and see which patients are appropriate and which do not need it and that way we can keep anybody from falling through the crack, hopefully. We also do monthly hip fracture committee meetings with performance services data reviews, co-management with physicians. There are weekly community geriatric rounds and then we have me, the Hip and Femur Fracture Program Manager, and I do purposeful rounding at the facilities. I start in-house and I see the patients and their families while they are here in the hospitals, but I also follow up with them after they leave.

I see them in the facilities and call them at their homes to make sure that you know they are getting everything they need. This has given us a much better understanding of what happens to these patients after they leave our hospital thereby hoping that we can continue to increase our quality of care while they are here. And as I mentioned, the HOPE consult, this is a great program, I just wanted to highlight this. This is in hospital and out of hospital. The HOPE Geriatric Program is a great thing. This is -- the geriatric nurse practitioner sees the patients while they are in hospital pre-discharge and then she follows up with them again once they get to the nursing facility and she really, really facilitates a smoother transition to bridge that gap between acute and sub-acute. So we are very thankful to have that.

And then this is our future state. So with osteoporosis having a much bigger impact on our patients, their families and our systems than I think a lot of people tend to realize, we are working on enhanced collaboration between orthopedic and endocrine with earlier endocrine intervention. We are also working on perfecting routine early identification of those patients who would need benefit from geriatric involvement. And we are also working on increased coordination and collaboration through all phases of care from ED all the way out into the community and one of the things we have done is we have created the SNF collaborative in which we meet as a hospital with the representative from the surrounding nursing facilities. We all get together in one room to discuss how together, sub-acute and acute, we can improve the process and the care for our patients and that's really a fun thing to do.

And we are also working on efficient and effective use of community resources. We have the HOPE, we have DEFT, we have DukeWELL but there is also palliative care and geriatric, Meals on Wheels, and I'm continuing to try to identify any community resources out there and find a way to get them to our hip fracture population to make things better for them. And then the last thing that we look at is the ideal state if we could figure how to avoid the hip fracture in the first place that would be ideal but until then we are going to continue working on our processes as they are. Thank you.

Alicia Goroski: And thank you Deborah, so I guess right before we transition into Q&A and group discussion time, I just wanted to kind of comment and reflect on I am going to back to your

future state slide. And kind of this final bullet of really I am glad to see this in here because I do think this whole kind of notion of coordinating effectively with those home and community based services in your local communities is really kind of to your point the future. You know how can we really engage and work pull those into the medical model. So I am glad to see that hopefully we will have some discussions on that. Great.

So now we are going to transition into open discussion time and Q&A. So we do have several questions that have come in through the group chat, so I am going to start off by seeing if we can make it through and get all of these answered. I will say that also if you have a question or more importantly if you have kind of an experience you would like to share raise your hand and then we can unmute phone lines. So again if you raise your hand then we can definitely call on you as a participant.

But what I want to do first is kind of we are going to go back to our first presenter and Nanci- I was wondering in particular because this was identified as a challenge by one of our participants on the webinar today- if you would be willing to just talk a little bit more about how you manage those fracture patients that you do identify as having dementia.

Nanci Smith: When they do have dementia they have -- they will have a sitter stay with them here in the hospital one-on-one to make sure they are safe. In elder care or geriatric care consults will be ordered, and they will see them from there and they do have there is a dementia care team that works with them and their families as well. And I know it is a challenge because we can't cure it we just need to take care of them and get them through this. Often people have aides you know sit in the rounds and I do round on these people. They haves aides and caregivers at home, so it is quite a challenge but one thing that I do like that I have seen that we do not do is the fracture information for the families. I think that's phenomenal and that's a great takeaway for me and for I think my hospital going forward.

Alicia Goroski: Great, great. So next I will kind of transition to Samantha and Randy, we did have several questions that came in while you were presenting, and I will start with this first one that Steven Maser asked, he asks specifically if you, do you have a hip fracture block time daily. Is it during the day and do the on call orthopedist caring for these patients commit to being available during that block time?

Samantha Rodgers: Yeah so we do have block time Monday through Friday, we do not have block time on Saturday or Sunday. So this block time started, we actually had part of our steering committee includes an orthopedic surgeon trauma surgeon as well as anesthesia as well as the manager from the operating room. So all of us all together did decide that we needed to make sure that there was an orthopedic room ready for our hip fracture patients and it wasn't going to be a room used for other traumas, so we did want an orthopedic specific room. Most of our elective cases start 6:30 in the morning and usually the last case is at 2-ish, so with their hip fracture patients depending on the time that the surgeon is available will go between 2 until the evening hours. On occasion we do have some surgeons who do operate early in the morning you know midnight 1 o'clock if it's necessary and they are available.

It does run into an issue on weekends where if the surgeon needs to do either a total hip or hemiarthroplasty and they don't have somebody to assist them then that case does get pushed until Monday, but if it's a gamma nailing, if it's any other kind of fixation that only requires a

surgeon than they will take any time that's available on the weekends, but for now it's just Monday through Friday after the regular scheduled elective cases.

Alicia Goroski: Great, thank you. And Samantha while I have you, there was another question from Dawn Rakiey and you know this I think is a great question. She just asked how are you getting your fractures out in three days or less? And she shared that that they are struggling to get theirs out in four or five days despite early mobility and you know some of the other things. And they are she just also shared that they are the only trauma one center within five hours and so they get a wide variety of elderly fracture patients.

Samantha Rodgers: I hear you on that. So before we started the program really we looked back to see what our average length of stay was, and we didn't- we decided on this metric not on the overall length of stay we did base it on from surgery to discharge. We did look at it as a post-op day length of stay. So when we first started we were about post-op day 6, 7, 8, 9, 10 really creeping up there. But since we started this program, we do have a member of our hospitalist program on both the steering committee and the practice council so that we found that was very beneficial just because I myself reach out to them every day just to make sure that okay what needs to be addressed in post-op one and two, what's their hemoglobin level, do they need a blood transfusion now before waiting for it to creep down to a lower number. What are their electrolytes, what about vitamin D, calcium? What are some things that we can start doing now so that way when post-op day three comes around we are not saying oh wait a second let's push it for another day? It is a metric that we do struggle with that's the one metric that we are far away from our benchmark goal of 90%. So over the quarters we do look to see how we're trending and we're some quarters about 70%. In the second quarter this year we had 80%, but we also do keep track of our length of stay post-op days four just to see okay how much further different are we. And sometimes it's just a patient or two that's going on post-op day four that we really could have captured to go on post-op day three. So we are not 100% I will be honest and tell you that, but we decided to keep that as a stretch goal because we do find that when you have that stretch you know everyone's trying to work towards that goal. So again, bring in my hospitalist, bring in a couple of the private medical doctors that you're working with and invite them to your meetings, let them know exactly what's going on, what are the issues, do drill downs so you can really find if there is any trends that you can help prevent for the future fractures.

Alicia Goroski: All right, great. And just one quick follow-on to that this question just came in from Patricia Richards any words of advice on how to educate your team kind of getting, you talked a little bit about this, but I guess just kind of what would be your number one piece of advice on educating your team on regarding that three day discharge?

Samantha Rodgers: Yes. So we have multidisciplinary rounds every morning on the orthopedic unit. We have the ability that we have actually two nurse practitioners: myself who follows the hip fractures and the traumas and then my coworker Janine who follows the total joint patients, but between both of us there is coverage Monday through Saturday. Neither one of us are here Sunday, so that does help to have rounds six days a week, so we know exactly what's going on. And then secondly, we do have a share point on our intranet that is updated you know as needed but that way any team member across the entire hospital has access to see any updates. And then we also do online learning where we created the PowerPoint question and answer so that way the whole hospital staff members were educated and know exactly what the goals are

with our program. And anyone in the hospital knows they can reach out to me, I make rounds anywhere where there is a hip fracture patient. So I'm not just specifically on orthopedics, I'm a hospital-based hip fracture APN.

Alicia Goroski: Okay great. And one final question Samantha for you and Randy there were several folks who said they would love if you- asked if you could share your patient guide.

Samantha Rodgers: So I actually led a webinar over the summer for NAON and for Geriatrics Society and had the same response. So I had a feeling that was coming. Yes definitely. So I can either send it out individually or if there is a place that we can send it you- it is copyrighted with our hospital, so we do just ask that you use it as a reference and for ideas. It took a quite a while for us to get it passed through all the committee. So definitely can use it as reference but just for that reason.

Alicia Goroski: Okay great. So we will just to kind of I am thinking to make that easier on you, if you want to just share it with us, we can then kind of get that out and again with that caveat to please use this as a reference we could use CJR Connect for that.

Samantha Rodgers: Sounds great, thank you so much, thank you everyone for your interest in that.

Alicia Goroski: Okay now David, I have given you the heads up you are going to be up next then we are going to move on to Duke. So David as I had indicated kind of in reaction to your presentation, there was question from Dawn as well asking about what that pain management that instead of narcotics is- is that something you can talk a little bit about?

David Broussard: Sure, first our orthopedic surgeons we were a big utilizer of Exparel and then of course the cost of that everybody started reviewing it and saying how much it cost and IV Tylenol and the outcomes and the research that we looked through there was no real effect between using Exparel and using multimodal. So our surgeons we- whether they developed it, or they'll take credit for it of course- but we use a compound, it's ropivacaine, epi, ketorolac, clonidine and they use that cocktail inside during in the perioperative phase and then the post-operative phase we use a lot of not IV- PO or liquid Tylenol, we do Celebrex, Neurontin whatever we can use to avoid the narcotics. Obviously we do have some of the issues with using oxycodone. But we try our best even we do it through a little mix of Decadron in there sometimes. Some of the surgeons seem to think that that helps. That's what we try to do, obviously there are from some cases that doesn't work: high tolerance low tolerance. We try to treat our patients individually, so we will see how it goes but we do, we do we have avoided a lot of narcotic use recently. Does that help?

Alicia Goroski: Great. Yes, I think definitely. Okay, so now I am going to move on to sorry I am just trying to kind of triage these questions here to Deborah and our Duke team. So Deborah we actually had a couple of questions- and I think you indicated you can address this one- asking about whether you're talking about those pumps when On-Q pumps when you talk about the pain blocks. And yeah.

Deborah Silverman: Yeah so yes I am talking about femoral blocks done in the ED and the funny thing about the On-Q question is that at Duke University Hospital they do typically insert a

catheter and use the block for pain management beyond sometimes into the post-op era. And if it's regional they do not use the catheter they do a straight block and if the patient if it wears off and the patient hasn't gone to the OR then they would have to redo it, but it's that's a good question about the On-Q pumps from Dawn because one of our hospitals does it with the catheter and the other one does not. But we do them in the ED and it seems to be very, very helpful with pain management.

Alicia Goroski: Great. So we have one, one recent question that just came in so Nanci going back to you, Dawn also had a question for you asking where do the sitters come from who sit with your patients, and is there a committee of people who rotate to sit with them or does it refer to their families?

Nanci Smith: No, it doesn't refer, I mean obviously their family is always welcome we do encourage them and they can visit any time here and stay, but typically there are staff members within our hospital that have been trained as sitters and that's the pool that we use. On rare occasion they can bring in their aide, we have one patient actually here now that has 24/7 home help. And that gets approved and that lady can come be with her continuation to care, a face she recognizes through all the turmoil and that is allowed as well.

Alicia Goroski: Alright wonderful. So I am going to go ahead, and I moved us along we do have a quick poll that I would like to invite everyone to respond to. And we can go ahead and make the most of these last four minutes, so we had a question and I do just want to say there were a couple of questions that our presenters actually have kind of private messaged me and said I don't actually have the answer, but you know they may be able to look into it and post it on the Connect site. So if you ask a question I think there was one about volume and then average length of stay. So if you ask those questions we are not ignoring you. They need to do a little research on those, but while we leave the poll open for another little bit and then Kelly asked, and this is really to all of you, so I will open this up. I want to mention we got about 90 seconds to do this. So think through and we don't have just jump in but how are you empowering families to care for your hip fracture patients at home in order to reduce SNF admissions? Anybody have you know advice on that?

David Broussard: We try to train them as soon as we can. First of all we would love to have family present, sometimes it's a shame we don't- we have a very high Medicare population that live home alone, but we try to train them up, we do family training, we do sessions with therapy. We try to make them realize exactly what care they are going to need so that when discharge is coming that they have a good idea what they can and cannot handle.

Alicia Goroski: Thanks David. Anybody else?

Nanci Smith: You know the vast majority of our patients, this is Nanci, go to subacute rehab. So I know the orthopedic staff does do a little bit of education about what to expect there. But as far as you know and again a lot of our patients come from long-term care facilities, they are home with home health aides or people and but that is a need and a big question because a lot of people do live with their family members and they feel that it's like it is way too much for them to handle, the frailty of these people. So I think it's something that really needs to be addressed and would most likely have a positive benefit for our patients.

Alicia Goroski: Yes alright. Well I want to just take a moment to thank all of our presenters. This again I think that there is so much interest in this topic. Today's session as I had mentioned earlier really, really highlighted how complex this population is. And the other thing that I think came through loud and clear in particularly Duke- you mentioned that there is no one single process and solution that is going to work across. You know you even said between your two different hospitals the process is a little bit different. So hopefully everybody out there heard you know at least a couple of things during today's session that you might be able to go back and test out in your own hospitals.

Just a quick reminder to continue the discussion on CJR Connect, the slide 54 includes some information if you do not have a Connect account. Also just a reminder, we do have two session four and five coming up in December and January. You can register for those. We have actually been kind of registering if you have joined one of these we are registering you for the next ones. So you will get registered for those, and then you can choose if you have a conflict we understand.

And just a final reminder, as I said, please take a few minutes to complete that post event survey. We do look at that and again we tested out that map based on a suggestion from one of you after the last session. So thank you again to our presentation, the hospitals that gave presentations, and thanks to everybody for joining us today. Have a great rest of the week.

Thank you.