Identifying and Communicating High Cost/Low Quality Drivers: Deep Dive on Post-Acute Care Provider Data (Group A) Transcript
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Isaac B: Welcome, everyone to our CJR Data Affinity Group. This is a breakout session on Identifying and Communicating High Cost/Low Quality Drivers: Deep Dive on Post-Acute Care Provider Data and we're excited you're here with us today.

Isaac B: We're going to go through some introductions. This is myself and Laura Maynard will be facilitating this session. In terms of the agenda, we'll go through today- Laura will talk about logistics. We'll have presentations from SC health and St. Francis. We'll go around and call on folks to have some discussion and pull questions. We will wrap up with some announcements. With that, I'll turn it over to Laura.

Laura M: Thank you, Isaac. Glad you're with us. Just some logistics, currently, all phone lines are muted. But later on in this event, we will open the phone lines for you to be able to discuss and talk with one another. We really want you to talk to each other through the chat and on the phone. Closed captioning is available by clicking on the media viewer in the panel on the right side of the screen. For group chat, you go to the top of your screen and you will see the cartoon talking bubble that says chat under that. The chat will open up on the right-hand side of your screen. We'll be using that quite a bit today. You'll see in the chat panel where you can chat to different individuals. Click it so it says "all participants" then you can chat to all of us and we can talk back and forth with each other. If you send it to "panelists only", it'll be for technical questions and someone will help you if you have a need for that. So we want to practice using that chat panel. Let's check it out. We want to do introductions in group chat. I want you to type in your name, your organization's name, and something you're hoping to learn about using data to develop partnerships with your post-acute care providers. If you, throughout the presentation, want to ask a question to someone in particular, use the "@" symbol in front of their name and we'll know who to direct the question to. Both questions and comments go in the chat box. We're going to practice doing that by clicking on chat to "all participants" and put your name, your organization, and something you're hoping to learn from this session. So continue doing that as we begin our presentations and as we do so, I am happy to introduce Pam Masters. Pam is the Program Manager for Accountable Health at St. Francis Health and SCL Health. She is going to share with us a little bit about their approaches to working with their post-acute care providers.

Pam M: Thank you. Good afternoon. I am from SCL Health System, which is a 12 hospital system. Can you forward to the next slide please? Thank you. We're a 12 hospital system located in Montana, Colorado, and Kansas. Five of our hospitals are participating in CJR and we all work together to determine our plan of action for tackling the mandated bundle and building our processes. I'm from St. Francis Health which is in Topeka, Kansas. We're a 259 bed hospital and we perform about 200 Medicare CJR cases annually. Next slide please.

Pam M: When doing a review of the literature and looking at our historical data, we discovered some common themes that led to some of the decisions built into our processes. First, we found

that our cost consistently exceeded target when our patients discharged to SNFs or to inpatient rehab. We also, at St. Francis, have an MSSP. For our MSSP population, we found that our discharge to SNF rate and our length of stay at SNFs exceeded target as well. We hired a nurse navigator to manage the preadmission risk as well as the 90 day post discharge episode. We determined some best practices to implement that includes preoperatively, interpretatively, and postoperatively. We engaged our surgeons, anesthesiologists, hospitalists, and primary care providers. We implemented some objective discharge criteria to determine the most appropriate level of care. We also developed a Plan B order set that is a safety net set that are for patients discharging at home with home health, but are at risk for readmissions. They already have their skilled order set for the home health to hold. It enables us to avoid unnecessary ED visits or hospitalizations. Finally, the piece I am going to talk the most about today, we engaged with our community partners and formed a Transitions of Care Counsil. Next slide, please.

Pam M: This is for our pre-CJR data. This is for all populations, regardless of payer. There are commercial payers and Medicare payers. We found that we had a 30% discharge to SNF and inpatient rehab. We only had a 3% discharge to home health. This allowed us some room for us to shift appropriate patients from the rehab or sub-acute level of care to home health services. Locally, we have two inpatient rehabs, 11 skilled facilities, and five home healths. We chose to align with four of our skilled facilities and three of our home health. We call them our preferred partners. Our partners were chosen based on quality data, and that includes their star ratings, readmission rates, referral conversion rates, and the ED visit rates. Next slide, please.

Pam M: For our post-acute collaboration, we determined first that we needed to engage our post-acute care providers. We did this by meeting with them and sharing that seamless innovations, for the most part, start in acute care but we'll eventually move to post-acute care. They will have an eventual impact and if they start working on their processes now, they'll be ahead of that. We also believe that by being a preferred provider, and being on that options list, they would have more referrals from patients who weren't familiar and who didn't already have a SNF in mind. Those patients, a lot of the time, would ask about who St. Francis would recommend, not that we can recommend, but if we have some specifics on our preferred provider list, that would indicate that. We asked them to consider the mindset this population can be managed, rather than a fee-for service patient and more like a managed care patient.

In regards to working with our nurse navigators, we ask therapists at the skilled facilities and home health, to start services within 24 hours even if it's a Saturday or a Sunday. We ask home health to frontload therapies for the first week and see them every day. Our nurse navigator goes to the skilled facilities and works with the staff there to develop a plan of care. Also, participates with the home health plan of care. We have the Transitions of Care Council. We developed alignment agreements with our preferred partners that outlined our expectations and the expectations they could have of us. We have monthly meetings with these partners and the discussion at each of those meetings talks about our root cause on readmissions, our length of stay, their length of stay, or for home health, how many visits they do, and we did ask that they aim for a goal of 8-12 days on average. That includes the fracture patients as well. We've asked that there be reports in any delays of care and we do a high risk patient review. We report to them on any patients that go to providers outside of our preferred network. We talk about the percentage of patients that are discharged to skilled versus what our goal was. All of us provide

any updates or changes to the program, and any best practices or innovations that we've implemented. We have a quarterly report that everyone is required to turn in. The skilled facilities turn in information about their star rating, length of stay, hospital admissions, ED utilization, fall rates, and staffing. Home health turns in information based on star ratings, length of stay, readmission rates, ED utilization. Actually they both talk about readmission rates. They also turn information about patient experience, which is an addition on the home health. Next slide, please.

These two graphs show some of our outcomes. Our initial discharge to rehab for skilled and inpatient rehab was 30%. By year end, it was down to 24%. We started out better during the first quarter but our quarter three data, we've had quite a few fracture patients. This impacted our skilled discharge rate. The second graph shows that we've had a baseline of 70% discharge to home. This includes the commercial payers on that number. The yearend discharge rate to home was 76%. This was just for the CJR population, Medicare patients. I feel like it's likely more than that. And then our home health referrals went from 3%, up to 15.5%. Next slide, please.

Our length of stay for skilled, which was one of our main focuses, went from 22 days per patient down to 13.9 days per patient. This number also includes our fracture patients. Our inpatient length of stay for the hospital went from a 3.89 to a 2.77. With our risk management and nurse navigator interventions, our readmissions rates showed a decrease as well, down from 11% to 9.5%. Again, the readmissions rate, we were doing really well during the first two quarters and during quarter four of 2016, we had quite a few readmissions that quarter, which impacted that number. Next slide, please.

Our overall goal of improving outcomes and reducing waste is being met through these innovations that we've implemented, as well as the collaboration we continue to develop with our community partners. The CJR program is instigating accountable action in our system and also allowing that transparent partnership with our post-acute partners to be built. I thank you all for the opportunity to present our work today.

Laura M: Thank you, Pam. That was very interesting and helpful. I'm hoping some folks will have some questions for you. At this time, we're going to open up the phone lines so that you can ask your questions verbally. That means your phone line will be unmuted unless you mute it on your end. If you've got background noise or a group talking with you, please mute your phone. We're going to unmute the lines now to see if anyone has questions for Pam. Does anyone have a question or a comment verbally on the phone line or we can see some of the ones that have come through in chat. You can also ask additional questions in chat. Does anyone on the phone have a question?

Isaac B: Laura, I can go ahead and kick things off. I'd be more interested to learn more from Pam's unique aspect about having your post-acute partners and this council reporting to you and having them share data with you. I'd be curious to hear what your market dynamics are and what precipitated that arrangement. My sense is that that would not be the case in most markets.

Pam M: Topeka is not the biggest city. We have a lot of skilled facilities but our sub-acute was fairly small. There is only one other hospital. We had a good relationship with those who had the higher quality scores already. We were able to sit down and have those conversations and be transparent about where the expectation with this bundle that CMS mandated and we talked about that. We talked about where we were headed with healthcare. The skilled facilities and home health were very open to working with us on this. We share information with them and they share information with us. It's a two way street.

Isaac B: That's great, thank you.

Laura M: We've had a question come in through Q&A from Nancy. She wants to know if you engage in any financial arrangements or gainsharing with your preferred providers.

Pam M: At this time, we don't. We kind of wanted to get things rolling and we've had some Year 1 goals to work on first. There were a lot of things to move into place quickly with this bundle, so that might be something we do in the future because we realize that we're asking them to reduce their admissions and reduce their length of stay for any unnecessary utilization. We have discussed that in brief, but at this point, we're not.

Laura M: Thank you. Are there other questions for Pam? Anyone on the phone line have a question you'd like to pose? Okay, if not, go right ahead and type your questions into the chat panel. If they're for Pam, use the @ symbol and we'll make sure she gets the question. We will move on forward and introduce Hailey Hill. Hailey is the Bundled Payments Program Coordinator at St. Francis Medical Center. She's going to share with us about their practices in regards to their post-acute care providers. Hailey?

Hailey H: Thanks Laura. My name is Hailey and I am the Bundled Payments Coordinator at St. Francis Medical Center. I'm going to share with you how exactly we're engaging our post-acute care providers and what information we're sharing with them. Next slide.

This is a little bit about our facility. We are a part of the Franciscan Missionaries of Our Lady Health System. It consists of five hospitals across the state of Louisiana. Our facility is located in Monroe, Louisiana. We're the only CJR hospital in our health system. We have one sister hospital in Baton Rouge, that were a part of BPCI and they are not in a CJR MSA. Their program is coming to a close. We have 504 licensed beds. Our volume for our DRG 469 and 470 for FY 26 was 439 cases. We're running 56% of them being CJR. A couple of important facts about our facility. We own our own skilled care and inpatient rehab. I felt that was important to share with you because typically hospitals who own their post-acute facility have a higher utilization of them and that is our case. We're running about 60% historically of our elective patients using skilled care. We also have our orthopedic surgeons that work at our facility are non-employed. This can make care redesign a little challenging. Next slide.

I'm not going to spend a whole lot of time on this slide, but I did want to take some time to tell you what our first step was when we realized we were in CJR. Our first step was to develop a governance structure. We have an oversight team, compliance team, a care redesign team, and a

gainsharing team. The care redesign team's first task was to truly dissect the patient pathway on a total joint procedure journey to really identify opportunities. Next slide.

This slide dissects our pathway into three different phases. The first phase being the pre-operative phase, next is anchor hospitalization, and finally, post-hospitalization phase through 90 days. What our care redesign team was to create a flow chart for each phase of each of the larger phases we've identified. For example, we developed a flow chart for our joint class. We mapped out the patients arrival, all the materials the patient receives, and every education piece that was presented to the patient through this class. The same thing was done for the pre-admit clinic. We mapped out their arrival, detailed the nursing interviews, and detailed any paperwork that was completed during that time, and then we also detailed all the pre-operative testing through the end of the appointment. That was done through each department and for anchor hospitalization, and again for the post-hospitalization phase. I did list some opportunities that we identified but I really want to focus on communication with post-acute providers. Next slide.

We knew we wanted collaboration with our post-acute providers and we really, after dissecting that pathway, we realized that our problem was that there was a lack of communication. Our old method was to send a referral to home health or skilled care. They accept the patient and we discharge them, and that's where the communication stops. We didn't have the care coordination to support a 90 day episode. So our care redesign team brainstormed different solutions we'd like to implement. One of those was clinical pathways and the other would be to improve discharge planning to really make it as efficient as possible. We wanted to develop some type of communications platform with our post-acute providers in the community. So I wanted to partner with our senior services manager and we brainstormed what kind of platform we felt would be most beneficial. We came up with the idea of doing quarterly post-acute meetings. I felt that for us, a monthly meeting was overkill for us. We weren't sure we'd quite have the content to present on a monthly basis but we certainly may change that in the future. We decided on quarterly meetings and we broke our post-acute providers into two groups. Mainly because we really wanted to promote communications within these meetings and we felt that if it was just one group, it would be more of a presentation setting and we wouldn't really have that conversation. So we broke our groups into home health, hospice, and DME. Our group two was inpatient facilities, so our nursing homes, skilled care, impatient rehab, and LTAC. From that point, we developed a standing agenda. Our senior services manager had her initiatives and her main goal. Her position was to keep the geriatric population in the community and out of the hospital. We did have some overlap from both of our initiatives. My goal was to focus on the bundled payment population. I developed a series titled "Are You Ready to Bundle?" We also have a quality presentation from attendees, and they are usually five to ten minutes. They will volunteer to do it at each meeting. They will discuss quality initiatives they have been implementing within their facility that has impacted care. We recently added an industry expert education section at the request of our post-acute providers. So many times, we'll have a physician come in and educate on certain items that the post-acute providers have requested. We always end with a question and answer open forum. We've had really great participation. In Group 1, we had 25 attendees representing 13 home health providers and hospice providers. In Group 2, we've had 40 attending, representing 21 facilities. To give you a background on how many providers are talking about, in our immediate area, we have about 18

home health and in a 15 mile radius, we have 30 nursing home facilities. We have really good participation. Next slide.

This goes into more detail about what exactly I'm sharing with post-acute providers regarding bundled payments. We kicked off our first meeting in April of 2016 and I provided an educational section on CJR. What exactly is CJR? What do hospitals expect from post-acute providers? How does CJR affect post-acute providers in the long run? I've also been very transparent with them regarding data from the beginning. I show them the historical performance year and what our variance target was. This really allowed them to see how big of a change were we going to have in our patient pathways. I also discussed readmissions at every meeting. We talk about where we are seeing patients readmit and from what post-acute settings. Why are they readmitting? On what timeframe during the 90 days are they readmitting? I also present discharge disposition with them. Historically, we had about 60% of our elective going to home. This has been our biggest focus. We generally manage our fractures well. We always come under target. Our opportunity is with our sick patients.

The other item offered is an audit of the historical data of the patients they cared for from 2012 to 2014. We broke it down by DRG and fracture status. We showed them how they performed overall to the target. We broke it down by each patient that was under their care. I've had Patient 1 who was a DRG 470 elective. I mapped out that the patient was discharged from the hospital and spent 25 days in skilled care. He was then discharged to home health and he was on service for two weeks and then he was readmitted because of this diagnosis. I would also put the cost associated with each care setting so they were really able to see that. I feel like this was very beneficial because it really allowed them to see how bundled payment reconciliation looks. It is important to be consistent in our care redesign.

In July 2016, we had our second post-acute meeting. I reported on how we performed for quarter 2 regarding home discharges for our elective patients, some were 47%. This was a little bit of an improvement from our historical data. We also implemented length of stay expectations or our skilled care patients. We took our target price and we deducted the anchor hospitalization and the average issues days. We analyzed the lump sum that was left over and determined that our expectation was that our patient would say in skilled care for five to seven days. We also implemented the stay notification. If the patient exceeded the five to seven day expectation, the nursing home would be contacting us and letting us know that the patient is leaving and he is getting discharged on a certain day and this is why. We also implemented home health pathways to make home health a little bit more consistent. We had our third meeting in October. We reported on a fourth quarter three discharge. We had 56% going home. We also educated them on new multimodal, continuous programs we were implementing for our patient to reduce the use of narcotics and reduce the length of stay, and for patient pain control.

What was important for that was that they could potentially be getting the patient sooner. In January, we had our most recent meeting and I was actually able to report on some financial performance. I had 16 complete episodes, not a lot, but I did give our post-acute care providers an overview of the episodes from April to May even though they weren't complete. They can have a bigger look on how we were performing. I was also excited that for quarter 4, we

increased our home discharges to 70%. This was a big jump and it's huge for us. Our core staff provided education for the SNF three day waiver. Next slide.

To wrap up my presentation, I just wanted to tell you what kind of impact we have seen from these community meetings. For the bundled payment program, we've been able to reduce home health by a thousand dollars on average. We also reduced our length of stay to 3.44, starting in October, to 3.12 through December. This would be the use of our multi modal program that we started. We expanded it to other surgeons and for January, we decreased again to 3.08. Not a huge change but we're going in the right direction and we're excited about it.

Another big thing would be our discharge disposition. Discharge to home, when we started off in April, it was 45% home. In January, it's now 90%. There has been huge progress there. Hospital and community wide initiatives, we had quite a few patients that were being sent to the nursing home and were expiring in our facility. During the root cause and analysis, when you determine there was a huge education opportunity, and advanced directives, after giving our facilities and community the education, we've actually decreased that by 42%. We reduced readmissions by 13% and referral acceptance time from 4 hours to 2 hours. As a community, we identified some transportation issues that affect all of us. We've had great impact and results from this meeting. This is the end of my presentation, I'd be glad to answer any questions.

Laura M: Thank you, Hailey. We appreciate that. I'm looking to see if there are any questions that are coming through in the chat panel. Also, if anyone would like to pose a question on the phone, feel free to do that. You can definitely do that. We did have one question come up and that's in regard to in working with your post-acute care providers, do you do a readmissions review? Do you have a point where you look at specific readmissions cases and review that with them?

Hailey H: Yes. I work with a nurse navigator and we sit down and review them. If we feel like it was something that could have been absolutely been avoided, we call the post-acute care provider and schedule a meeting with them.
Laura M: Excellent. Do you find that to be helpful? Has that contributed to reducing the readmissions?

Hailey H: I think so. We actually had a spike in readmissions in quarter 2. They were the highest it has been historically. We drastically decreased that from quarter 2 to quarter 3. I'm seeing an impact and hopefully we can see it for the long run.

Isaac B: Hailey, it looks like you're doing a lot of analysis for your post-acute providers as you're looking at a lot of different information. What data sources are you pulling from? Are you pulling just from the CMS claims data that we send? Are you looking at other data sources?

Hailey H: Unfortunately, the CMS claims data is awesome but it's a huge lag in time. I manually track all the discharge dispositions. Readmissions are a little more difficult because I only know if they're coming back to my facility unless the patient calls me or tells me when I call. A lot of it is manually tracked.

Isaac B: You answered my follow up and it was who is doing the data analysis. It sounds like it's you.

Hailey H: Yes, I've also contracted with a company who actually analyzes it all so that it makes it a little easier for me to analyze it.

Isaac B: Sure. One more follow up. In terms of formatting and providing that, is it in a dashboard? Is it an excel spreadsheet? Do you have another technology platform that you're using?

Hailey H: I typically use a PowerPoint and it's a simple dashboard that I'm showing them. Of course, the readmissions are all in there. Variance is all in there. Variance to target- I haven't had that one in there as long because I haven't had the most current data yet. But it is a dashboard in a PowerPoint presentation.

Laura M: Thank you. Do others have questions? Alright. If not, please feel free as we proceed to, if you have other questions, go ahead and put them in the chat box and we'll get back to them as we can. At this point, I want to ask and shift gears just a little bit. I want to engage those of you that are participating in the webinar a little more. I am going to push out a poll. I would like for you to respond. Basically as a result of participating in and learning from this data affinity group, my hospital has done what? Select all of these that apply. I am launching the poll and we would like for you to click all that apply. Let us know which of these you have done. Have you taken action? Changed the way you do some things? Improved your processes? I will give you a few more seconds. Click on those as you can. We will look at the results of that poll. Can we push the results of this one?

Be thinking as we work toward showing you the results, of what specifically you've done and learned? Yes, we have a group with no answer. The majority of you have discussed new possibilities or new directions. Many have taken action. A good group of you have also done some things that may include changing the way you do some processes or improving your processes in some way.

At this point, we are going to talk about just that question. We are really interested in hearing from those of you that are on this call, as a result of participating in this affinity group, what have you done or learned? What sorts of things has your hospital done or learned? We're going to unmute your phone lines and see if anyone will share with us what have you done or what have you learned. I'm going to jump on in and call on some of you if you're uncomfortable speaking or don't want to give an answer, feel free to pass. But I am going to ask and see if Denise Evans-- would you be willing to share with us what your hospital has done or learned?

Denise E: I represent Mercy Health, which is a twenty three hospital system in Ohio and Kentucky. Right now, 11 of our hospitals are participating in BPCI or CJR. Listening to whatever is doing, especially around post-acute, trying to help the hospitals create a committees where they can meet with their post-acute providers and implementing procedural order sets that would help drive the patient has been helpful. We use the data coming from the claims and I agree with the speaker earlier that the data is a little dated but what's nice is that we also have

internal data so we can show some trending. The CMS data gives us validity with the physicians. So really, what I learned in all of this is that as I listen, it allows me to say are we on the right path? Can we do it like how the speakers have presented? Or do we need to tweak? Sometimes, it's nice to know that you're in the same boat with everybody and you're headed down the same river. Every once in a while you'll get a golden nugget and you're like wow I never thought of that. I think at this point in time, we all tried most of the same initiatives to improve our journey hear in CJR and BPCI but the meeting brings a little tweak every once in a while that someone has thought of and in that, I very much appreciate that. Though again, most like what we've heard here today, we too have a steering committee that meets with all the heads of the markets and tries to drive the standardization. We're on Epic, so we've built an Epic dashboard/registry to capture a lot of this information. This is how we're tracking in real time. But it's good to hear how other people are doing it, just like the speaker today, who has to do it manually. It's nice to know that everyone is doing the manual work as well because we can't seem to meet all of our needs electronically.

Laura M: Thank you so much for sharing that. Let's see who else might be able to share with us today. I am wondering if Charlotte would be able to share what your hospital has learned or done.

Charlotte C: Hi this is Charlotte Caroline from HCA. I'm the senior financial analyst working on our facilities that are involved in the BPCI and CJR hospital programs. As the analyst, I was definitely less familiar with what the programmatic elements have been put into place, but would like to echo that with what data pieces we're using. We use of course the data feeds coming out of our hospitals and we're looking at the discharge status codes. We're seeing what levels of care our patients are utilizing after that anchor in patient stay. We rely on the CMS claims data but because of the delay, it makes it difficult to actively track those patients over time. In the moment, it's difficult to actively track them and have an impact on their episode at that time. We use the claims data to go back through during our reconciliation and also just to verify the data that is coming from our hospitals. We see what readmissions are occurring and what ED visits are occurring outside of our system.

Laura M: Thank you, thank you so much for sharing. Let's hear from Pam Brownfield. Would you share what your hospital has learned or done as a result of participating in the group? I know you've been really active in the group and participated all along… what have you all learned or done?

Pam B: I hate to say this but I'm going to have to get off this call to get to another meeting. I will send you some notes to share with the group.

Laura M: That would be fantastic. Thank you so much. We always continue these conversations on CJR Connect and so that is a good place for us to continue talking about this.

Pam B: Okay, great.

Laura M: Dan, how about you? Could you share what your hospital has done or learned?

Dan B: I don't know that I have a lot to add at this point in time.

Laura M: Okay, that's fine. We can always continue the conversation on CJR Connect if folks want a little bit more time to think about it and then be able to share out with the group. It's always helpful to helpful to get the little tidbits of information from each other. What have we gained? What have we learned through the process of participating in this?

Anybody else that is on the call want to voluntarily jump in? I won't have time to call on everyone. Is there anyone that would like to jump in and share with us what you have learned or what you have shared?

Nancy G: This is Nancy Gomez from St John's Riverside Hospital. We're a small community hospital in New York. What we looked specifically, we targeted our readmissions and what we were finding is that our emergency room physicians needed to be on board with respect to what is a possible surgical site infection or not. What we did is that we met with them as a group and decided that instead of them giving the automatic dose and then call the orthopedic surgeon, only for him to say it wasn't an infection, to call the surgeon first and really evaluate and reeducate them as to what exactly is a surgical site infection. We've noticed that even if the patients do return to our emergency department, for maybe some bleeding or excessive redness that they were worried about, the ER doctors are not automatically jumping to give them the IV antibiotics and admit them. We did see somewhat of a better result with that. Our readmission rates, we are a very small hospital, and I'm not talking just about CJR but I'm talking about all of our joints. We have seen a much better outcome and the patients are being seen in the ED and being sent home, instead of being readmitted.

Laura M: Great, thank you so much for sharing that. Anyone else have a comment on something that you've learned or done as a result of participating in the group?

Isaac B: Laura, this is Isaac. I'll jump in here and provide a couple of quick comments. I think this is a useful discussion and I think we've highlighted over the past few sessions about how we can sort of use various types of data, whether it's the last session being physician data. Previously, we talked about physician score cards. Talking about various data and data sources that we can use to engage in these conversations and engage in these partnerships are really needed, right? So, taking a look at if I'm a CJR hospital, I am going to take a look at my episode costs in general and looking at the biggest chunk of that cost is probably going to be in acute care stay. The next highest, it would be the post-acute case. Those ERF and SNF stays are more costly. It's looking for appropriate discharges and using that data to then engage in those conversations. This is something we've been learning through this. I think it's been useful to go through the group and hear the stories for this. I think there's a bit of contrast. Pam is sort of using post-acute providers for them to get data for the groups and there is a contrast with Hailey where they are providing analytics for their post-acute care providers.

Laura M: Thank you Isaac. At this point, I want to gather more information from the group in general. I want to learn more about your experiences in the Data Affinity Group. We're going to quickly push out two to three polls in a row. This first one shares with you the goals of the Data Affinity Group. This is what we've been trying to accomplish throughout. The poll is

launched. Please feel free to click the response. Our goal is to increase interaction and mutual support with each other, identify and discuss common drivers of both low quality and high cost, and to increase your use of dashboards and to encourage and monitor improvement. How well have we done that? So click on how well we have achieved those goals. Select one and give us that feedback. We won't be pushing out the results of this poll, or the next few. This is for our information so that as we develop future affinity groups or action groups, we will have your input to utilize. We will finish that and move onto the next.

Our next poll question that we're going to push forward is rating yourself on your level of expertise to implement the CJR model. On a scale of one to ten, with one being the lowest and ten being the highest, how do you rate yourself on utilizing your data to implement the model? Again, one is the lowest and ten is the highest. Just pick one. We're going to give you about 30 seconds to make your choice. This is just helpful for us in general. We won't be pushing this out. We won't be sharing this information particularly. It is just for us to see have we learned something? Have we gained something from participating in this group? Alright, we will also then talk a little bit about action groups.

There is a difference between an affinity group and an action group. This has been an affinity group. You saw this when we asked what have you done? The majority of you have learned things and talked about the things you have learned. Action groups are different. In an action group, you agree to work together to either test a change or implement a change. You're going to do something and make a change. There is an expectation for an action and there is an expectation that you'll report your progress on the action to the group. You will also share your tools for doing that and that you'll share your processes for that. Because of that expectation for a little bit more intensive sharing, it's usually a closed group. New people can't join once it begins. Once it gets started, the action group is closed so you can develop more trust and transparency within the group. The goal within the group is to implement a change or to test a change and to support each other in different ways in doing that particular action or change. It should increase a lot of sharing of ideas and strategies. So with highlighting that difference between affinity groups being for discussion and learning and sharing and talking, and action groups being for actually doing something, testing that change, and then talking to one another about how you did that and what helped and support you have for each other in doing that, we were wondering if you might be interested in any type of an action group that could develop as a result of this. Would you be interested in participating in an action group on a data related change? As a group you would pick that change and decide what you would implement or test and how to go about that. If you think you might be interested, select yes, no, or maybe. We'll give you a few seconds. This is not a commitment. It is to gauge general interest. We would have additional information for you if we go this route, if we decide there is enough interest to have an action group. Then we will get you more information about it and you would have an opportunity to register for that group.

Again for more information gathering, we have one more poll. Which of the topics would be of most interest to you for an action group? If we were going to have an action group, would you be interested in one on using data to engage physicians, on using data to develop partnerships with PAC providers, or on some other topic. The poll is going and click which one is most

appealing to you. If you pick other, please type into the chat box, what that other topic might be.

Isaac B: Just to chime in on that, just for everyone's awareness, the CJR team at CMS, we are looking to provide you with a variety of opportunities to engage. We do that in a different ways. We have the CJR Connect site where you can get on and pull down documents or chat with your peers. We offer these affinity groups, which you're in now, where you are taking a deeper dive on particular topics. We facilitate discussion. An additional way we'd like to offer if there is interest, is to focus on change. That is sort of our role here. It is to help accelerate the change that you are doing in your organizations and hospitals.

Laura M: Thank you for sharing that with us and giving us your thoughts on that. I want to move forward on Announcements and reminders for things that are coming up. One is to continue discussion. We've mentioned is previously today but CJR Connect is a great place and go to the Data Affinity Group and you can continue the conversation with one another and you're sharing there. If you're not familiar with that group or with CJR Connect, the information is on the slide- how to request an account, how to get there. It's a very robust discussion forum. A lot of great ideas are going back and forth. Feel free to continue your discussion there.

We also wanted to make some announcements about upcoming events. There is an additional one that is not listed on the slide that I want to mention. On Wednesday, February 22, at noon EST, there will be a webinar event on Advancing Care Coordination through Episode Payment models and introduction. That webinar CMS is going to talk about the various aspects of the advancing care coordination through episode payment models, cardiac rehabilitation, an incentive payment models and changes to the CJR model final rule. That will be very interesting. It is on February 22 at noon. The registration link is available on CJR Connect. The other two upcoming webinars that we have are for all CJR participants hospitals. March 9 on Care Coordination and Management, which is the first of our series on that? It will be about developing community partnerships. This topic grows right out of this one for the affinity group on sharing your data with your post-acute care providers. Then at the end of March, even more involvement for the Data Affinity Group, we'll be sharing with all participants in CJR some things that have been learned from this data affinity group. We'll be calling upon some of you to present, some of you to share briefly and give response to the presentations. Some of the great learning experiences that we've had in this group can be shared out with other CJR participant hospitals. As always, if you have got any questions, send an email with questions bout any of these topics or events. Send an email to LS-CJR@lewin.com and we'll help you with that.

If you have other model related questions, share those with CJRSupport@cms.hhs.gov. As usual, we do have a post event that will pop up for you after this event and we very much appreciate it. We appreciate all the surveys. We realized that we asked you for a lot of input today. It's very helpful for us and we appreciate you taking the time to do that. Isaac, any closing thoughts or comments?

Isaac B: I appreciated everyone's input and participation in these groups. I think the more you all share, the more that it is useful for everyone. If you need some additional tips on Connect, we're happing to provide you with that as well. I appreciate everyone and we'll see you on the 22nd for the EPMs webinar. Thanks so much!

Laura M: Thank you!