Adapting and Updating: Clinical Protocols[i]

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Alicia Goroski: Good afternoon and welcome to the CJR Webinar, Adapting and Updating Clinical Protocols. I am Alicia Goroski and I will be today's facilitator along with my colleague Laura Maynard.

First, I'm going to quickly review today's agenda. I'm going to go over some logistics, particularly related to the webinar platform. And then Laura is going to review the portion of the CJR model toolkit that contains a lot of great information on clinical protocols. Then we will move into the presentation portion of today's call, and we are pleased to have two CJR participant hospitals sharing their experience with you today.

First, we will hear from Margaret R. Pardee Memorial Hospital, and second we'll hear from North Shore University Hospital. Following each presentation, we'll do a pause for brief reactions, questions and some discussion. And as always, we will finish up with announcements and reminders. Before I move on to the logistics I just want to let everyone know particularly if you are out there listening, but having trouble logging into the Adobe Connect platform, that there was a recent update to the Adobe Connect platform. So you may have trouble joining the actual webinar. If that occurs, please be sure that you are using Google Chrome, and you may need to download the Adobe Connect application. If you continue to experience technical issues, accessing the platform, you can always reach out to us at ls-cjr@lewin.com. and we'll do our best to assist you. Thanks.

Additional logistics are that all telephone lines are muted and will remain muted for the duration of today's event. We do encourage active participation by comment, question and reaction in the chat pod. Now I'd like to read a disclaimer regarding today's event: The Centers for Medicare and Medicaid Services, its employees, agents, and staff assume no responsibility for any errors or omissions in the content of this webinar. CMS makes no guarantees of completeness, accuracy, or reliability. For any data contained or not contained herein. CMS shall not be held liable for any use of the information described and or contained herein and assumes no responsibility for anyone's use of the information. CMS does not endorse any strategies, tactics, or vendors referred to in this webinar. The views and opinions expressed in this webinar are those of the participants and do not represent the official policy or position of CMS.

All right, now I'll spend just a minute or two reviewing the platform. You should see the slides right now in the largest box of your computer. Just below that you should see live closed captioning and to the right, event resources, and to the right of that closed captioning. To the right of that is the chat and in the upper right hand corner is the dial-in information. If at any point during today's webinar you would like to expand the view and enlarge the slides, you can hover your mouse in the upper area of that slide and you should see four outward facing arrows. Click on those to enlarge the slides. If you'd like to return to the original view, click on those four arrows and they'll now be facing inward. Just a tip on downloading resources: you need to click on each resource that you'd like to download. And then the Download File button will open a pop-up window that will allow you to save each individual document.

Now let's take a moment to chat. So in the that kind of lower right hand corner of your screen, you should see the chat to everyone. A reminder that what you've typed into there is visible to everyone on today's event. We encourage you to submit questions for the presenters using this mechanism. Often, we have chats that end up going on between the participants. We ask if your comment or

question is directed to a specific presenter or another person who's commented, use the @ symbol and that person's name. That just allows folks to follow the conversation a little easier.

Let's take a moment now to invite everyone to say hello in the chat by typing in your organization, where in the U.S. you're located, and if you can share one clinical protocol that your hospital has recently updated or adapted.

All right, as you guys are saying hello and I'm starting to see some come through in the chat, I'm going to now turn it over to Laura, to point you to some great resources in the toolkit.

Laura Maynard: Thanks, Alicia, and thanks everyone for joining us today. The CJR Model Toolkit 2.1 is available for download in that resources pod on the webinar today. It's also available on CJR Connect. Within that there's information on clinical protocols. That's found primarily under the primary driver of Right Care, Right Time. There you will find the narrative the content about that secondary driver, which is Standardized Evidence Informed Clinical Protocols, found on pages 23 and 24 of the toolkit. Some of the different protocols that have been shared by CJR participant hospitals and included as examples in the toolkit are things like infection prevention, ambulation, pain management, physical therapy, and preventing pulmonary embolism and deep vein thrombosis. But there are others. So, look there to get a little more information about that. You'll find that on page 9 in the toolkit, it lists Tactics for Implementing and Updating Clinical Protocols. And there are also some potential process and outcome measures for each of those. So, we encourage you to check out the toolkit, look for these sections related to clinical protocols, and get a reminder of some examples of approaches that various CJR participant hospitals have used related to these protocols.

Now, I want to launch a poll: which of these clinical protocols have you adapted or updated over the course of CJR? So this might be something that you had in place before you began in the CJR model, or it may be something that you implemented within that first year or so and now you've made an update to it. Sometime over the years you've updated or adapted it or made a change in the way you were doing. And if you click other, please type into chat and let us know what these other protocols were that you've made adjustments to over time. We're going to give you just a moment or two.

Looks good. Very interesting to see. So another, a couple of seconds to click. I see, some responses are still coming in. And we can show the results. It looks like predominant updates have been made in pain management protocols and a close second on that is in physical therapy and ambulation protocols. So, really interesting to see what people have updated. We'll return to the slides now.

I am happy to introduce our first speaker. Dan Hein is the Administrative Director of Orthopedics & Sports Medicine at the Margaret R. Pardee Memorial Hospital. And, Dan, I'm going to turn it over to you and just say next slide when you're ready for me to move them along. I'm starting on the slide that shows where Pardee is located.

Dan Hein: All right, thank you very much, appreciate that. And thanks for the opportunity to take you through a brief journey of our experience here at Pardee. I've been here for three years, and I'm on the administrative side of things. So this will probably be a less technical discussion, but I did want to give you an overview of where things have progressed and where we are and where we're going. So as you can see, Pardee is located in beautiful Hendersonville, North Carolina in the mountains. Recently we've had a little bit of snow, which here in the south creates great consternation and gnashing of teeth. But we've managed to make it through that. So I know travel is greatly restricted, but if you if you're ever in this neck of the woods, it's a great place to visit. We're

part of the University of North Carolina Healthcare System, but we are nonprofit county owned hospital.

And on the next slide, you'll see in terms of the map of North Carolina, we're located in western North Carolina. So our primary service area is basically those five surrounding counties. But we're noticing, really pre-COVID (COVID has certainly restrained things), our service area was expanding into the parts of the upstate of South Carolina and Northeast Georgia. So, becoming more of a regional of footprint was something that we were experiencing before our collective worlds came to a screeching halt. Just wanted to orient you to where we were relative to the rest of the State.

Next slide. Again, just for context, you'll see we are a 222-bed acute care hospital. 322 physicians across 37 specialties, close to 200,000 visits at our outpatient practices, and 30,000 ED visits. So you can get an idea of the scope of how Pardee fits within the area, and then I'll talk a little bit more specifics about our orthopedics program on the next page.

When you look at our service mix, I think this probably is pretty typical. We are doing most of the things that I would say most orthopedic programs are doing, what I would call bread and butter orthopedics. We don't do a whole lot of advanced trauma. We're limited on peds and we don't do orthopedic oncology. We have a very robust sports medicine program and then all of the other elements in terms of pain medicine, rehab, advanced imaging, things that are typical with other programs, you can see here as well.

If you look at the following slide, you can see certainly that CJR episode volume has increased over time. Part of it is that we've added providers, which has intrinsic growth associated with that. I'll just give you a little bit of information in terms of how we're aligned. We don't employ any orthopedic surgeons. We have one group that we have a PSA relationship with and another that's independent that do some of their cases here. So that's been the model within which we've been working through the CJR. I'll tell you a little bit more specifically about how we've done that, given this alignment model that we find ourselves in.

One of the things that my boss told me on the following slide, which I thought was interesting and always stuck with me is that this the CJR or quality in general is not a destination. It's an ongoing journey, because you never quite get there. And so, a lot of times when we look at the objectives and the goals and trying to obtain all of the elements that we're trying to get to, it can be a little bit overwhelming. But we've found that we've just got to chomp off on it in smaller bits and pieces. So stepping back far enough and taking, big program elements and breaking them down into bite-sized chunks I think has helped our staff and our team more easily digest this.

The point of this slide is again big picture stuff. As I was putting this together, I thought about the last three years. In year one, we had almost no direct line of sight into specific data points in quality metrics and outcomes. So we were really flying blind at that point. Despite that, we intrinsically knew what we needed to be doing. But we just couldn't prove to ourselves nor could we tell the story of how we were doing it.

Then in year two, we understood more about the program and we were more educated, but we still didn't have the infrastructure in place. And so by sheer force of will, we sort of tackled some of the places that we knew were the lowest hanging fruit, like length of stay and SNF utilization. We took the bull by the horns and really wrestled with making improvements in those areas, which we did.

That brought us to year three, which is really an exponential leap in our minds. We got some very specific tools and data and dashboards that we can now use to really educate our teams and providers that we didn't have even eight months ago. I'm finding that having those and the visibility into that has greatly increased our capacity to move forward quickly on the areas where we want to improve. So again, these are very broad brushstrokes into how we've progressed over time.

The following slide shows an example of two of our clinical protocols or checklists. These have to do with blood conservation and infection prevention. I know most of you, if not all have probably more sophisticated and more detailed examples of this, but these are just ones that we happen to be utilizing at this time as a point of reference.

The following slide shows what we have put together (and it was a really heavy lift) an overall framework, which is an action plan that covers five categories. We think these five categories encompass everything we need to be doing relative to CJR, in those buckets of work. You can see quality review at the top and care delivery and standardization, which are two of those five. The others are leadership, physician strategy and alignment, personnel and morbidity and mortality review. So we have a framework to work through all those within the context of CJR in the effort of trying to improve everything that we're doing in the program.

Real time Initiatives that we have going on in the following slide are pretty self-evident. One of the things that's impacting us, as it is everyone, is the COVID factor. We're having to shift resources, move people around, the vaccines are going on, and we're trying to leverage personnel and staff to accomplish things across multiple departments that we never dreamed of. So that's created all kinds of challenges that frankly, we never foresaw. But certainly it's forcing us to think in different ways.

And then lastly, on the following slide, one of the points I wanted to bring up was CJR is just one of multiple programs that we're all involved in. As I was putting these together, one of the things that popped into my head was: who defines quality? And certainly, the CJR program is the most robust and advanced and has, in my opinion, move the furthest along. But on any given day, there may be commercial payers out there, there may be third party rating platforms, there may be other accrediting bodies, and the patient and the providers determine what quality is. So trying to overlay all of those areas and the data that's associated with it to objectively measure quality for the benefit of the patient, is something that is a complex puzzle to solve. So trying to put all these metrics together in order to do that in that complex landscape is somewhat of a moving target. I think it’s also what makes it a challenge and fun for us to try to resolve.

I know I've met my time limit, and so with that, I'll just say our biggest challenge over the three years have been group physician alignment. That's been a difficult one. We've seen our results improve over time in terms of length of stay, discharge to home, and home health, and our spending by quarter and average spend has certainly gone down. But we certainly have a long way to go, and the actual metrics and the protocols are the way to get there. With that, I appreciate your time and the opportunity to share this with you.

Laura Maynard: Thanks so much, Dan, really appreciate it. As folks are typing in their questions, we really encourage you to use that Chat pod to submit any questions you might have. I did have one question in regard to those action plans that you mentioned. You referenced an action plan for different key areas including care delivery and standardization. Who develops those action plans and who reviews and implements them?

Dan Hein: We develop those in conjunction with a third party that we engage with. But mainly with we have a dyad leader and a multidisciplinary team that we had multiple engagements with over time, so this has sort of been a work in progress. It's sort of like building a house: you build the foundation, and then you continue to add to it. So we had sort of the framework upon which our internal teams came together. And we found that, purposely or not, we sometimes we didn't even have all the right folks at the table. So that was a learning process too because even when we think we're not working in buckets or in isolation, we realize we need so-and-so or this department or this personality here, and that's an ongoing process.

Laura Maynard: Great, thanks very much, appreciate that. We did have a question come in. This came in with the registrations for this event, so I don't know that it is as directly relevant to your presentation. But I'll go ahead and pose it to you to see about your patient engagement. Do you use a patient engagement platform to collect your patient surveys and track your progress electronically?

Dan Hein: Yes, we do.

Laura Maynard: Okay, great. Is that effective? Do you think that works?

Dan Hein: I think it's effective to some degree. I think over time, it becomes a little less effective. I think that's the extent to which you have somebody that can stay on top of it and help interpret and maintain the conversations. So there's ways to manage that that I think can make it more effective.

Laura Maynard: Right. Thanks, that's very helpful. And then, just one final question before we move on. You had mentioned the recommendations and initiatives that you have in place right now are going forward in planning, pre op optimization, and ERAS for your total joint population, standardizing blood utilization, some of those things. But you also mentioned the disruption that you're having from the pandemic at this point in time. Are you seeing some delays with some of those initiatives based on having to redirect resources at this current point in time?

Dan Hein: Yes, we're having to do some surge staffing. So clinical folks are being re-designated to perform other duties as that's priority, and certainly slowing down some of these efforts. We're trying to work around those as best we can within those constraints.

Laura Maynard: Excellent. So keeping those on the radar, keeping them in the forefront to the extent that you can while dealing with the emergent concerns.

Dan Hein: Absolutely.

Laura Maynard: Yes. Well, thanks, Dan, very much. If other questions come in for you, we'll pose those as we go. At this point, I'm happy to introduce our next speakers from North Shore University Hospital, we have Michael Langino. He's the Assistant Vice President for Orthopedic Surgery at Northwell Health. We have Macsood Khalilullah. He's the Director of Operations of Transitional Care Management at Northwell. And Alanna Carcich is the Director of Operations for Orthopedic Surgery at Northwell. So I'll turn it over to the North Shore Team.

Michael Langino: Good afternoon, everyone. Thank you very much for having us. This is Mike Langino, and I'm going to start out our presentation today. I'm here speaking on behalf of North Shore University Hospital. For those who are not aware, North Shore University Hospital is a member of Northwell Health. Northwell Health is a large health system that is New York based. It's a 23 hospital health system that treats over two million patients annually. On the left side of the

screen, you see the footprint of Northwell and where all the locations are. And then to break it down to North Shore specifically and what we'll be speaking about today with our journey in CJR, North Shore is a quaternary care hospital that has 756 beds, about 2,000 nurses, 6,000 employees, 4,000 physicians, does about 86,000 emergency room visits a year.

We serve a very diverse community. So I just wanted to share this slide as a little bit more background of who we are and some of the challenges that we face. I think what's most interesting here is North Shore University Hospital is situated on Long Island in Nassau County, but it's also right on the border of Queens County. Queens County is actually one of the most diverse places, language wise in the United States. On the bottom right of the screen, you'll see some of the top languages we have experienced here within our programs, and it just gives us a little bit of pause in thinking of different ways to try and educate our various patient populations.

This next slide represents who we are as a team. On the left hand side of the screen, you'll see that is a busy orthopedic department. We participate with all of the orthopedic specialties. There's nothing actually that we don't do. We do a minimum amount of pediatrics at North Shore Hospital, and that's basically because we have affiliated children's hospital about two miles from this location. I think what we're most proud of in terms of our successes with CJR is the interdisciplinary team. We have a large interdisciplinary team that meets our quality initiatives, joint replacement initiatives, and just general department initiatives. We have very engaged partners from all the various departments that one would expect to interact with, and I think that relationship that we've developed over time with those departments and working collaboratively with them has gotten us to a point where we've had some significant successes in the program itself.

A little more granular about who we are. As mentioned, we do all those specialties at North Shore Hospital. We do about 1,000 orthopedic surgeries a year. But in this past year, about 650 of them were in total joint replacement cases, and our Medicare fee for service of the CJR population is probably about 30% of that.

The approach that we've taken as a group at each of our hospitals actually is to have these local Joint Preservation and Restoration groups. We just abbreviated this as JPAR. Each Hospital in our system has a JPAR group that is comprised of the joint replacement physicians who do the care. The goals of the group here on the screen. So collectively, the things that we strategize and partner with our physicians are centered around access within our practices, outreach to the community (whether that's directly to providers or potential patients), preoperative screening, looking at ambulatory surgery programs, and our inpatient hospital programs. We also partner with a post acute network. A unique thing about Northwell is that we do own our own post acute network so we're able to align with them even closer than maybe some others would if we didn't have that partnership. We also have a significant focus on orthopedic research and education of our residents.

This takes us into one of our collaborations that we have that Mac will be speaking about.

Mac Khalilullah: Thanks, Mike. So good afternoon, everyone. I will talk a little bit about Northwell Health Solutions. Northwell Health Solutions is the care management organization for Northwell Health. We provide care management, as well as administrative and analytical support for all of our value-based programs across all 13 hospitals. North Shore University Hospital is one example of one of our partner hospitals that are enrolled in the CJR program and we provide system wide assistance to each one of these hospitals through administrative support. So the actual administration around downloading data and information staying on top of CJR regulations and changes, and then also

providing updates to each hospital in terms of performance. We take that data and provide a dashboard view, which we'll get into in a couple slides, to show what exactly is the trend and change across not just North Shore, but each one of the hospitals. So we're able to then benchmark, for example, North Shore University Hospital against other tertiary sites within our system, but then also against our system as a whole to share best practices and any changes or trends.

We work very closely with the hospital to make sure that they're aware of all these changes and information. In addition to that, we provide care management through our navigation team. Our team is made up of about 70-plus clinicians from advanced care providers to registered nurses to resource coordinators that provide care management for all of our CJR populations across each hospital. This care management is a 90-day engagement post discharge where patients will receive follow up phone calls, 24 hours after discharge, and they also receive a visit if they're a high risk patient that requires it. So our navigators provide both telehealth visits and in-person visits, although we're leaning on more telehealth these days. That engagement will continue and the engagement points will change depending on the patient's risk level, and we'll follow up with those patients up to 90 days after discharge, making sure that any adverse events are reduced. Through that we've been able to lower readmission rates and improve home discharge rates with this engagement. And I'll pass it back over to Mike and Alanna Carcich.

Alanna Carcich: Thanks, Mac. So just to advance to the slide on CJR Programmatic Goals, with some actionable items that we've worked on over probably the last five years:

Improving our preoperative patient education rate. Historically, before our CJR performance, we were around 80% in educating our total joint replacement patients.

Looking to enhance our post update zero rehab services. Prior to our CJR efforts, we were really ambulating about 30% of our patients on the day of surgery.

Ultimately looking to reduce the hospital length of stay. Historically, they were around four days. So as you can notice here, big culture changes that happened over the years.

Increasing our discharge to home rate. In the past, we were discharging about 20% of our patients to home. Food for thought on the North Shore University Hospital campus: we actually do have an SNF on the campus located up the hill, so 80% of the patients were essentially going up to the Stern Rehab Center prior to our efforts.

And to prevent any avoidable readmissions.

How did we share these goals? Mike had mentioned the JPAR committee, and that's really where many of them stemmed from. We set targets there on what we were going to strive for. But sharing these goals with the entire interdisciplinary team is kind of how we have achieved a lot of our successes. So this was the universal message at our PI meetings, hospital leadership meetings, department huddles with the rehab team, with the nursing team up on Southern Tower and so on throughout the building. So we were all kind of driving the ship in the same direction.

Here are some challenges we faced along the way, and I just mentioned some of the things we've done to mitigate and I'll expand in the upcoming slides. We had some preoperative patient optimization challenges, home safety assessments before patients came into the hospital.

Early mobilization with the rehab services team, and how we were sharing which patients were coming through the building on a regular basis. How to prioritize, who should be getting services on

day zero, and did we have acceptable staffing that accommodated kind of our heavier or days from the rehab team?

The historical reliance on the SNF utilization. I mentioned, we have a SNF up the hill. In a community where we are set in treating our community members, everybody had a wonderful five-star experience up at Stern, so why not have all of your joints done there? So one need turned into four joint replacements that patients had a wonderful experience up there and really had to change that expectation in the culture of both our community and our staff.

And then we have frequency and compliance of homecare visits. Mike had mentioned Northwell has a home care agency. How we mitigated this was really shared accountability for this patient population on what we can do to enhance the therapy at home model for these patients. They really came to the table with a commitment on when they were going to see these patients. Upon discharge, somebody would be in the home to see them within 24 hours and then X amount of visits over two weeks. So that was something that was a strong game changer for this program as we progressed through. I'm going to kick it back to Mac to share this beautiful, colorful dashboard, and talk us through it.

Mac Khalilullah: So this is one example of a data dashboard that we create for all of our hospital partners, but in this case, North Shore specifically. So you're not getting the full view here, but the dashboard is dynamic and there are filters across the top that all of our hospital partners can click through. And so this example specifically is showing North Shore but if we were in the real dashboard, we could click that hospital line and select say North Shore and also look at Long Island Jewish Medical Center. We can compare and contrast one or the other or the entire system, and so the data inside it is filterable. The program we use is Tableau. That’s just the platform that we pull all of our data into. But our analytics team puts together these dashboards on a monthly basis using the CMS claims information. Over the years we've progressed in terms of what is available in these dashboards. We started with just summary information like cases, this day readmissions, home discharge rates, SNF discharge rate. But we've progressed into patient level information in terms of what exactly are the drivers of readmission, how many days after discharge patients are coming back. We're now progressing into understanding all ED arrivals and seeing what treatment release rates are compared to between different hospitals in terms of cost drivers and so on and so forth. So we've gotten more progressive in what we're able to view and how we're able to view it. I think that's helped our sites really progress in terms of understanding what exactly their drivers of success are.

Alanna Carcich: And some of our key program elements, and really what made us as successful as we are:

Engaged physician leadership. So we do have an employed and voluntary complement at North Shore. The majority of the volume does sit within our employed physicians. They are very engaged and motivated. To boast about them a little bit, I wish they were on this call to hear this, but they really are all hands on deck. They collectively put together this joint replacement protocol that you see the very small image on the right. It is a multimodal pain protocol that they collectively agreed upon and shared with all of our residents, our ACPs, and our nursing staff members so everybody's on the same page on the joint protocol and experience.

As we focus on the entire continuum of care, the office team became a part of the program, even though they don't sit within the walls of the hospital. So we partner very closely with our office

practices, our surgical scheduling team, and our physician coordinators, to make sure that we are sharing the same message from pre-op consult to post-op visit. And I'll elaborate a little bit more on the Joint Commission standards, but that was something that we are measured on formally. It became kind of intricate as we were driving change throughout the building.

Effective preoperative education. We did have a class in person pre-COVID. That is also supported by a formal joint replacement education book. We have a formal PowerPoint presentation that is now a virtual class. It is hosted weekly, and we coordinated those visits with our pre surgical testing visits. In the archaic time when patients actually came to the hospital for PSC and joint education, we wanted them to only come once and get the full experience ahead of time. So we coordinated all of those efforts, three weeks ahead of time prior to the surgery, where we shared all of that formal information.

Now in a post COVID world, all of those same efforts are in place. They're just hosted virtually and we send those books to everybody's home. They have a video of our class available on our website. They also do a 10-day Zoom education course in addition to the pre surgical testing and COVID testing visits prior to surgery.

I mentioned the protocol on the right and standardization of clinical pathways. This wouldn't have been achievable without our physician leadership and cascading that information throughout the building.

Enhancing our rehab services. The PT team has always rounded with the interdisciplinary team, but they have done a lot to meet the demand and the volume of the joint replacement volume in the building. So we've shifted the staffing models earlier in the morning, later in the afternoon, staggered the OT schedules to make sure that we had appropriate staffing on our highest volume operative days.

And we've always tried to kind of keep the patient experience on the floor focus of our minds and making sure that everybody is receiving the same care and the highest level or highest quality of care.

I mentioned the Joint Commission briefly. We are an Advanced Center of Excellence and many of the measures that we are held to both in the bundled payment project, as well as the Advanced Center of Excellence really coincide. So these may not be new to anybody on the call. But really collecting outcomes on our patients is the measure. We use Force Therapeutics to collect our outcomes, share therapeutic videos and education, as well as help stay close to our patients via their navigation software.

We look at our regional anesthesia measures. The anesthesia team is part of our PI working group, so we bring those measures to the table monthly with them. We have some separate initiatives. It's called AARP, the Accelerated Arthroplasty Recovery Protocol. That is our PACU Length of Stay initiative that collaborates with the U.S. protocol as well.

Early ambulation, which I've spoken a lot about. How we've worked with PT, I mentioned expanding their hours of operation and then all of our discharge-to-home initiative. Force has really helped with that as well as a lot of therapy that either is received at home or an outpatient PT is also listed on their platform as well. So patients do have options to watch videos over and over again as they go through their rehab or post acute phase of care.

How we've been successful, and the goals we've achieved from then till now. Our patient education rate is over 90% regularly. Our ambulation rate on day of surgery is also over 90% regularly. This number is mostly PT evaluations on day of surgery. We complement that with our nursing ambulation on the hours that PT is not there, so our nursing team is educated on how to safely ambulate our patients. So in the later hours of the day, they are walking patients to and from the bathroom and getting them up and out of bed and for some reason they've hit the floor at a later time.

Our overall length of stay is less than two days at the current time for both our hips and our knees. Our discharge to home rate is over 85%, which we're super happy about. That's really been a great success coming from where we were in the past. I mentioned that SNF up the hill has really changed their culture up there as well and most of our patients are going home. And then our current readmission rate is 9.8%. Ongoing initiatives, the PACU Length of Stay project is really a bare of a project that we're looking at. So we will continue to focus on that in 2021 moving forward. And that summarizes everything. I will open it up to questions.

Laura Maynard: Thank you so much. And we have had several questions come in. I also want to encourage participants to continue asking questions in that Chat Pod. There was a lot of interest in your patient education via the Zoom classes. Could you tell us a little more about that? How many patients are there? How do they sign up? Just a little more detail about that?

Alanna Carcich: So we host everything. We organize it through the department on the hospital side. So every week, we get a list of our patients that are prepped on the operative schedule for the upcoming month. We call them, we get them registered for the class (kind of old school manual, we make a list of patients coming through), we collect their email addresses and we send them the link virtually. So they get an email with the link for the class. The material that is shared in the class is a PowerPoint presentation. It is hosted by one of our nursing team members. She is a former nurse on the ortho unit, she now sits in a different role, but she teaches and hosts the class with us and somebody from the admin team joins as well. They run through the PowerPoint with them and open it up to questions and answers. We have about 15 to 20 patients attend the class every week, and we encourage them to attend with a caregiver. Now in the post COVID world, what is interesting is patients cannot come to the hospital with a family member. So that's a really big differentiator than anything we've received in the past. As you know, two brains are better than one, four ears better than two, so we really try to encourage somebody to participate in that class as well.

Laura Maynard: Great, and do you get pretty good uptake on that? Do most patients participate in the class? Is it mandatory in any way?

Alanna Carcich: It is mandatory. We say that it's mandatory and highly encouraged. We do not cancel surgeries if a patient does not attend the class. But to be completely transparent, we make every effort to make sure that we touch all of these patients. So if they cannot log on to the Zoom, we will call them, make sure that they have a book, make sure that they understand the material that's given to them and make sure we answer any questions. So no, we're not canceling cases if a patient cannot log on to a Zoom, but we're making every effort to make sure that we're speaking to these patients and answering their questions before their experience.

Laura Maynard: Wonderful. So that was addressing one question that came in if you have patients that do not have internet access. So if that's the case, you handle it by telephone and by sending them the print materials. Okay, I'm looking at other questions coming in. I did have a question about

standardizing protocols, wondering, are your protocols standardized all across the Northwell System or are the protocols specific to North Shore?

Alanna Carcich: So they started specific to North Shore. We work in a regional model here so we've shared our protocol through JPAR and through some of the local hospitals that are close to us. So many of them have adopted the similar protocol. It has been shared as “best practice”, and we encourage every local facility to create something similar. But we tried to move away from the “every physician has a different kind of preference” because as you look at it across the system or across the enterprise, it is somewhat consistent in the care that they're delivering. So it's local to North Shore. It's been shared at JPAR and everybody has something similar to this.

Michael Langino: I'll just add to that. From an order set perspective, it has been standardized for all of our sites that are on the same EMR. When we make order set changes, the benefit is of having the JPAR group and a physician leader from each site being able to weigh in on some of the language in the order set. Once it's updated in the EMR, it's on that for all sites that are on Sunrise. So it's been pretty standard and unified in terms of clinical care providing across the network.

Laura Maynard: Excellent, thank you. Another question. You had mentioned culture change, and that addressing some of these big improvements that you've been able to make require the change in the culture. How did you approach changing the culture? What sorts of things did you do to address that side of it?

Alanna Carcich: When we shared the goals throughout the building, the ortho PICG meeting was really the first stop shop, setting that message there. But again, that group only had our ortho nurse leader, anesthesia team leader. Let's say it's 15 people or so but it's not the 16 in every department. We then began to huddle with each of these groups. So we've done consistent huddles, and in services on the orthopedic unit with the physical therapy staff. The case management team joins the orthopedic unit. They sit up in the same area, so they join in the huddles there as well. So consistently sharing that message, it happened for years, it wasn't a six-month change. This was something that we had to really drive the message home. Also, to our physician leadership, they knew the goal set, but you have to say it more than once we shared it at every meeting that we attended and our team attended until it just became common language.

Laura Maynard: Right, thank you. Thanks for sharing that approach. And one other question came in. Actually, there have been two that are similar and related. One has to do with the patient engagement. The same question we asked Dan, about using an electronic platform for your patient engagement surveys. Then another question came in regard to those surveys, the HOOS and the KOOS, Jr., usually that's distributed at the pre-op education class, so how are you getting that done now?

Alanna Carcich: It's distributed via Force for our providers that use the Force platform. They get that ahead of time, so the patient does get their Force account. And the first thing that they're given is a welcome video from their surgeon and then their KOOS or their HOOS outcomes tool. For patients that are not on Force, they do get a link. We use REDCap as our outcome link for most of our services, so we do have this also built into REDCap and it's really the same process. Everything is emailed to them, they fill it out, and then the postoperative intervals happen automatically to the patient's email address.

Laura Maynard: Thank you, thanks for sharing that. And going to move on along now and open things up to our participants, but also encourage our presenters to share as well. Those of you that

are participating today, type in the chat some answers to these questions. And either Dan or the team from North Shore, feel free to speak up and respond. We're wondering, what indicates a need to update a protocol? How do you know it's time to revisit a protocol and update? I would encourage everybody to type that into chat, but also any of our presenters that would like to speak to that one.

Dan Hein: I think one of the things that occurred with our approach is when we engage at the system level, for example, enhanced recovery after surgery. If we look at those benchmarks and objectives and compare them to some of the protocols that we have and look for common denominators in areas that we can streamline. Those sorts of parallel initiatives often will prompt an update in protocol.

Laura Maynard: Thank you, thanks for sharing that Dan. Looking to see if anybody's typing into the chat, but I'm not seeing anyone yet sharing on that one. I had another question come in and I'll go ahead and jump there before we move on along. Asking about average time in PACU and I'm assuming that's for the North Shore team, since you indicated an ongoing initiative about PACU Length of Stay. So what is your average time in PACU?

Michael Langino: It's an initiative that we're doing across the network. Some of our best performing hospitals are doing 90 minutes. Our goal is two hours. I could admittedly say that we have a number of hospitals that are still in the three-to-four-hour range. What we've noticed is that in some of our larger hospitals that are multi-specialty hospitals and have a number of competing initiatives, it's a little bit harder for us from a logistical and bed management perspective to get the patient out of the PACU to their recovery room in a two-hour period. In some of our smaller hospitals or more ortho centric hospitals, we're finding a little bit easier to accomplish that. So it continues to be a work in progress, but we set ourselves an enterprise goal of two hours or less.

Laura Maynard: Right, thank you so much, I appreciate it. We're going to move on now and launch a few polls. So I want to ask all of you to respond to this one. Which of the risk assessment and optimization strategies that are listed here have you either updated or adapted recently, and when we say recently, like over the last year or so? Any of these that are related to risk assessment and optimization, whether it’s things like changing your preoperative assessment or assessing financial and social risk factors, stratifying your patients based on the risk assessment, the whole list there. You can pick all of them that apply, but do click and let us know which ones of these you've updated in the last year or so? I will give you just a minute.

We are interested in gathering some information about this to inform some potential future events and products but we also just wanted to have you share with each other. Let's go ahead and show everybody the results. So you can see that pre-op assessment is strong, as well as optimizing patient health prior to surgery, also prehab. So those are areas that people have been updating and making changes on over the past year.

Then let's jump to our next poll. We have another one, again, trying to gather a little info from you. What are your top priorities for your CJR program over the next six months? So short term what are your top priorities? You can type it right in there into the poll response and click the little piece of paper next to it that says send the answer and that will send us the poll responses. Top priorities for your program over the next six months. We'll give you just a couple of moments for that.

Rather than broadcasting these, we're going to leave this poll open for a moment or two. And that way, we can move on to our announcements, but leave it open. We'll share the results of this out on

a future webinar. But keep on plopping in there. What are your top priorities for your CJR program over the next six months? I think some real interesting things come through, so that's great. Thank you so much for sharing those. And thanks for putting some continuing questions and comments in the chat. We really appreciate it.

Moving on back to the slides got a few quick announcements and reminders. Reminder of the disclaimer that the Centers for Medicare and Medicaid Services, its employees, agents, and staff assume no responsibility for any errors or omissions in the content of the webinar. CMS makes no guarantees of completeness, accuracy, or reliability for any data contained or not contained herein. CMS shall not be held liable for any use of the information described and or contained here and assumes no responsibility for anyone's use of the information. CMS does not endorse any strategies, tactics, or vendors referred to in this webinar. The views and opinions expressed here are those of the participants and do not represent the official policy or position of CMS.

The CJR news is a way to get an update on all things CJR. If you're not receiving our newsletter, the link there ls-cjr@lewin.com, reach out to us send us an email there and we'll see about getting you on the distribution list. If you think you're on the distribution list, but you are not receiving CJR news, make sure that we're on your safe sender list and not going to your spam folder by clicking on the link that's in this slide.

CJR Connect is a great way to find the resources from this webinar, to talk to one another and share ideas, and to find a large library of other topics. So if you don't have a CJR Connect account, the last bullet on this slide lists the link where you can go to request an account.

Upcoming events - On January 27, Wednesday from 2:00 to 3:00 PM Eastern Time, we will be holding a webinar sharing the evaluation results from performance year three. Then on Wednesday, February 10th, another webinar on pain management and CJR model, this will be part two on multimodal pain management.

Reminder, any follow up or unanswered questions, send them to ls-cjr@lewin.com. Contact CJRSupport@cms.hhs.gov for any technical or programmatic questions that you may have. And please take a few minutes to complete the post event survey that will pop up right here. We appreciate your feedback and we really utilize that in planning future events. Thank you so much for your participation. Thank you for hanging in there with us, as we've run over just by a minute. And we really want to thank our speakers.

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