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**Centers for Medicare and Medicaid Services
National Conference on Care Transitions
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Welcome

Linda Magno: Good morning everyone. I'm Linda Magno, Director of the Medicare Demonstrations Program Group at the Centers for Medicare and Medicaid Services. And I'd like to welcome you all this morning to CMS' National Conference on Care Transitions.

We're very excited with many of you attending this conference in person. We're expecting more of you. We've had to increase the size of the conference and very excited also that there are nearly a thousand people participating in the conference by audio.

So, why are we here today? I'm going to spend just a very brief period of time, we've got a lot of ground to cover. But we're here today because hospitalizations account for about 33 percent of total Medicare expenditures and represent the largest single program outlay.

And the recent review of Fee-For-Service claims found that 1/3 of Medicare beneficiaries – 1/5, I'm sorry, of Medicare beneficiaries who are hospitalized and that's nearly 2-1/2 million beneficiaries were readmitted to hospitals within 30 days of discharge, and nearly 1/3 were readmitted within 90 days.

The Medicare Payment Advisory Commission in 2007 estimated that Medicare spends approximately \$15 billion on readmissions into that \$12 billion that is – for cases that are considered to be preventable.

But as significant as the economic costs of readmissions and their impact on the Medicare budget are – we must keep in mind that preventable rehospitalizations represent a failure of our health care system to provide care that is safe and effective, efficient, and patient-centered. This is the failure that we must work to address, because we can and because it's the right thing to do for our patients, or in the case of the Medicare Program, our beneficiaries.

Since August 2008, quality improvement organizations in 14 states have worked to develop community-based care interventions, community-wide programs to improve care interventions as part of the QIO's 9th Scope of

Work. In addition, CMS has also worked closely with the Administration on Aging to provide grants for the development of Aging and Disability Resource Center care transition programs.

AoA recently awarded 16 grants to states to coordinate and continue to encourage evidence-based care transition models.

So, our goal today is to share learnings from these projects so that we might build upon these efforts to improve care transitions and reduce avoidable rehospitalizations of Medicare beneficiaries and by spillover of these programs and their affects on all other patients.

In the Affordable Care Act, Congress has given us two powerful tools to focus our attention on preventing rehospitalizations. First of all, funding, specifically \$500 million in Section 3026, the Community-Based Care Transitions Program, for CMS to pay for interventions to improve care transitions among Medicare beneficiaries. And secondly, beginning in 2013, penalties to hospitals with high readmission rates.

We hope that today's conference serves as a useful forum for health care providers and for community-based organizations to learn about some of the care transition models and interventions that have been used in a variety of programs and settings, including the work of the QIO program during the past 2-1/2 years around the country, and hope that it is a useful guidance regarding how best to lay the foundation for the successful implementation of such interventions.

We'll start out today by having Juliana Tiongson, Project Lead on Community-based Care Transitions Program, provide an overview of that program. In the interest of leaving the maximum amount of time for our speakers, I'm not going to provide speaker's bios as they can be found in your notebooks, at the end of the presentation session and just before the tab listing in-person participants of today's conference.

At the end of each agenda segment, there will be a brief opportunity for participants to ask questions. We will first take questions from those

attending the conference in person. As time allows, those participating by phone will also be given an opportunity to ask questions.

If you are unable to ask a question due to time limitations, please email your questions or comments to the CMS Care Transitions mailbox at caretransitions@cms.hhs.gov. We'll see that flashed up on the screen later.

Note that today's event is being recorded and transcribed and an audio download of the conference will be available on the CMS Care Transitions web page in the coming weeks. For those of you participating by telephone, you can find today's presentations on the CMS Care Transitions web page. It has a URL is too long for me to read, but you should have received at least one email reminder of that web page from CMS over the past week.

So, with that, I would like to introduce Juliana Tiongson of CMS. Thank you.

Community-Based Care Transitions Program

Juliana Tiongson: Thank you, Linda. And thank you all for joining us today to learn about this very exciting opportunity for acute care hospitals and community-based organizations.

The Community-based Care Transitions Program, otherwise known as the CCTP, mandated by Section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high-risk Medicare beneficiaries.

CMS is concerned, along with MedPAC and many of you participating in our meeting today, that increasing rates of avoidable hospital readmissions will result in negative health outcomes for Medicare beneficiaries, impacting our levels of safety and quality of care. The CCTP seeks to correct these deficiencies by encouraging communities to come together and work together to improve care transitions and improve patient experiences during those critical times.

The CCTP program goals are to improve the transitions of beneficiaries from the inpatient hospital setting to other care settings. Sorry, we're having a little bit of technical difficulty. OK, thank you.

So, the slides do not advance on their own. So, back to the program goals.

The first goal and these are in a particular order is to improve the transitions of beneficiaries from the inpatient hospital setting to other care settings, or to home; improve quality of care; reduce readmissions for high-risk beneficiaries; and document measurable savings to the Medicare Program.

And although the legislation only requires reducing readmissions while maintaining quality of care, we have set the bar higher and we are striving to really improve the quality of care for the beneficiaries.

And in terms of documenting measurable savings to the Medicare Program, the legislation stipulates that in order for the program to be extended or expanded beyond the five years, the Secretary has to determine that it is a financially sustainable program, meaning that it's reduced Medicare expenditures. So that of course is also another goal.

Eligible applicants – eligible applicants are statutorily defined as acute care hospitals with high readmission rates in partnership with community-based organizations, or community-based organizations that provide care transition services.

In either of these cases, there must be a partnership between the acute care hospitals and the community-based organizations. We know that medicine is a team sport and requires strong partnerships in order to achieve both improved quality and cost savings.

The definition of CBO – this is the statutory definition of CBOs – is community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.

We do intend to be flexible to the extent possible when determining who is a community-based organization as long as they do meet this statutory definition and they are based in the community where they will serve.

Some of the key points are that the CBOs will use care transition services to effectively manage transitions and report process and outcomes measures on the results. Applicants will not be compensated for services already required through the Social Security Act or the CMS Conditions of Participation. And lastly, applicants will be required to participate in ongoing learning collaboratives.

One thing that we are going to be doing is we're going to be having learning – a technical assistance learning contractor who's facilitating ongoing meetings with all participants, ongoing in-person meetings and these probably would occur quarterly. And it's a model that's been used effectively at other agencies to spread the learnings early and often and disseminate methods that are working. It could be adopted by other participants.

The requirements of what we would expect to see – some of the things we would expect to see in people's interventions, and these are outlined in the statute as well is, initiating care transition services no later than 24 hours prior to discharge, providing timely, culturally, and linguistically competent post-discharge education, ensuring timely and productive interactions between patients and providers, and providing comprehensive medication review and management, and providing patient-centered self-management support.

The preferences. Preferences as outlined in the statute must be given to applications that include participation in a program administered by the Administration on Aging, or programs that provide services to medically underserved populations, small communities, or folks in rural areas. Physician group practices, particularly primary care practices, we will be giving consideration to as well, as we believe that it is ultimately the responsibility of the delivery system to absorb these – the provision of these services, the care transition services.

Some application guidance. We are requiring that applicants do their homework and complete a thorough root cause analysis to inform them of factors that may be specific to their communities that are resulting in high readmission rates. The proposals must specify how the root causes will be addressed.

And we are also asking applicants to describe how they will work with accountable care organizations and medical homes that develop in their communities, and how they will align their care transition programs with related initiatives that are being carried out by other payers, including Medicaid, Medicare Advantage and the private sector.

OK. So, a program solicitation will be announced shortly in the Federal Register. We are striving to have that announced by the end of this month, which after which time, we will accept applications on a rolling basis.

And we have our program web page address up there as well as in your notebooks. And any questions, because we are on a very tight time schedule today, any questions that don't get answered, please send them in to the Care Transitions mailbox and we will answer your questions. Thank you very much.

Linda Magno: With that, we'll go ahead and take questions, starting with people attending the conference in person. If you have a question, please step up to one of the microphones in either aisle and we'll try to get your questions answered while we await Dr. Berwick's arrival. Thank you.

We have a question over here. Please identify yourself.

Allison Silvers: Allison Silvers from VillageCare in New York. Just a quick question. You said you were accepting applications on a rolling basis. Is there a quantity that after you reach that, you don't have anymore? Is there – how competitive is this?

Juliana Tiongson: Thank you for your question. Yes, we are limited by the 500 million, which sounds like a lot of money, but it ends up you know, not being as much as you

would think. However, we want to encourage people to really do their homework and do root cause analysis and not just rush to get your stuff in, fearing that, you know, we won't have funding available.

We're looking for – and we're asking a lot of the applicants. And you'll see that when the solicitation is published. It's not something that you can probably turn around very quickly. But, of course, you know, we can only award what we can afford to award. I hope that helped.

Linda Magno: I'd like to add to that just for a moment to add to what Juliana said. In addition to wanting very thorough applications, it's a matter of organizational readiness. And many organizations that are eligible to participate in this program may not yet be ready, may not have the staff in place to undertake care transitions, may not have done the training necessary.

So, we're really expecting application to just have some time in terms of being able to accept applications on a rolling basis. We don't think that there are huge numbers of organizations that have all the pieces in place, have done the root cause analysis, have done the training, and the staff has the relationships, the partnerships between community-based organizations and hospitals and other providers in the community.

And therefore, we expect it's going to take time for those dimensions to really develop and be ripe enough for an organization to come in so that once when we approve an organization, it's actually ready to start implementing and providing care transition services, because once we begin paying for those services, we want them delivered. We don't want to be paying for those services to an organization that's still putting the pieces in place to develop and to deliver the services six months down the road.

So, we think that that – that allows for some real flexibility and time. And we will be keeping track of sort of the drawdown, if you will, on the funds available for this project so that we can provide some information as we move along in terms of where we are relative to having to close down applications.

There'll be as much information we can make available on that, we will make available on our website on an ongoing basis. Next question over here.

Selena Bolotin: Selena Bolotin with Qualis Health Washington. Can you better define the criteria for hospitals with high readmission rates?

Linda Magno: That will be described in the solicitation. We are looking at existing data that are recorded by hospitals for purposes of – for purposes of Medicare's Hospital Compare Website. And so, we're going to be looking at that data and we will lay out the specific criteria. A question over here.

Andrew Koski: Andrew Koski, Home Care Association of New York State. One of the guidelines talks about working with accountable care organizations and medical homes. In particularly in rural communities where they may not be ACOs or medical homes, would that rule out the organization from applying?

Juliana Tiongson: No. The point we were trying to make was just if there are such organizations in your community that it would behoove the applicants to work together with them. And again, I mean, if you're talking about a rural area, rural area is one of the preferred groups as per the statute.

David Shulke: Good morning. David Shulke with Health Research and Educational Trust. We're an affiliate of the American Hospital Association. I wanted to ask about your discretion how far you're going with your discretion under the statute. There's some things – priority is definitely given to certain kinds of organizational partnerships. And there are other things that you might prefer.

I wanted to ask you about – so, in the QIO presentations that have been happening over the last several days, one lesson seems to come across really loud and clear that it's a good idea to have providers across the continuum involved in these efforts, so it's not just within the hospital box, although that's very powerful to make a big difference to people doing more than ever before in that setting, involving the nursing homes and home health agencies and the AAAs and as are preferred in the statute.

These other providers seem to make a big difference if they're involved and have more impact and might even help you with your ACO recruiting or enlarging the pool of those. Is there anything that you can do and you're planning to do to encourage applicants that come with a whole array of community-based providers and not just, you know, with a hospital, or only hospitals?

Juliana Tiongson: Yes. We do understand the importance of including all of the downstream providers, you know, as many as possible and we encourage community partnerships.

As far as the funding mechanism goes, we will be paying community-based organizations. It is up to those organizations to, if they so choose, you know, make arrangements with other partners and to compensate them in some way.

Nancy Vecchioni: Hi. I'm Nancy Vecchioni from MPRO, Michigan's Quality Improvement Organization. I have a couple of questions. Number one, you talk about high-risk Medicare beneficiaries. Will that be defined specifically? And will we have to include in that application any types of numbers of the population served by our proposal?

Also, what about dual eligible beneficiaries, will those be included in that?

Juliana Tiongson: Yes, dual eligibles are included. It's Medicare fee – it mostly targets Medicare Fee-For-Service beneficiaries, which includes duals. In terms of numbers, those details will be available in the solicitation.

I think we do have some expectations as of today, although the package is still in clearance, that we would like to see some numbers. And I'm sorry, what was the first part of – what was your first part of your question?

Nancy Vecchioni: The definition of high-risk Medicare beneficiary.

Juliana Tiongson: OK. The high-risk Medicare beneficiaries in the statute are defined with minimum HCC scores as determined by the Secretary, those having multiple chronic conditions; those with cognitive impairments, depression, or history of readmissions.

We know – I mean, we don't expect organizations to have access to HCC scores. If a beneficiary has multiple chronic conditions, they will have a high HCC score. So, has that answered ...?

Nancy Vecchioni: Thank you.

Juliana Tiongson: Sure.

JoAnne Reifsnyder: Hi. JoAnne Reifsnyder, Care Kinesis and Genesis Health Care Corporation. So, just a couple of things quickly, a follow on, on the previous comment from this microphone.

Genesis Health Care Corporation is a provider of skilled nursing and long term care. Would we qualify as a CBO if we're partnering with an acute care system in the community? That's one question.

And then, secondly, could you elaborate on AoA participation for the purposes of this solicitation? And then, third, you said preferences to physician practices; would you also give preferences to community-based nurse practitioner practices? Thanks.

Juliana Tiongson: As far as the community-based organizations go, again, we are trying to be as flexible as possible on that point. But you do have to meet the criteria that's specified in the solicitation, which is having a board with multiple health care stakeholders, including consumers, and being based in the community that you're proposing to serve.

The AoA grantees, that is specified in the statute. I know that several ADRCs, Aging and Disability Resource Centers and Area Agencies on Aging are – have received formal training in some care interventions and are providing those interventions in their communities, either in conjunction with some of the 14 QIOs in the 9th Scope of Work or separate and apart from that.

So, we do need to give preference to those organizations that have experience, that are AoA grantees, that are trained on these things, and they've been providing these services.

And the third question, in terms of nurse practitioners with primary care practices, I think it just goes back to that we're going to be flexible, but you need to meet the minimum statutory definition for CBO. OK. Are there any questions from the people on the phone?

Operator: We will now open the lines for question and answer. To ask a question from the phone, please press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question and pick up your handset before speaking to assure clarity.

Please note your line will remain open during the time you are speaking, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Ann Corrigan. Your line is open.

Ann Corrigan: I'm on the phone and I'm wondering how we will know the order of the presentations that we downloaded. It's hard to follow because not all the names are listed.

Juliana Tiongson: Yes. If you have the agenda printed out, then you should be able to follow along.

Ann Corrigan: Thank you.

Operator: Your next question comes from a participant whose name was not captured. Please state your name and organization to identify your line for our presenters. Caller, your line is now open.

Your next question comes from the line of a participant whose name was not captured. Please state your name and organization to identify your line to our presenters. Caller, your line is now open.

Stephanie Hammonds: Hello?

Operator: Your line is open.

Stephanie Hammonds: Hi. This is Stephanie from HRSA in the Office of Pharmacy Affairs. I'm just wondering; we have a lot of work very closely aligned with this program through the Patient Safety and Clinical Pharmacy Services Collaborative.

And my question is, how can our teams potentially participate in this program as many of them are based at federally qualified health centers? Are they eligible? Thank you.

Juliana Tiongson: Can you repeat the question?

Stephanie Hammonds: Hello?

Juliana Tiongson: Yes. Can you repeat your question?

Stephanie Hammonds: I'm sorry. I'll pick up the phone. This is Stephanie. I'm in the Office of Pharmacy Affairs at HRSA. And we're doing a lot of similar work right now in the Patient Safety and Clinical Pharmacy Services Collaborative.

We have a lot of community-based teams providing very concentrated comprehensive medication therapy management to high-risk patients, many of whom are Medicaid patients. And I'm wondering as part of federally qualified health centers if they are eligible to participate in this program and how we might partner with you in that work.

Juliana Tiongson: Well, I would encourage these teams to try and partner with acute care hospitals in their communities. I think that that could be a possible opportunity. I mean, I don't know that they would qualify as CBOs but that goes back to the definition of CBOs as outlined in the statutes.

Stephanie Hammonds: Right. We do have, with the expansion of the 340B program as part of the Affordable Care Act, one of our new eligible entities is the Critical Access Hospital. So, I think that's a very ripe opportunity for partnership. Thank you for your response.

Operator: And your next question comes from the line of Colleen Stukenberg. Your line is open.

Colleen Stukenberg: Hi. I was just wondering. Can you give us some examples of some CBOs because I'm not sure if you're meaning nursing homes, home health care agencies, the physicians' offices, or what direction you're heading with that?

Juliana Tiongson: I don't know that I can give you specific examples. I mean, as long as you meet – your organization meets the definition that's required, then we would consider you as a CBO.

Colleen Stukenberg: So, any of those possibly could work?

Juliana Tiongson: I'm sorry. Any what?

Colleen Stukenberg: Any of those could possibly work?

Juliana Tiongson: Possibly. I think we have time for one more question.

Operator: OK. And your last question comes from the line of Sherry Bronca. Your line is open.

Sherry Bronca: Hi. I'm from the University of Utah and Intermountain Healthcare and Geriatrics. And organizations who are ready to participate may be higher performing and already have lower readmission rates, would there be additional important information to be learned by higher performing groups being allowed to participate as well as those lowest performing groups?

Juliana Tiongson: I'm sorry. We're having a difficult time hearing you. Can you restate your question slowly please?

Sherry Bronca: My question is that organizations who are ready to participate may be higher performing and already have lower readmission rates. Would there be additional important information to be learned by having some higher performing groups participate as well as the targeted lowest performing. In other words, the people with the highest admission rates are participating but may be the least prepared to have additional benefits?

Juliana Tiongson: Are you referring to acute care hospitals?

Sherry Bronca: Either community groups or ...

Juliana Tiongson: That don't necessarily meet the definition of high readmission rates?

Sherry Bronca: Yes. So hospitals that are already doing, you know, medium to better performance who could possibly improve even more.

Juliana Tiongson: Right. Yes. The statute does not preclude those hospitals from participating so long as they are connected with a community-based organization.

Sherry Bronca: So, even if they are below the cut off for the high readmission rates?

Juliana Tiongson: I mean, we are – if the hospital is the applicant, then they need to meet our definition of the high readmission hospital. But if a CBO comes in with multiple hospitals as partners and some of those hospitals do not meet the definition, they would still be eligible.

Sherry Bronca: OK. Thank you.

Linda Magno: As it turns out, the best laid plans are just that. Plans. We've just gotten word that Dr. Berwick is stuck in traffic, but should be here within about five minutes. So, we do have time for a few more questions.

If there are additional questions here in the room, please feel free to step to the microphones. Otherwise, the operator will go ahead and take additional questions from the telephone lines.

Operator: Your next question comes from the line of Roxanne Tena-Nelson. Your line is open.

Roxanne Tena-Nelson: Hello. This is Roxanne Tena-Nelson from Continuing Care Leadership Coalition of New York. And my question is, how you are, you know, about what your real goal is in looking for something that is, you know, one CBO with multiple hospitals is what you're talking about? Are you looking multiple CBOs and one hospital with a high readmissions rate?

Is there any particular focus? Are you looking for a broad – broad programs or kind of very established programs?

Linda Magno: If you could repeat the last part of the question after the one CBO with multiples hospitals and the one hospital with multiple CBOs, it would help, and if you could go a little bit slowly.

Roxanne Tena-Nelson: No problem. So, I'm just wondering about the focus for what you're looking for. If you looking for something that is very broad with multiple provider organizations with multiple CBOs in an established sort of community relationship? Or, are you looking for something very small in focus with one CBO or maybe two CBOs and a hospital that has a high readmissions rate?

Really, trying to look at what is the scope of the focus of this solicitation.

Juliana Tiongson: The solicitation is directed as is the statute to eligible organizations and eligible organizations come in two forms. They come in the form of high rate – high readmission rate hospitals that partner with a CBO, a community-based organization, or they come in the form of community-based organizations that provide care transitions across the continuum.

And we would expect any community-based organization that applies for this program to be working with multiple providers. It could be just one hospital, but it could be multiple hospitals. In general, we want – we want breadth because we do believe that care transitions are a community-based problem. They're owned by the community, not generally just by a single hospital, unless it happens to be a single-hospital community, in which case, the hospital is a critical component.

But there are other providers as well that are connected to and associated with the care around care transitions. So, we are looking for breadth, but we are not precluding individual hospitals in partnership with a single community-based organization from applying. So, it's both. We have a question on the floor.

Roxanne Tena-Nelson: All right. Thank you.

Kristina Lunner: Good morning. Kristina Lunner with the American Pharmacists Association. We were thrilled because medication use is often an issue around hospital readmissions we were thrilled that this section included a medication management component.

Just curious. For the pharmacists and the pharmacies across the country who are working in hospitals or long term care settings as individual consultant pharmacists or in a retail setting, what's your— how are they being incorporated? Or, what are your recommendations for them as they look to engage in these activities?

Linda Magno: Since the critical criteria for applying is these partnerships between hospitals and community-based organizations or community organizations and hospitals and other providers.

It's really critical that other organizations that believe that they have something to contribute to improving care transitions and to working on this issue within their communities need to contact with, need to work with, need to identify the community-based organizations and hospitals that will be looking to participate in this program.

And we've heard from many organizations that believe that they have interventions that make sense for improving care transitions, that they have success and some evidence or a growing body of evidence. But we are not directing anyone to specific types of programs or organizations, rather we are looking for the delivery system and the community-based organizations that which they work with to come forward with what works, with what they believe will work in a particular community. Another question over here.

Amy Boutwell: All right. Thank you. Amy Boutwell from the Institute for Healthcare Improvement. My question – thank you for many of these clarifying points. And I think I am just seeking final clarification on the extent of the breadth.

Might a community-based organization be as interlinked as part of a state or an entire state should we be able to meet the criteria of the community-based organization and incorporating the providers there?

Linda Magno: We would certainly look at that. I mean, again, we are not – we're trying to avoid kind of a one-size-fits-all approach to what would work in the different communities. And I'm going to imagine we're not talking about a very, very large state because I would imagine that could be really difficult. But I don't see anything that would preclude us from looking at applications from a statewide endeavor.

Amy Boutwell: Thank you.

Linda Magno: Question over here?

Gail Hunt: Yes Hi. This is Gail Hunt from the National Alliance for Caregiving. I know that you've mentioned consumers in terms of being on the boards of the CBOs, would family caregivers also be involved or would they be eligible to be considered a part of the consumer category because specifically, like with Alzheimer's they definitely are the people that are being the consumers along with the patients.

Linda Magno: Absolutely. And I guess let me say something more broadly, I think, about community-based organizations. I hear a lot of questions about it. We are going to be – trying to be flexible, the statute does not give a lot of guidance and it's from that that we really desire to be flexible but we will – we do believe it will be incumbent upon applicant organizations who consider themselves to be community-based organizations to provide documentation that they actually do meet the requirements.

They will have to provide information on the board compositions and have it, who the representation is on their boards so that we can basically assess that as part of the application process that what we are dealing with does in fact meet the statutory criteria of the community-based organization.

Madeleine Biondolillo: Thanks. I'm Madeleine Biondolillo from Radius Healthcare in Massachusetts. And I think you just started to allude to my question. I was

wondering if you could give us a little bit more specific guidance on the nature of the partnerships or affiliations in the CBO? Is there an expectation that there be some particular language of interdependency, that there is a miranda of understanding or the structure of the board or that kind of thing?

Linda Magno: There will be some guidance in the solicitation and if that still leaves people confused, we will be monitoring our email box regularly and will take questions on that during the open solicitation period and take questions in writing and post the answers so that everybody is free to see what we are saying in response to any of these questions.

So if you're still uncertain once the solicitation is out and available for people to review, I'm sure there'll be a lot of questions that we haven't thought of or that we have in our mind but we haven't laid out completely. And we will address those kinds of things at the time.

Nancy Vecchioni: Can you hear me?

Linda Magno: Yes.

Nancy Vecchioni: Nancy Vecchioni from Michigan's Quality Improvement Organization. You keep referring to governing boards and when I think about a governing board, I think within a hospital setting. What about a steering committee for that particular community that includes representation from across the continuum... patients and families, the whole gamut? Would that be considered a governing board?

Linda Magno: We would have to look at again, the make-up as a part of the application process.

Nancy Vecchioni: Thank you.

Keynote Presenter

Linda Magno: And I see that we're out of time for questions. And I'm going to go ahead and welcome our next speaker to the stage, as I said I'm not going to give you bios. Dr. Berwick is here to join us today and his bio is in the back, he is the

Administrator of the Centers for Medicare and Medicaid Services. I'd like to have you join me in welcoming Dr. Berwick. Thank you very much.

Dr. Donald Berwick: Thank you, Linda. It's a pleasure to be here with you and I apologize for being a bit late, the traffic coming into town was just more than I anticipated, so thanks for your patience with me. I wanted not to miss the chance to welcome you all here to tell you how excited I am about the work on care transitions and take a few minutes to put that work into context then I welcome some of your questions as you – as you pursue this most important task in reforming health care.

As I was driving here, I actually was remembering an experience I had many years ago, it was probably 15 or 20 years ago when I happened to be on service teaching at a children's hospital in Boston where I was on faculty. And it was my habit in those days to look for issues in quality with the residents and the medical students that I was teaching generally to try to find out how we were doing with patients and to orient those young people toward inquiry about the experience of care.

I had a sort of turning point experience in that context that's closely related to the work you're all here engaged to study and pursue. I walked into the room of a young boy named Kevin, a 15-year old boy. I had not met him before but I introduced myself as the attending physician, and I said to him, Kevin, you've been here often and I thought you might help us understand how to make our care better.

Kevin was 15, he had a syndrome called short bowel syndrome which I believe was from birth and due to surgery he didn't have a lot of intestine and therefore had to be very careful about his nutrition and was frequently in and out of the hospital dealing with challenges. He'd been in the hospital probably 30 times in his young life. But he was doing well and he said to me what all patients would say right at the start, he said - no, everything's fine, you're terrific here. And I said, I know that Kevin, we're terrific but surely something could be better, could you come up with anything? He said no, no you're fine. I said no Kevin, I'm insisting.

So he said OK, and he wrote on a piece of paper three things that I've kept with me for many years - his suggestions for how to be better. He said well OK, I have three requests. So the first thing he wrote down was please tell me what you're going to do before you do it to me. It's kind of hard to deal with the surprises and if you could just make a plan with me, I can do a little better.

His second question was, he said you know there are a lot of you – doctors and nurses all around me – do you ever talk to each other? He said it would be great if you talk to each other. And then his third thing he wrote down was, he said you know, I've been here a lot, in fact, I've probably been in the hospital more than you have. He said if you ask me what I think, I can help you. Wisdom from a 15-year old. Tell me what you're going to do before you do it – make a plan; please talk to each other – be a team and ask me what I think – I can help too. In fact, it's my life not yours.

So we can call it care transitions, or continuity, or seamless care, or coordinated care or whatever that's what the heart of this is – it has to do with creating for people who try to help, the opportunity to plan, the sense of teamwork and the possibility of strong and ongoing partnership with family and their loved ones. I see the care transitions work as completely continuous with that vision of what care ought to be. We're in a very interesting time in American health care right now, all of us together, not just CMS a time of transition itself to the future care system we want.

If we think about that for a minute, we'll rediscover that the stewardship of transition, of continuity, is at the very heart of what our country needs. In the Centers for Medicare and Medicaid Services, I proposed when I arrived five months ago that we consider ourselves as a major force and a trustworthy partner for the continual improvement of health and health care in America. That CMS shouldn't see itself just as a payer, or just as a policy maker or regulator but rather more as a partner and a force for the improvement of care.

I've been working very hard with my colleagues against no resistance at all to make that a reality. What do we mean by improvement? Well, we have to reference the social need to realize what we mean by improvement. The social need is pretty clear, it's for three things, a three-part aim. First it's to

meet Kevin's needs – it's to provide better care for individuals every day. We were chartered to do so already ten years ago by the Institute of Medicine in the Crossing the Quality Chasm report which gave definition to the pursuit of better care for people like Kevin. It said that when we are sick or well but in care, there are six dimensions to our experience that need improvement.

Safety – we shouldn't be harming people in care. Effectiveness -We should be assuring that care matches science. That we do everything we can for people that can help them and we don't subject them to care that can't help them. Patient-centeredness, which is what Kevin was talking about - that's, I'm the boss. I know a lot, let me be a full participant even the leader of my own care. Timeliness – delay is defect in health care as in any other industry. Efficiency- this refers to waste – wasting time and effort, redundancy and nonsense in care and Equity – closing racial and socio-economic gaps in health care. Safe, effective, patient-centered timely, efficient, equitable care. Society needs that. That's better care.

The second thing we need is not to be sick in the first place, and that's the pursuit of better health, and you know, as all Americans do at some level that the pursuit of health really doesn't lie in health care, that only 10 percent of the variation of health is attributed to care, most of the variation has to do with many other factors – genetic endowment but also social conditions, disparity, environmental threats, substance abuse, poor behavioral choices, obesity. These are not things that lie within the health care system. They lie outside of it but determine whether we get a heart attack and break our arm or have many of the diseases that afflict us. So we need better health.

And the third thing is lower cost. That's on the screen, it has to be. We can't afford the health care system at its current level of expenditure, it's not sustainable. Just pick up the morning paper in the morning.

The modern view of improvement in which you are now part of the army- is the simultaneous pursuit of all three of those - better care, better health, and lower cost. Authentic assistance to the social needs of our country today, meaning the simultaneous pursuit of all of three of those and that's what I'm

asking of CMS - better care, better health, lower cost - it defines what we want.

How do we get it? Well, one way to get it would be keep yelling at the system to do better. That violates an axiom I heard in Africa a couple of years ago working in Ghana where one of my colleagues there told me a proverb, that went roughly, weighing a pig does not make a pig fatter. The pursuit of better in any part of your life you already understand, whether it's tennis, chess, your marriage, cooking, quilting, or whatever you love to do, the pursuit of better doesn't involve yelling.

It doesn't involve weighing the pig. It involves learning, growth, development. It involves figuring out how to hold the racquet a different way and trying that. How to add a little more paprika and see if that's better. How to sit down with your significant other and say how's it going?

Learning and change and improvement are all together in the modern view. When you're involved in the improvement of care transition you become learners and teachers and exchangers of knowledge. That's the pursuit of improvement. It's the method. If we want safe care? We'll have to give care differently to be safe.

We're not doing such a hot job of that apparently. If you read the New England Journal last week, Chris Landrigan and his colleagues produced a landmark study of progress toward safety in a state where a lots been invested in safety – North Carolina – showing that we're stalled, that patients are getting injured.

We need to end that. We need to make care safer. To do that will involve systematic, rapid, ambitious pursuit of different forms of care. Safer care so Kevin doesn't have an infection. So, he doesn't have to wait, so his dignity is respected.

So there's a whole set of changes around the pursuit of better care for individuals that would lead us to better if we are willing to change. The same goes for prevention. If we don't like the obesity characteristics in the country,

we'll have to change the way we approach the problems of nutrition and the choices we make in our lives.

If we don't like the discontinuities in care, the fact that we drop the ball so often, that we don't speak to each other, that we don't ask the patient and family what they know and use that information, we're going to have to change the way we deal with people through time and space, also.

That's the hallmark of integration. It's the hallmark of proper management transition. So, all improvement is change, not all change is improvement, but all improvement is change and we – together, you and I – are after changes in the way we deal with the needs of people over time and space. And that's at the heart of the nature of transition.

Of all the changes we could make in care, probably none are more leveraged than that. The reason is that so much of the need we're trying to meet lies among people who have chronic illness (inaudible) for a long time.

So many of the defects that have been introduced into care have to do with defects and handoffs. It happens as people move around. Kevin comes in hospitalization after hospitalization. It's the thread that knits all of that together, that keeps him healthy and safe and not the event and yet we have so long paid for events, paid for fragments and trained people within disciplines instead of working on what I know you all are working on – which is the sense of teamwork he was asking for.

Now we have the new law, the Affordable Care Act. It gives us so much leverage. As a student and advocate for improvement, what I see in that law are more tools and more opportunities than the country's ever had before for the pursuit of that reform, integration that I was talking where you want to get. It lies, of course, in coverage first. We can't get that unless we provide coverage in our country and now millions of more people will have the certainty and security that lies in having accessible and affordable insurance coverage, whether that happens through the exchanges or through expansion of Medicaid or through the ending of the use of preexisting conditions of coverage, all of which that law will put a stop to now.

So, coverage is essential, but it's not enough, because coverage of care in a system that's defective will only produce more widespread defects. And so, the changing of care is necessary in order to achieve what we want. And the law has in it all sorts of opportunities. They have incentives in the law for starters, for hospitals and caregivers. More and more over the years that that law will play out, we'll see more and more relationship between what they get paid and how well they do.

They'll be more interest in supporting them to pursuit of reliable care and continuous care, better outcomes through value-based purchasing, forms of reward, and contingencies in which hospitals that don't get safer will find themselves not rewarded for that.

But more importantly, I think, there are supports in the law, opportunities to help our country discover better and better ways to give care. Not just weighing the pig, but taking care of it. The forms of that in the law are many. We have, for example, accountable care organizations, the reconceptualization of how we can support care on the Fee-For-Service side of Medicare to produce the kind of integrated care that Kevin was after when he said "Do you ever talk to each other?"

The accountable care organization answer is "Yes." We do and we will. We're a team. And that rule, the preliminary rule, the notice and proposed rule making will be out just after the turn of the year, I think. You'll see how we're trying to migrate payments and supports toward that form of accountability and the opportunity to integrate care.

We have the new Center for Dual Eligibles that (inaudible) is going to set up that will be announced informally shortly, but it's already in the works now. Forty percent of the cost of Medicaid in the state currently going to the care of dual eligibles. And the states are writhing in the costs right now. Well, the way out of that box is better care for dual eligibles, lower cost through improvement. We know it's possible. You know it's possible. And that center will be able to sponsor and support learning and change to help take care of dual eligibles, to integrate so we do talk to each other.

We have the new Center for Medicare and Medicaid Innovation, a tremendous, important national investment in supporting innovation all over the country, probably the most thrilling aspect of the law to me, is the way that can release the energies of the country to discover new things. And demonstration efforts, projects like the one that you are hearing about today that would allow ambitious, forward-thinking, change-oriented people who give care, organized care, to reorganize that care to better meet the needs of the people that need us the most.

Transitions, continuity, integration... Do you talk to each other? Do you ask me what I think? Will you make a plan and tell me what that's going to be in advance so we can do this together? All of that is absolutely at the heart of the kind of change and improvement in care that I think we can achieve if we are systematic and ambitious about it.

So, thanks for your interest. You're going to learn a lot today, from each other most of all. And from scholars and others that are in the room. And I hope you'll stay closely involved with CMS and all of us as we try to navigate our country to what we need -- better care, better health, lower cost for improvement, all achieved through change. Diligent, respectful, collaborative change in the care that we offer. Thank you very much. I am happy to take questions. I'll do my best with them. There are mics on the side here.

Carol Wagner: Hi, Don. Carol Wagner from Washington State.

Dr. Donald Berwick: Hi Carol. Nice to see you.

Carol Wagner: In Washington, we've worked hard on many initiatives. And our results are good compared to the rest of the United States. And in particular, some of our rehospitalization rates are really good. And yet we know that there's a lot more we can do.

On some of these initiatives, such as the one we're talking today, it almost appears that the efficient states or the efficient hospitals are not being

rewarded with resources to make them even better. Which we know we can still do. Is there a way we can help those hospitals also?

Dr. Donald Berwick: Well, as I say, there are investments in the new law toward innovation. I look forward to closer and closer partnerships and relationships with all of the leaders who want to really help changes be made. I'm very familiar with those, as you know, that are happening in Washington, I'll be there in two weeks and am looking forward to that.

So, I think us staying in touch with you about all of the innovation opportunities that appear in the law is one answer to that question. The innovation center, the dual eligibles work, the demonstration projects that will be emerging like this one as that law plays out, that should really help.

There also is – there is a reward system. Value-based purchasing that is now going to enter the hospital industry where if we measure properly and are sophisticated about what we're measuring, hospitals, in your case, Carol, hospitals that get, that are more and more successful will find themselves that that will be linked to the level of payment that they receive.

And on the downside, hospitals that aren't working as effectively on readmissions or on patient safety, for example, will find themselves actually getting less of money. There will be a much closer relationship between the performance we want, the output we want and what people get paid.

I think that we're going to see our whole industry, not just Medicare and Medicaid, but the private sector move much more towards purchasing what we're after which is better health and better care and lower cost and rewarding places for that.

Kristina Lunner: Good morning. Kristina Lunner, with the American Pharmacists Association.

Dr. Donald Berwick: Hi

Kristina Lunner: Hi. We appreciate what the agency has been doing with medication therapy management services in the Medicare Part D prescription drug benefit and we

are very excited about how the new ACA, you know, the new health care reform law, reflects medication use and the need to address that. We just encourage the agency to continue to look to pharmacists in the long term care hospital and community centers, to address the medication needs and the prices that patients face right now.

We're concerned that many of the models of the demonstration programs rely upon Fee-For-Service, Medicare Part B payment. And as you know, with the DRG payment, they're not – pharmacists, clinical services are not currently reimbursed. So, as we look forward in innovative and using, you know, health care providers at their highest level of their license, and you know, optimizing the entire team, we just encourage you to continue to keep in mind the pharmacists and what they can bring to the table.

Dr. Donald Berwick: Thanks for that. I mean, there is no word in the whole field of change we're in that's more important than the word team, especially for the chronically ill. They experience us as a unit, whether we're doing it together or not, and the concept of everyone getting together around the patient – the patient and family – with the person at the center is crucial to the kind of innovations we need. Every one of the disciplines that can bring help to the patient needs to be able to do that and to do it as part of one single system. Pharmacy is certainly central to that and all of my work on patient safety through the past two or three decades, I can't tell you how often it's been the pharmacists that's come to the floor to help actually make the care safer and to lead that. So I thoroughly support anything you guys can do around building (inaudible). Any others? Is there a telephone connection with some questions on it?

Linda Magno: Operator, could you open the phone lines, please?

Operator: At this time, if you would like to ask a question, please press star followed by the number 1 on your touchtone phone. Please state your name and organization prior to asking your question. To remove yourself from the queue, please press the pound key.

And your first question comes from the line of Paul Funaro. Your line is open.

Jim Riley: Hi, good morning. Thank you. This is actually Jim Riley. I'm calling from NewCourtland, in Philadelphia, Pennsylvania. We are an organization that has heavily invested in the transitional care models in the – for long term care facilities. My question is, technology, remove monitoring biometric sensors and those types of devices. Would there be any preference or any additional consideration given to organizations who actually leverage that type of technology?

Dr. Donald Berwick: Thanks, Jim. One of the delightful things that has happened to me in terms of my knowledge base since I've arrived at CMS is that I have become more familiar with the modern views of the proper use technology and monitoring the kinds of things that Jim was referring to. I'm so excited about it. I think that as we really think about progressive, ambitious, exciting change... change which changes the game in terms of better health, better care, and lower cost through improvement. These abilities to extend knowledge and information much more widely than we ever thought before could be pathfinders. So, I am very enthusiastic about the kinds of experimentation that you may want to engage in terms of safe and secure but really, ambitious and new forms of telemedicine and monitoring and connections like that, I'm pretty excited about that field. That may turn out to be one of the biggest tools we've got.

Linda Magno: We have time for one more question from the telephone.

Operator: Your next question comes from the line of Kerry Conway. Your line is open.

Rosemarie Dougherty: Hello. My name is Rosemarie Dougherty, I'm a AAA case manager here in Bloomington, Indiana. And I just – we had great difficulty in hearing Dr. Berwick, and I was wondering if there is any way for people listening remotely to give some kind of feedback during a presentation, so that we can truly hear everything that is said. Thank you.

Dr. Donald Berwick: Thank you so much, ma'am. Sorry, you had trouble hearing it. Is this meeting being recorded now?

Linda Magno: This meeting is being recorded and it will be available on the CMS website within the next few weeks. So, for those of you unable to hear any part of the meeting, we're sorry for that. And I hope that the recording of the meeting, will work out what is apparently happening with the audio. We're also some trouble sometimes hearing the questions here. But please bear with us and we will try to speak slowly and into the microphones and we will try to continue to monitor the sound. Thank you.

Dr. Donald Berwick: Thanks. I'm sorry for the difficulty, Rosemarie. Thanks for your feedback.

Hospital Implementation of Care Transition Programs

Linda Magno: Please join me in thanking Dr. Berwick for making time in his schedule to be here today.

I'd like to now ask our next panel to move quickly up to the stage. I'm going to give the names of our panel and let them introduce themselves as they present and they'll be presenting in I believe in the order as listed here:

Robert W. Pryor is the President and CEO Designee and Chief Operating Officer of Scott & White Healthcare.

Jennifer Markley, Senior Director for Medicare Quality Improvement and Director of the Texas Care Transitions Project, the TMF Health Quality Institute.

Robin Jones, RN, Quality Care Coordinator with Valley Baptist Medical Center in Brownsville, Texas.

Jeff Critchfield, MD, Chief of the Division of Hospital Medicine and Medical Director for Risk Management at San Francisco General Hospital.

Mark V. Williams, MD, I'm not going to go through all his fellowships, Professor and Chief, the Division of Hospital Medicine, Northwestern University – Feinburg School of Medicine and Principal Investigator for Project BOOST.

Matthew J. Schreiber, MD, Vice President and Chief Medical Officer of Piedmont Hospital.

And Cathie Berger, Director of the Area Agency on Aging, the Atlanta Regional Commission.

Welcome all of you.

Robert Pryor: Thank you. It's a pleasure to be here. First, I'd like to start by talking a little bit about my, what I believe to be truth and what I believe to be assumptions as I move forward. First, truth. I don't do the project, all I do is remove the administrative barriers to allow the team to do the project. So, I am not the one that does it.

Second, when they asked me to talk about the economic impact of transitions to a hospital, I said, "Well, gee, this should be quite simple because a highly reliable, safe, quality organization should produce economic benefits and then I step down. Right?" They said, "No, you need to do a little bit more than that, so, I will."

It's in all hospitals best interest to work with the community and we worked with the ADRC in our local community to connect with our patients and the communities in which they live. There's a time when physicians used to take their horses and the horse and buggy and visit the patients on the farms and where they lived, to understand about what is the context in which they're trying to get healthy as they go back into the communities. Well, those days are gone. We still do bloodletting, though. We only put it in small little tubes now rather than big pans. But, we don't connect with the community as we have in the past and as we should.

We need to better identify at discharge the needs of the patients as they go back into the community and transition from that acute care setting back to the home. And I worked in the intensive care unit for 20 years clinically and one of the things that I was noticing more and more is that as our patients left the high intensity of the intensive care unit, and then by necessity had less

interventions in the hospital bed and then further decreased the interventions as they went home. This produced a lot of turmoil, a lot of angst with our patients and also the families that give care to the patients.

There's a need to link the goals of hospitalization with what the community does and how the community interacts with the health and well-being of our patients, as they go back into the community. The failure of good transitions is just way too expensive for us to continue.

So, I'd like to start with what I'm going to try to do. I'd like to talk about Scott & White Healthcare's position in our community, the care transition impact on safety and quality and then try to give a very high level overview of the impact of the care transitions that we see.

First of all, Scott & White Healthcare is imbedded in our central Texas community. We're in the heart of Texas, deep in the heart of Texas. We are an integrated delivery system, a multi-specialty physician group practice of around 1200 providers. Primary and specialty care is given and one of the things that we have is we're fortunate in that we have a high percentage of primary care clinics in our network. About 35 percent of our providers are in primary care.

We have hospitals, long term acute care facilities, skilled nursing facilities, home health and hospice services. And we've been accountable for the health, quality of life and cost containment of high quality care in our community for over a century in central Texas.

The care transitions allow the right care at the right place at the right time. These transitions occur within our system and across other systems that refer patients in to us and also allow the right sizing of our hospitals. Scott & White Healthcare's business is the health of our community. As Dr. Berwick so nicely summarized, we want to produce safe, effective patient-centered, timely, efficient and equitable care in our communities.

This has been shown a lot. This is the Dartmouth Atlas Study of the Medicare total cost non-capitated per beneficiary reimbursement in 2006. If you look at

the red circle, that's central Texas, the heart of Texas, where we are, and you see a sea of green, an island of green and a sea of blue in Texas. This shows that in our service area, the cost is less than \$7,500 per beneficiary.

This is the heart of Texas, and if you can see, it's very hard to see on the screen, the red dots are our 60 clinic sites, 12 hospitals, surgeon centers, dialysis centers throughout the central Texas region. And throughout that, again, we focus on primary care and the transitions of care from the hospital back to the home and then the community.

Care transitions, of course, impact safety and quality.

Safety – if we have good transitions and good handoffs, we can decrease medication errors. Now, I'm going to state the obvious now because what we're talking about is our most fragile patient at the most vulnerable period of their transition, as they go back in the community. We could also decrease other adverse events for the patient and/or system errors, as we help facilitate these transitions, that these exacerbations should be diminished.

Now, let me state that nobody likes hospital readmissions. The doctors don't like it, the nurses don't like it, the pharmacists, the other care members of the team, and the least of all, the patients and the families do not like it. One of our hypotheses early on was that for every time you readmit the patient into the hospital, the cost and complications can actually increase exponentially, not linearly. So, it snowballs and as these fragile patients get more ill with rehospitalizations, costs go up, quality goes down, quality of life goes down and the patients suffer. The accountability for patients' health includes – should include the known consumer needs post-discharge, so we can keep that transition going.

The economic impact on communities for the consumers.

Well, every time they keep coming back, there's another copay. That's an economic cost. There's additional treatment, that's a personal and an economic cost. So, the last thing I want to do is go in and have another

central line put in me or another endotracheal intubation because I've got a hospital-acquired pneumonia and that wasn't taken care of adequately.

There's also caregiver time and resource utilizations from the families that give care. And the daily functioning is decreased, the quality of life of the patient is diminished. For our community, the employers suffer because as we go home to take care of our elderly parents, we don't show up for work.

The long term care health facility impact is if we deliver a patient that's still in need of major services, back to the long term health care, of course, they come back because there's a limit to what we could do in the long term care facilities. The home health agencies are further impacted, and the AAAs with care coordination and transition programs are flooded if we don't do the job right at the time of transition.

The economic impact on the health system.

Well, everyday, we need to earn our community's trust by taking care of our community. We need to develop consumer loyalty around our health care systems. But more than that, I would submit to you that this can protect the operating margin. It opens beds to more high acuity patients that need it where we're not doing rework, but we're doing the work for the first time and not doing rework after rework after rework.

And not only that, but we're in an area where we're actually adding hospital beds and hospitals in our community with a cost of about \$1.2 billion per hospital bed, we need to make sure that we right size the construction of our hospitals because, as we put the burden of fixed cost into more and more hospital beds, that we frankly have to pay for over a 30-year bond proceed. You know, this is adding fixed cost to the health care cost, not just the variable cost that we talked about but also the fixed cost that we incur for a long period of time. And, of course, this also can avoid the penalties for excessive readmission.

We need to optimize the efficient use of our resources, take advantage of the economies of scale when we have them and produce safe, effective staffing ratios.

So, our approach is that intervention doesn't necessarily produce good outcomes. And we've had a three to four-year history of working with our community partner in the transition. We can show that we can implement this, but now we need to do further studies and add evidence to show that the interventions can be personalized to the patient as they leave the hospital.

Because in order to give patient-centered care, our transitions of care has to be personalized in order to give that patient-centered care because that's essentially what patient-centered care is, a personal discharge plan for every patient that leaves our hospitals and goes back to the community.

So, we also need to know what consumer characteristics and behaviors predict readmission so that we can prevent these readmissions and what interventions at the patient level can address their identified personal needs.

With that, I'd like to thank you for allowing me to be here today and be a part of this. And you can call me, contact me at anytime. Feel free, there's my data. And contact me anytime for questions.

Thank you.

Jennifer Markley: Good morning. I'm Jennifer Markley. I'm going to be talking about a project that we did in south Texas, it was one of the 14 care transition projects that were done around the country in the last contract. So, we began the project in August of 2008. There were 14 communities, as I said. Our goal was to reduce hospital readmissions through improved quality at the patient transitions, and to do that in a community-wide setting.

So, our goal was a minimum of 2 percent reduction. Twenty-eighth month of the project, which was November 2010, that was only 18 months of work. We have to keep that in mind, we've got data lags involved.

Comprehensive community-wide cross-setting effort and to yield sustainable and replicable strategies, and that's hopefully what I'm going to help you see today, is how to replicate the improvement that we saw in the project.

So here are the 14 communities. And we are the one that is very, very southernmost tip of Texas. We're about – in Brownsville, where my partner hospital is located, we're about a mile from the Mexican border. This area is often studied because of the demographics, the poverty and the barriers to care. One of the things that really helped us engage the community down in south Texas was that when we came, we said, “We are not here to study. We are here to implement and we're here to make change.”

And they were on board with that. They were tired of being studied and they wanted to try and make real change. So, this area down here is the hospital referral region. The Harlingen Hospital Referral Region, it is 35 ZIP codes. It encompasses the cities of Weslaco, Harlingen, and Brownsville. Brownsville is the one that's about a mile from the Mexican border.

And it was a great community to work with. They had a lot of pride in their community. They want to provide excellent care. And they were very easy to engage. They came at the project wholeheartedly and gave it everything they had during the course of the project. It was a wonderful community.

This is a sample of the data that we gave the providers quarterly so that they can look at their data and see both how the region was doing and also how the hospital itself was doing in terms of readmissions. And so we broke it down, and one the things that I want to be sure and draw out here is that the hospital readmission rate is not solely the responsibility of the hospital. It is the responsibility of the community. Downstream providers play a role in terms of the quality of care. And then the communication that happens between the hospital and those downstream providers is a dual responsibility that everybody should participate in.

And when you look at this data, you can see how the downstream providers contribute to the readmissions within the region. And I want to draw out a couple of things here for you. On the top, second to the top line, you can see

that within the region, looking at the top boxes, 2736 patients were discharged from the hospital to the home with self care and physician follow-up, no other provider, that's 55.7 percent of the patients in that community are being discharged home. Six hundred and forty-eight of those that were discharged home were readmitted, which was a 23.7 percent readmission rate.

The readmission rate for the home health providers was 15.6; for the in-patient rehabilitation facilities, 16; long term acute care centers were sending 16.1 percent back. And look at our SNF. Our skilled nursing facilities were 12.3 percent of the referrals, but of those 31.3 percent were coming back within 30 days. This is the community data that you'll all need to be aware of. And it's why it's so important within this care transitions project that we work across the community setting.

And then looking at the bottom boxes, this is the actual facility that we're going to be highlighting today. And you could see that their numbers were pretty similar. They were actually higher in terms of their home, 26.9 percent of their patients discharged home were coming back, 32.9 from their SNF. And, overall, you can see in the gray box – or the orange box on your screen – 22.1 was the readmission rate within the Harlingen Hospital Referral Region and 23.3 for our hospital.

So how are we going to... oops, skipped a slide. Oh, I don't have it. I've got one that you don't have. And it's an important one. I apologize. One of those is how are we going to do it. And way that we approached it was we offered the hospitals and the providers within the community options in terms of evidence-based practice that they could implement and that we knew from research that they could be effective if they were implemented well. And so one of the things that we offered was the reengineering discharged. And that involves a research study that was done with the Boston Medical Center.

It was funded by AHRQ. RED stands for Re-Engineering Discharge. And again it was Boston Medical Center. Dr. Brian Jack was the lead on the study. And they came up through their research with 11 mutually reinforcing components – follow-up appointments with the physician, outstanding tests and studies were resolved and taken care of prior to discharge, post-discharge

services were arranged. The patient was educated. They knew what they needed to look for and they were prepared for self care, keeping in mind that about half of them in this community were going home to self care, so how well were they prepared to be that once they were released from the hospital.

Medication reconciliation key, especially reconciliation between the home medications and the hospital medications. The patient needs to understand very clearly what's changed, what's new, what's been discontinued at the point where they're going home to self care. Getting the discharge summary to the primary care physician in a timely and efficient way so that when that patient comes for the follow-up physician appointment that there is a discharge summary available and the primary care physician knows what happened during that course of hospitalization.

The patient needs to know what to do if problems arise, what are the red flags, what are the things that they should be looking for in terms of changes in their condition and what should they do about them and who should they call and how soon should they call once they get home. Assessing the patient's understanding, making sure that the patient truly understands by doing teach-back, by asking the patient to explain in his own words what he's heard the educator tell him. A written discharge plan for the patient that's easy to read and that the patient can understand, that is large font, that is appropriate health care literacy, not a printout from the EHR.

Reconcile the plan with the National Guidelines for Quality and provide telephone reinforcement for the patient after discharge. Part of the RED was making one follow-up phone call two to three days after discharge to make sure that the patient would keep their appointment, that they understood their red flags. If they had any questions about their medications, any questions about the follow-up services, that was an opportunity to resolve those, reinforce the teaching, reinforce the follow-up so that the patient would understand the importance of the discharge plan.

And, now, I'm going to pass it over Robin Jones who is going to share about the hospital in south Texas.

Robin Jones: Hi. My name is Robin Jones, I'm the Quality Care Coordinator at Valley Baptist Medical Center Brownsville.

Valley Baptist Medical Center Brownsville is a 280 bed licensed acute care hospital. We are a faith-based organization and we're not for profit. This doesn't include a separate 37 bed psychiatric facility that we also have. We're a level 3 trauma designated center. We're also joint commission accredited for our hospital and lab; and we're stroke-certified. Again, we're located in the southernmost tip of Texas on the border of Mexico.

When we began the care transition project, our baseline rate was 23.3 percent for all cause 30-day readmission rates. Our hospital compare heart failure readmission rate was 28.1 percent based on the hospital compare data from 2006 to 2009.

We began with the implementation of Project RED, our initial focus began on the heart failure patients in our telemetry unit. The reason that we decided to start with those patients was because three of our top five DRG readmissions were for heart failure related diagnosis. And we decided that would make the most impact in our facility.

In May of 2010, we decided to expand to all diagnoses in the telemetry unit. We partnered community-wide with our downstream providers and we implemented the use of electronic health record in 2008 to improve our hand-off communications. We worked with our corporate compliance department in order to give our physicians and our physicians' offices access to our electronic medical record to have this information available to them.

We're also actively involved in regional workgroup meetings with the entire lower Rio Grande Valley to find out what other acute care hospitals and issues they're having in their communities. We also educated our medical staff, including our physicians, on medication reconciliation, health literacy, patient safety, and CKD. Our population, our demographic area, we have a very high incidence of diabetes, heart failure, and kidney disease.

All the components of Project RED were implemented and monitored in our 30-bed telemetry unit. We had a team approach to administering all 11 components and incorporating them into our hospital processes. This included working with the nursing, care management, pharmacy, and the core measures team who all contributed to this process.

In working with the nursing and care management, we educated the patient about his or her diagnosis throughout the hospital stay. We started this with every patient that comes in has a learning needs assessment along with daily teaching of their diagnosis and what's going on with them and their care for the day.

We also discussed with the patient any tests and studies that have been completed in the hospital and also the tests that are pending once they leave, if there are any. We review the next steps for what the patient is to do if a problem arises and this information and a contact number is provided on the discharge instructions.

Nursing provides a follow-up telephone call reinforcement two to three days after the patient has gone home. Before the patient is discharged, we actually make the appointments for the patient and make sure that they understand when the appointment is and then coordinate it with the patients and the families so that they are able to make that important post discharge appointment. We also make sure that we provide them with a written discharge plan that is the appropriate language for the patient and we assess their degree of understanding with teach-back.

Care management organizes the post-discharge services that the patient is going to need when they leave. They start this on the admission with the patient. They also expedite the transmission of the discharge instructions to the downstream providers, making sure that they have that information before the patient leaves.

Nursing, pharmacy, and care management confirm the medication plan. I was also very fortunate to also be the medication reconciliation owner for the process at our facility and understanding the strengths and weaknesses that we

have with our medication reconciliation process. Nursing and core measures also work together in reconciling the discharge plan with the national guidelines for the core measures.

In monitoring for effectiveness with the patients, the patients are given surveys before they leave. And the patients are able to tell us what their knowledge and their understanding of our discharge process is. The questions that we ask on the discharge survey for the patients... They're both given to the patient in English and Spanish, and the patient is the one who fills this information out. We do have assistance if they have difficulty in being able to sign these surveys.

We want to make sure that they were taught about their diagnosis throughout their stay. We want to make sure that they have appointments with their physicians made for them prior to them leaving. We want to make sure that any tests or studies, medical equipment or services are also explained to them before they leave.

We want to make sure that they know who to call if a problem arises. We want to make sure that they receive a copy of the written discharge plan and that is easy for them to understand and read. We want to make sure they have an understanding of the discharge plan and the information they need to take care of themselves once they have returned to their home, make sure that they have a list of the medications that they are to be taking once they're discharged and any new medication or any exchange medications. And we want to make sure that they understood the teaching and they're asked to teach back.

The process that we give them includes having a case manager runner that gives out a daily length of stay report. That report is given to case managers, the telemetry supervisors, charge nurses as well as quality. The floor staff is responsible for completing all the components of the RED prior to discharge. The case management runner delivers and retrieves these surveys that we give to the patients and forwards the completed surveys to me. And then two to three days after discharge, I call the patients and make sure that they

understood their discharge instructions and are able to troubleshoot any problems that they do have.

We do track our patients' survey results to make sure that we understand where our problems lie. Ninety-three percent of our patients surveyed said that they received the information about their diagnosis. They also understood the follow-up appointments on 94 percent of the cases. Eighty-eight percent of these patients had a follow-up appointment scheduled within a week after their discharge from the hospital and 99 percent of our patients surveyed said that their written discharge plan had information needed for their self-care management and that was really easy for them to read and understand.

As you can see, these are our patients that we actually surveyed, and we tracked them within 30 days of discharge to see which ones surveyed actually came back. And we see in March and April, we were about 23 percent and then in May we saw all of our interventions, our education come together. And since May, our readmissions for this survey group have been less than 10 percent in almost all of the months. We continue to see that downward trend for the latter part of this year.

Jennifer Markley: I'm just going to pick it up and do some closing data real quick. This is looking at the remeasurement period. The one thing that I want to point here and I'll show you this, it's not very helpful in this format, but I'll show it to you in graphs in just a second. But we not only had a reduction in readmissions, 30-day readmissions. We had a reduction in admissions in the community. And so if you look at the numbers and compare them to the first chart, you'll see we had 342 less discharges, or less admissions to the hospital, and that's a 14 percent decrease.

This is looking at the Harlingen Hospital Referral Region by the different downstream providers. And this is looking at the hospital compared to the Harlingen Hospital Referral Region. And what you'll see if you do the math here, is that home health agencies decreased by 2.7 percent. That's a 28 percent relative improvement. Patients discharged to home decreased by 5.9

percent on their 30-day readmission. That's a 22 percent relative improvement.

IRFs, the inpatient rehabilitation facility in this community was not working with us. The LTAC had a 1.5 percent decrease in 30-day readmissions, 6-percent relative improvement. Look at our SNF, 19.9 percent reduction in 30-day readmissions. That's 60 percent relative improvement. They did a terrific job.

And then, overall, 4.6 percent, 20 percent relative improvement. And this is over 18 months, moving very quickly. This is showing, again, keep in mind that we started quarter 3 2008 so that the data prior to that, we were not working. And then we're starting to see this drop off here. Their data continues to fall through 2010, 4.7 percent – 20.34 percent relative improvement is what they're showing.

Looking at their HCAHPS, what I want to tell you that in May and October of 2010, May and October 2010, which is not on this chart, their medication management patient satisfaction is 94 percent. The discharge planning satisfaction is 93.8 and 93.1, and appointments to the physician, 93 percent in their target population.

This is information on RED where you can go to contact RED. And there's my contact information if you want to contact us with any questions on the data or the project. Thank you.

Jeff Critchfield: Good morning, I'm Jeff Critchfield. I'm coming from San Francisco General Hospital. I'm having a little bit of fun. It feels like we're at a national convention. I'm following on the heels of my colleagues from the great state of Texas. So this is great. And I'm looking at Mark and going to tease him about coming from the city of broad shoulders, from Chicago. I'm coming from San Francisco, where I guess we can say, only in San Francisco.

What I'm going to talk you guys about today is our readmission project called Support from Hospital to Home for Elders based at the San Francisco General Hospital. A couple of key objectives to be clear right from the outset... One, I

really feel a distinct privilege and a responsibility to be able to share with you as a member of a Safety Net Hospital some of the challenges that we face with our patient population.

I'll address specifically how in our SHHE project, Support from Hospital to Home for Elders, we attempted to address some of those challenges. And I think we collectively – and, everyone, listening on the line, we have just a real treat today in the sense that there are a number of evidence-based models out here. And what I want to share with you today is how we drew from the evidence base and made decisions based on local needs to make our own hybrid.

And I just want to acknowledge them. We have today in the audience Eric Coleman who has done work on this. Mary Naylor's going to be talking later. Mark Williams has done work with BOOST. So we really have a real privilege today to have some of the innovators who've done the work with this.

And I'll be real clear about how we went along and made decisions about them. From the outset, it's essential. I really have to acknowledge our funder. The Gordon and Betty Moore Foundation gave us a three-year very generous grant to design the intervention with a very clear point... they wanted us also to evaluate it. They knew we were going to make some changes and they wanted us to be able to add to the evidence base. And in particular, they put a lot of money into the Bay Area thinking to actually change the whole region with regard to readmissions.

And I want to acknowledge Mary Beth Sharp and her real vision about that work. We're also collaborating with Brian Jack's group, specifically Michael Paasche-Orlow with the Project RED. And they've been noted, the group before us. And I want to introduce quickly San Francisco General Hospital. We're a large hospital, over 500 licensed beds. We're the only county hospital in San Francisco. We're the only trauma center in San Francisco. We're a level 1 trauma center. And all of our faculty and all of our house staff and fellows are University of California, San Francisco trainees and faculty.

I did want to just lay the groundwork, a lot of work at our hospital has been done around health literacy and we estimate two-thirds to three-quarters of our patients have limited health literacy. And I'll talk a little bit more about that later.

So, there we go. The key questions that we wanted to do with SHHE were to fill holes that we saw in the literature. We wanted to really look at readmissions among low income elders using key components of prior clinical trials. We wanted to look at how feasible is telephone follow-up. And I told you we're going to make some decisions. We were initially very excited about doing home visits. I think Eric and probably Dr. Naylor will talk more about that. And we really felt there was a great need in our patient population.

But as we made a clear decision with our funding issues, that we didn't think we could afford to do that. And so we really wanted to make the cognizant of creating a sustainable program and so we placed an investment on telephone follow-up, which I'll talk more about. And we really felt like we could help inform what are the factors that go into low socioeconomic patients that contribute to their readmissions so we could help design improvements going forward for patients who are being cared for in those kinds of systems.

From the outset, our study design – I'm going to share with you some results from a pilot study. The literature really excludes people who don't speak English. So, we specifically said we're going to enroll and we're going to set up a program that looks at Spanish-speaking patients, Mandarin-speaking patients, Cantonese-speaking patients, and focus on patients over the age of 60, which is a growing patient population. We from the outset, said we're going to do it throughout the house, particularly on the services that disproportionately have readmissions so that's medicine, family medicine, cardiology, and neurology.

And for us, we said we're going to do it only for patients who are transitioning to home. Major issues with transitioning to long term care facilities acknowledged. We wanted to focus on home. And really make a special point. Home for us means also patients that go to shelters, home for us also means patients that are in so-called SROs who, those of you know, in San

Francisco who live in the tenderloin or the south of market in single residency occupancy hotels where there's 40 of 50 people in a hotel, a single bathroom for a floor, no cooking facilities in the rooms, you know, pay from week to week, those kinds of things. And if people have a telephone, they could be in our study.

We enrolled people in the SROs even when there was only one hospital, there was only one telephone in that hotel. There would be one telephone at the front desk and people would stand in line to make phone calls. So we'll talk more about that also.

What's the nature of our intervention? The nature of intervention RED has introduced already. From the outset, we had dedicated nurses as part of our project who started interacting with patients essentially within the first 24 hours, worked with them throughout the hospitalization, were with them on the day of transition.

I mentioned the language piece, language is an important determinant of culture. It's not synonymous with culture. So we made also the investment and we're going to have culturally concordant nurses so we had a Hispanic nurse, we have a mainland China nurse and we have an African-American nurse, who interestingly was born in San Francisco General Hospital and commutes an hour and a half because she really feels strongly about the mission there. Now, in the Bay Area community, an hour and a half means she lives 10 miles away, but she still comes back every day. So, it's not that bad.

Also, in our work in the pilot, we started out thinking we're going to do some great teaching and what we realized very quickly was we were doing talking at. We were doing talking at patients and we love to talk at patients. We love to help them and fix things for them, it feels so great. And we realized that wasn't working. And I really want to acknowledge Eric Coleman. I anticipate he'll talk more about this. He was influential for us of this kind of concept of coaching.

We have a lot of substance abuse at our hospital and there's a big movement around motivational interviewing. And so we took a coaching model based on motivational interviewing, which essentially was a lot of curiosity, a lot of questions, a lot of helping things percolate to the surface. And as you'll learn from Eric and what we learned, that's where things get very, very interesting. We were teaching about heart failure and they were like, you know, "I just need a ride to dialysis. You know, could you help me figure out how to get a ride to dialysis?" Well, what? But your left ventricular, what happens....

We love that stuff. So, the other piece that we felt, because of the health literacy, we really wanted to put an investment into what do people go home with. And a part of our collaboration with Project RED also is we set up collaborations with engineered care who licensed the software that was published in the annals paper around Project RED. And I'll show you some examples of that. We ended up translating that into multiple languages. Here's what it looks like if you haven't seen it. It's got pretty colors. It's very clear around health literacy. Chris Corio, he's actually the CEO, he's here today, we're kind of teasing him by putting his name on the after hospital care plan.

It's got, anything you want, it's in there... All your appointments, phone numbers. Here it is in Spanish. Here it is in Chinese. It's configured through Chinese. We've heard a representative from the pharmacy already talking about it today, med reconciliation is an enormous, enormous challenge when you bring in multiple-languages, cultural understandings about how to take medications. Here's an example of the after-hospital care plan that shows each of the medications, how to take them, why to take them. Let's see if I can get my pointer to work.

On the end, you'll see little figures, we were trying to also use figures instead of like BID or TID. We're trying to say things like take it in the morning when you get out of bed – so there's a little image for there, take it in the evening, take it at night. We're trying to use literacy work that's been done. And I hope Mark and others may talk to you with BOOST, they've done a lot

with teach-backs. We're going to teach back also, but just really focusing on patient-centeredness becomes really crucial.

What about the post-hospitalization? I told you that Dr. Naylor and Dr. Coleman have done a lot of work with people going in to the home. And I think we would think that that would be great. We decided we couldn't afford that. And so we ultimately made the decision that we're going to have folks make phone calls who have prescribing ability, also not a cheap decision, quite honestly. So... And we're studying that, but we had nurse practitioners and physician assistants calling at day one and three and then days seven and nine, going through the after-hospital care plan that the patients have or their caregiver have in front of them. And that's really important.

And we're finding significant challenges when patients have socioeconomic challenges, they make decisions about which medicines they're going to buy and it isn't always based on whether they have a seizure, it may be what they can afford. And so really understanding that, and we also know from our other experience when you go in to the home and actually see what they have in the home, it becomes very challenging to find out what they're taking as well.

What we learned. Here's some of the issues around safety nets. So, 80 percent of our patients, non-whites. About half have less than a high school education. About 50 percent were born outside the United States, the residents. But we also are taking care of non-doc, undocumented residents who are contributing to our economy, who are contributing to our society and we feel it's important to take care of them as well.

A striking number, three quarters are single, divorced, or widowed. So, issues around social isolation, enormous. We know depression will contribute to readmissions. And ninety-two percent earn less than \$20,000 per year.

Success is remarkably, we were able to contact over 80 percent of our patients by phone within the first 10 days. And I think this really speaks to the relationships that we developed in the hospital. There were amazing stories of patients who are in these downtown hotels we'll call, as we said, we make an

appointment to call and someone will pick up the phone and he's like, you know, he just want to go to the bathroom, he had to go upstairs, please don't hang up, he's coming back, he's been waiting for you to call. There's like one phone in the building and this person's like waiting for us to call because they feel like they're being heard, their needs will be met. And it's very powerful.

For the research study, 98 percent were able to reach 30 days. Strikingly, these folks are really very ill and their very connected. Ninety-three percent had seen a primary care provider in the prior six months. Forty percent had been in the emergency department and a third had already been hospitalized in the last six months. These people are in the system. They're just very, very ill. Twenty-three percent were readmitted within the first 30 days.

An important point, those of you who are using primarily administrative data, we learned a quarter of our readmissions were happening at outside hospitals. So, if you're really going to follow your readmission rates, you also really have to kind of think what's happening in your region to be very clear about that. And, strikingly, about one in 18 of the patients readmitted to their trial were dead in 30 days. Yes, 5.5 percent dead in 30 days. Very dramatic.

We've got a randomized controlled trial we're doing now to actually see with the intervention we've done, what impact is it having compared to the usual care. And I'll leave you with a couple of core lessons, and I think again, I hope I've really made the point. Really, this is about relationships. Dr. Berwick talked about the team. The patient being an important part of that team. Coaching is essential. And it's not easy. We are wired to teach and do and save the people. And when they go home, we're not there. So that's powerful, the teach-back, the cultural concordance we think is very important. It's a very powerful thing to see patients when someone walks in to the room that speaks their language and looks like them, using material that's there that's in their own language.

And I want to also acknowledge the morbidity is very high. These interventions will probably have a sweet spot. Some of these patients probably don't need this much. A lot of patients probably need more, and so how do you find the right level for the right patient? And, quite honestly, I

think it's important to start talking about palliative care. You know, identifying, and you know, I think we can be more sophisticated. Palliative care is not hospice care. It's identifying who could really benefit from conversations earlier on about their needs.

I'll leave you with preventability of readmissions. And the question of how do you factor in socioeconomic issues of preventability? So, if a person had a house would this be a preventable readmission? If they lived in a neighborhood where in home health support felt safe to go see them, would this be a readmission? I'll leave you with that. And then really, finally, what an exciting day to have the chance to talk about balancing the different evidence-based approaches to like local needs, local realities.

I'll end there. We have a wonderful team. I've talked a lot about a number of them. Here's the group. And if you've got any questions, my information is in there. Email is the best way to get a hold of me. And I'll be here the rest of the day. Thanks very much for your attention.

Mark Williams: Thanks, Jeff. It does, I feel like I'm at a convention of people attempting to reduce readmissions and I'm incredibly honored to be able to speak same day as Don Berwick. I'm going to talk to you a little bit about Project BOOST. And I'm going to assume this is going to advance. There we go. And our website is there, hospitalmedicine.org/BOOST, which is the Society of Hospital Medicine. And so this emanated from hospitalists who are caring for a lot of the patients in hospitals as you're well aware. There's now probably about 32,000 hospitalists in the United States, so that we outnumber cardiologists, and about the same number as emergency medicine.

And I think there a tremendous opportunity to have a quality improvement lever in the hospital to, honestly, put ourselves out of business. I'd like to have fewer patients coming to the hospital overall. And I want to also thank Tina Budnitz, who's been the project director and driver of Project BOOST. And I especially want to thank John A. Hartford Foundation who has been funding care transition work for a long time before it was a popular issue, because it was the right thing to do. So thanks to the John A. Hartford Foundation.

And this has been a problem for a long time. In fact, this has been a problem my entire life, and I mean, since the day I was born. I found this article published in 1979. It talked about how for more than 20 years we've been advocating improvements in patient continuity of care, but this simply has not happened. Out of this, this study emphasizes the current lack of effort by health care providers in hospital and nursing homes to find a workable solution.

Back in 1979, go back 20 years, you know when I was born then, so it's been 50 plus years and we really haven't really fixed this. And I'm thrilled that now we have this congregation of a lot of smart minds to, finally, maybe fix this continuity issue. I was incredibly lucky to be able to collaborate with Steve Jencks and with Eric Coleman when we did this analysis of the Medicare database finding out that we weren't doing well.

That one in five Medicare Fee-For-Service patients were getting rehospitalized in 30 days. Half of them never saw an outpatient doctor before they were readmitted. And this also impacted patients who were originally hospitalized for a surgical issue, and that 70 percent of them were getting rehospitalized for their chronic medical illnesses. And a big price gap. And that's why CMS and the health care reform legislation are targeting reductions in readmissions. And you'll see in these slides -- highly variable across the United States. And so we can certainly learn from each other.

This was a more recent article that I think we need to look at. And I'm going to go over it because there is some very important information in it. Seven million Medicare patients with heart failure studied from 1993 to 2006 with 30-day follow-up. Now, what you heard on the news was the fact that length of stay during this time in the hospital dropped from nearly nine days down to less than six and a half. So, a two and a half day reduction in length of stay. You also heard, though, that 30-day readmission rates increased from 17 to 20 percent and post-discharge mortality increased during this time.

So the message that came across was, we're kicking the patients out of the hospital sooner and they're either coming back or dying. And I don't think

that's that's the message of this article honestly. I think what we need to look at is that as you go down further, in-hospital mortality declined and overall 30-day mortality declined. But what is really the message is the patients are incredibly ill and complex. The mean age – now this just took Medicare patients getting hospitalized – but the mean age of people in this sample was 80. Half of them had high blood pressure, over a third had diabetes, and over a third had COPD.

In addition to their heart failure. We have a tough task ahead of us. But we really haven't done a great job about the discharge process. I love this quote. I always use it. Roger Resar, Senior Fellow with the Institute of Healthcare Improvement describes the discharge process as “random events connected to highly variable actions with only a remote possibility of meeting implied expectations.” Now, he's a lot smarter than me because he has this terrific title. He's an agent of Tremendous Change and Global Innovation Seeker. I want to become that someday.

Now, I got told a long time ago, the way to succeed is to work with the people smarter than you. And that's what we did with Project BOOST. We got Eric Coleman to chair our advisory board. And then we got representatives from those groups that are actually taking care of the patients and helping them transition from the hospital to home. Social workers, case managers, geriatric medicine, health IT people, insurers, regulatory agencies. And we involved patients in developing our toolkit to try and improve the discharge transition process.

And these people did a great job. And they held our feet to the fire. We originally were trying to call this Extra Stops. And they told me pretty bluntly on a phone call “That's stupid. No one wants to stop what they're doing as they're trying to move patients through the system. Why don't you try and move things along quicker?” And, thus, we came up with BOOST -- Better Outcomes for Older Adults through Safe Transitions.

And so BOOST is a toolkit. It's freely available, thanks to the Hartford Foundation, on the web. We have comprehensive risk assessment tools to

identify which patients are at high risk for readmission. We have a patient-centered discharge process. And I was thrilled to hear the story that Don told about... engaging the patient, they are truly the experts. So we use teach-back. We use checklists so we don't forget this. We use and ensure that patients have follow-up appointments prior to discharge, and that they actually follow up.

There's good evidence coming out that scheduling the follow-up appointment doesn't solve much. It's getting the patient there. And we have follow-up with the patients at 72 hours with phone calls as a recommendation. And then I'll talk more about mentored implementation. But this is, if you will, the secret sauce. Helping hospitals implement these quality improvement projects. And we've developed a BOOST community collaborative to share our learning. And so, I'm thrilled to see that CMS is looking to develop increasing learning collaboratives.

So I'm going to show you a couple of the tools. What we refer to as our TARGET, our Tool for Adjusting Risk, A Geriatric Evaluation for Transitions. And there are these eight Ps. Does the patient have a prior hospitalization? That's actually the biggest predictor of whether or not they are going to get rehospitalized. Are they on problem medications such as (inaudible), insulin, (inaudible), medications that are very risky for patients to take and they really need to understand them and make sure we've got a safety net in place as we transition them from the hospital to the home.

Are they suffering from psychological issues as depression? This was mentioned by Jeff. This definitely increases readmission rates. Do they suffer from a principal diagnosis such as heart failure or COPD, which is the third most common cause of readmission? Polypharmacy, you increase the number of medicines, you increase the complications and the likelihood that they are going to have problems. Poor health literacy, I'm thrilled that this is getting some attention, we've been looking at it since 1991. So, slowly, things are getting the attention they deserve.

And then is there adequate patient support at home? Are we engaging their caregivers? So, that that's whose taking care of them. You're going to hear

from Matt Schreiber of Piedmont Hospital. And he told this wonderful story, I'm going to steal from him. As he commented, when I walk into a room, I ask the patient do they have a daughter. If they do, whew, things will probably work out OK.

And then palliative care, we actually added this P because we've realized that we need to help patients to discuss their goals of care as they're transitioning through this complicated system. And, again, we've develop checklists. I'm a huge believer in them. And if you've not read it, please read Atul Gawande's Checklist Manifesto.

We've got something called the General Assessment of Preparedness that we try to implement at hospitals. I'm not going to go through this, but I think it's important just to look at the fact. There's three columns here. The discharge process begins on admission, and that's when the checklists need to be initiated. And then as you get closer to discharge, there are other issues and then finally the ones at discharge. And sometimes things as simple as does the patient have keys to get back in their home when they're leaving the hospital.

We highly recommend a very patient-centered education tool. We've got something called the PASS and then another tool called the Discharge Patient Education Tool. I'm mainly going to show you some clips out of the DPET, or Discharge Patient Education Tool just because it's easier to see. Either one works. The PASS has the advantage in that it's one page and it's what they've implemented at Piedmont so you'll hear more about it.

But if you look here, these are patients that are comments "I had to stay in the hospital because..." the medical word for this condition is, I also have these medical conditions and we check through this using teach-back to make sure patients understand. We also go over what happened to the patients in the hospital. We have some evidence that we're going to be submitting for publication soon where we found that one out of five patients don't even know what the reason for their hospitalization, they don't know their diagnosis. And this is at a hospital with a good insured population.

So, go over their tests. Go over their treatments, making sure they understand them and making sure they have their follow-up appointments and if they understand what warning signs and symptoms they need to look out for and how to respond to them. And the how to respond to them is not call 911 and go to the emergency room. That's a great way to ensure readmissions. So mentored implementation is what we consider the secret sauce for Project BOOST. And this is providing the hospitals that are trying to implement this toolkit an experienced hospitalist who has quality improvement experience and understands care transitions to help these sites identify their barriers and then overcome them.

And as I learned moving through the land, you never can be a prophet in your own hospital. And so these mentors serve as the outside experts, if you will, consultants to help hospitals implement the toolkit and check up on them. And also hold their feet to the fire to move along their timelines.

We've developed the network now where hospitals participating in BOOST communicate with each other via listservs, emails. We have forums for sharing ideas. We have a newsletter that we send out showing how hospitals have reached their key milestones. And we have updates, status reports, and so forth. So, it is truly a BOOST community. It's growing rapidly. You'll see a bunch of dots in Michigan, and that's because BlueCross BlueShield in Michigan implemented the project.

You are going to be seeing a lot more dots soon in California because the California Health Care Foundation has provided funding to enroll hospitals. And I just heard yesterday that L.A. Care is funding another 10 hospitals in southern California so it'll be going from there and I hope to be announcing within a week another collaborative with BlueCross BlueShield of Illinois to implement Project BOOST as a platform for the discharge process.

So we've got some analysis, we've been calling hospitals up, a lot of this is going into peer review. The hospitals felt that the BOOST toolkit enhanced care for the patients, the site mentors were essential for this and that very importantly that participating in this facilitated quality improvement across the hospital in other areas.

In other words, there was value delivered beyond just Project BOOST and I think it was because we brought quality improvement tools to the hospital. How to run a meeting. How to enhance collaborative teamwork.

Other important barriers to identify. Most hospitals, as they began to look into this, especially developed flow maps came to realize that their discharge process was worse than they realized. Roger Resar was right. There are a lot of competing demands in hospitals and a lot of quality improvement issues. But there's nothing like funding and penalties to focus people on this issue so I'm actually delighted that the health care reform legislation is now being rolled out, if you will.

And a lot of them pointed out there's lack of resources or administrative support for this and this is why we try and work with hospitals to have BOOST activities replace efforts that aren't necessarily working not just (inaudible) on additional levels.

One quick example, we've had number of case studies we going to be finalizing and closing our data collection at the end of this month, actually and we're excited about it but I need to wait until I've got further data. But this is one example of a hospital. 582 bed community teaching hospital that piloted BOOST on one 30-bed unit and in three months they saw 30-day readmissions decline from 12 percent to 7 percent. Again, these are same hospital readmissions, so we don't know what happened outside their hospital.

Very importantly, they saw dramatic increase in patient satisfaction and this got their hospital CEO quite excited along with a decrease in length of stay. You are going to hear a much more detailed discussion or review of implementation of Project BOOST with one hospital and so I'm basically going to hand this over to Matt Schreiber from Piedmont Hospital in Atlanta.

Matthew Schreiber: Thank you very much, Mark. My name is Dr. Matthew Schreiber. I'm the Chief Medical Officer at Piedmont Hospital, a 500 bed facility in Atlanta. And I just want to take a quick second to thank Dr. Berwick for fighting

through all the local traffic just to come here and hear me speak. That was very kind of him.

In the next 15 minutes, I hope to answer the three most common questions I get asked about my involvement in Project BOOST. That is number one, why did I join? Number two, what was my magic in implementation? And number three, were you actually able to move the proverbial dot?

I believe that the primary reason that Piedmont was so successful with implementing Project BOOST was because it was embedded in the total process redesign that the patient care experience in our hospital.

That is to say for me care transitions is really inseparable from transitioning the way health care is delivered. BOOST has become the way our hospitalists do the work of discharge and now, we're working to make it the way that the hospital does business.

The reality is that care in the U.S today is too costly, outcomes are not good as they should be and our patients and workforce are intensely dissatisfied. But I'm very pleased to announce to Dr. Berwick today that I have the answer to what ails medicine and it's stunningly simple.

All we need to do is find a way to make people happier to do more work better. Piece of cake. Before I talk about how we moved from the current state that you see on the slide which I think is a pretty common current state in hospitals around the country and how we move to a place where we had people happier to do more work better, I need to tell you about three key humbling realizations I had before we got started. The first was, I wasn't going to be the one with the idea that changes the world. That was going to come from the people who do the work. Second is that historically we spend the majority of our time preparing to change, we develop metrics, we develop dashboards, then we spend the next largest increment of our time analyzing the data and we spend least the amount of our time, actually doing the behavior change and verifying that we are continuing to do the behavior change. And I understood that we are going to have to turn that energy pyramid upside down.

Thirdly, I understood that personal leadership is the tool that helps you overcome the dissidence of change and that creating win-win relationships is the key to sustainability. So I took one med/surg unit to experiment with and I got everybody that interfaced with the patient around the table and I asked them a series of questions.

I ask them, “Have you ever thought the world would be a better place if only everyone would let you to call the shots? Have you ever thought why am I doing job X when person Y really is the expert in that or why is person Y doing what I could really do best? Have you ever had the experience that no one completed the task that was everyone’s job? Have you ever found out the hard way that no one was responsible for something that was very important? Have you ever felt that the patient was getting in the way of our care process?” And then they looked at me and said, “Have you ever felt that the rhetorical questions would never end?”

So these are the lessons that I learned from our process. I learn that if you ever have a problem, you need to ask the people that do the work. They have all the answers even though they may not know that they have them. I also believe with all of my heart that you cannot buy, contract or write a job description that will get you anywhere beyond good. You need to tap into people’s mission motivation.

And amazing things will happen when you tap into that motivation and when you collaborate with exceptional individuals, in order to reach a common goal. I also believe with all of my heart that people in health care are superior people that every single person who works in health care could probably earn more for doing less in some other field, yet here they are.

I believe that taking exceptional care of people is the best business plan. I believe that we are our greatest asset and that the best recruitment plan is a retention plan. I believe that when you get people together to sit around the table, you need to force them to always say what they can contribute to the solution of the problem, no matter how small that is, otherwise you sit around

and hear statements like the only problem with my department is your department and you get nowhere.

I believe we need to be focused on the outcomes, and we need to hold ourselves accountable and say out loud that we are not going to accept effort dependent failures. It is not acceptable to fail because we didn't try hard enough. I also think that we need to focus in the hospital on post discharge services and phone follow-ups because ultimately the patient success is the only thing that matters. And that our responsibility for the outcome of patients does not disappear when the patient disappears.

The tools that we employed to change the way we do our work are neither novel nor rocket science. If Piedmont deserves any credit for doing anything at all new, it's for actually implementing the things that the experts say work for the problems we all know we have.

One of the key things that we did was to organize the med/surg unit around the attending physician, instead of around nursing expertise or disease state. This allowed us to redeploy physician time that was previously wasted just walking from unit to unit and channel it into tasks that were more value added to the patient care experience.

We also reshuffled the job descriptions and responsibilities of the people working on the units in an intelligent fashion. We made sure that one person was clearly responsible for each major task and that everyone on the unit knew who that was. We used a whiteboard located centrally to make sure that everyone on the unit could see everyone else's work here.

We made sure that assessments turned into actions and that the patients and families were included in those plans and results. And we used the BOOST toolkit to guide us for the discharge piece of our process and up on the screen you can see the elements that helped guide our discharge process provided to us by BOOST.

I think one of the things people like to hear from me is in granular detail, how do you begin to win the sort of hand to hand combat that occurs at the

transactional level on the med/surg units? That's really our kind of the niche that I fill. So I feel like we have a 50 dollar whiteboard that provided Piedmont Hospital with about a million dollar impact. And I'd like to walk you through one little example of how this works.

Of course, we were focused on decreasing length of stay, reducing hospital cost and reducing readmissions. We recognized that one of many barriers to discharge for us was getting patients seen by our respiratory therapists to perform an exercise oximetry test on the day of discharge. We felt like we were losing valuable hours on the day of discharge because we couldn't get these timely assessments to determine whether or not patients on oxygen needed oxygen in order to be discharged safely.

Well, so when we took a look at why aren't these – why aren't these assessments happening in the timely fashion, it became abundantly clear that, the RT's time was swallowed up by delivering nebulizer treatments and that that got the higher priority and they just didn't have time to wean the oxygen.

We also discovered that despite having the typical policies, procedures, and protocols that are designed to kind of reduce the frequency of nebulizer treatments to give the minimum necessary for the patient that it wasn't actually happening. So, on the whiteboard we developed a little symbol that indicated which patients were receiving nebulizer treatments and which patients were receiving oxygen.

This allowed us to identify for the physicians making rounds to pay particular attention everyday to those patients requiring nebulizers to make a critical assessment and judgment about whether they could reduce the frequency or discontinue the nebulizer treatments at all.

Then we took the time that we garnered from reducing the number of nebulizer treatments that were required on the unit to the RTs and told them, now you are responsible for being very aggressive about weaning our oxygen.

We decreased neb usage significantly. We ended up decreasing oxygen utilization on this unit by 50 percent which translated into a 30 thousand dollar savings to the hospital on the use of medical gas.

We had fewer patients that needed exercise oximetry on the day of discharge and those that did were getting more timely assessments, we improved our discharge times, we had – and we ended up having fewer readmissions for patients with respiratory illnesses. It's the addition of many multiple small elements like this that gave us our results.

So the next legitimate question is did we actually succeed in making people happier to do more work better? So you saw the current state about how people were feeling which are actual quotations that I collected are and these are pretty close to actual quotations that I collected a few months after we started this new process.

I heard from the hospitalists, "I'd rather see 20 patients like these than 15 patients the old way." They said, "I can discharge so many patients because I know they are no loose ends." I heard the nurses say, "When did all the hospitals get there lobotomies? They're so nice and so responsive now. It's great always having them around." I heard the doctors say, "When did the nurses get all there lobotomies? They're excellent and they're so well informed and so helpful, they make sure everything goes right and they will take great care of our patients."

Of course, these are the same people who have been working together forever. It's just now they are in a team environment and great things happen when you collaborate with exceptional people.

Did we succeed in doing more work with the same amount of people? Well, the number of bed turns on this unit doubled compared to the same period on the same unit in the year prior. It also turned out that this unit had twice the number of bed turns than the next most efficient med/surg unit in the hospital.

The acuity of the patients was going up, we had nurses doing additional duties like actually going to the emergency department to bring patients up to the

floor, going to the ICUs to bring patients to the unit, hanging blood, rounding with physicians, and their staffing metrics were still based on the traditional midnight census like they ever were.

Did we succeed in doing better work? I would argue that we had higher patient satisfaction. We had higher staff satisfaction amongst nursing, amongst the hospitalists, and amongst the ancillary support services. We had much better communication with our home health providers and primary care physicians. We were making appointments for our patients prior to discharge. We had a much higher rate of patient understanding and that they could teach-back why they were in the hospital when we called them at 72 hours. We saw clear reductions in our readmission rates. So I would argue that we did achieve better work.

The bottom line and this is my data slide, if you will. I know it's kind of busy but I just wanted you to have something to take home with you. The bottom line is that we decreased the variance between our length of stay and the geometric mean length of stay by 66 percent. I don't think there was anybody in our administration that thought I'd get anywhere more than 10 to 15 percent down.

At the same time as dramatic reduction in our length of stay we also have a very significant reduction in readmissions. In our under 70 population, we saw a decline in readmission rate from 13 percent to 4 percent and in our over 70 population we saw a decline from 16 percent to approximately 11 percent.

And this happened in the context of higher volumes, as well as, increasing severity of illness for our patients, our case mix index had gone up from 1.3 to 1.45 which is really significant. The way I know we really had tapped into something is we spread this same process now to three other units and we saw the exact same trends happening in length of stay and readmission reduction as we did. And now these gains have been sustained for a period of approximately two years.

In the end, I think that medicine has focused on episodes and domains of care and responsibility. And we need to focus not on how well we did "our job"

but rather on the patient outcome. The reality is we're going to need to accept the fact that we are all responsible for the whole shebang. That we choose to subdivide responsibility for our own convenience that is on the inpatient side we're responsible for what happens to the patients after they leave the hospital. In the community side, they're responsible for what happens to the patients prior to coming to the hospital. We are all interconnected and we must all focus on providing the best care of the patient.

I do recognize that about 90 percent of health care is actually delivered in the ambulatory environment, but I think the majority of the teachable moment if you will, occurs in the hospital. That's when they're our hostage, they're captive audience there and we need to make the most of their time that we spend with them while we are in the hospital. I also believe that we already have all the help that we need to cure what ails medicine and it's all of us. Thank you.

Cathie Berger: Good morning. My name is Cathie Berger. I am the Director of the Area Agency on Aging at the Atlanta Regional Commission, and as you can imagine what a pleasure for us in Atlanta to be working with Piedmont Hospital and to work with a lot of direction coming from Dr. Schreiber and I don't think he knows how much his thinking of making changes within the system has influenced us at the Area Agency on Aging.

And, I want to begin to say to you that I firmly believe that care transitions provides to us a tremendous opportunity to shift and to bridge the gap that exists between the acute care and the long term care system, to address the divide, that still exists between the medical services and the provision of support of services.

In Atlanta under the leadership of Piedmont Hospital, we have created the Atlanta Care Transitions Workgroup and the workgroup brings together everybody that has a stake in care transitions that are working to the common goal of achieving such transitions and it does include hospitals, home health agencies, service provider agencies in the community.

Our hospital, Georgia Hospital Association and our QIO, And we're all working to promote the common understanding of care transitions, to share our best practices and to educate the medical, as well as the social services network, as well consumers, on what the practice of safe transitions really entail.

At the Area Agency on Aging, we are concerned about this issue. We are one of twelve Area Agencies in Georgia. There are 635 in the nation. And, as an Area Agency on Aging, we have over 40 years gained a lot of knowledge and understanding of the needs of older adults which are living in the community. We also have established a robust, Coleman community-based service network and, a network that is keeping thousands of older adults in the community.

And the way that we as a network are supporting care transitions is through our ideas, through providing information and counseling to people who are seeking information about long term care options, about what is available in the community. We provide care management. We provide direct support services in the homes of individuals who are returning home. And, we are out there educating the consumers about what is happening in the health care system, et cetera.

Also, just to point out to you that we're not alone. We are part of a national network beginning with the Administration on Aging, 50 state units on aging, 600 plus Area Agencies on Aging and 20,000 direct service agencies.

In Atlanta, under our transitions workgroup, we have established the framework and this just shows you how we see the community on both sides of the hospital supporting transitions work.

How do we do this? How are we working with Piedmont Hospital? How are we working with other hospitals in the Atlanta region to support care transitions? Going back to our role as ADRC, as the agency that in Atlanta is receiving 70 thousand calls a year from individuals who are seeking assistance with their long term care issues that are wanting to know what is available to them.

What we have done is we've taken the care transitions approach, the care transition tools, the protocols, and incorporated that in how we do information counseling. We are – as we receive those calls from individuals who are either in the hospital, many times its families calling us or once they have transitioned out of the hospital they are back home asking for assistance. We are asking them the right questions. We are following up with the questions that were asked in the hospital, reinforcing all those points about safe transition.

We are also providing them with all the options that are available, always empowering the consumer to make the right decisions about what they need at a given point, provide information, educational materials, and we do follow up. Did you get the services? How is your transition going? Did you follow up with your physician?

In – as I've mentioned to you, we get 70 thousand calls, we have 15 certified information specialists, and we have provided them with a statewide resource database with 24,000 listings. These individuals are social workers or nurses and they are very well prepared to follow up and to support what has happened in the hospital.

In a care management programs, we are, again, incorporating the care transition protocols. We are making sure that people understand their transition plans. That they understand their medications, that they are taking them when they should taking them, that they are watching for the red flags, and that they are – that they are making sure that they have their medical appointments right and also that they have personal health records.

What we're also doing is making sure that the services that we have put in place, those home and community-based services, are supporting the transition plan. Do we need to increase the in home personal aide who is coming in to provide assistance? We're looking at that at all times, looking at how do we support this transition process. We are tracking hospitalizations and just as the matter of interest, we implement the Georgia Medicaid Waiver Program. And looking at one year of admissions, a third of the people that we

are serving in that program were hospitalized and twenty-two percent of them returned within 30 days. So we are watching those numbers and looking at how do we go back to the hospitals and how do we help to reduce the numbers there.

Also, want to quickly point out that we do have this extensive service delivery system that includes a range of services – home delivered meals, in home services, et cetera, that are supporting people as they come home. These are funded under the local, state and the Older American Tax Funding. We also are providing those services that are supported under the Medicaid Waiver Program.

We need to know, that unfortunately our aging service system is often faced with long waiting lists, I think we can all talk about that. We also are charged with the responsibility to make sure that the service we do have are targeted to the right people, those in greatest need.

Now, the unintended consequences are that very often we have lengthy intake processes and we're not there immediately when the individual comes out of the hospital.

To respond to that need, we are piloting with one of our service agencies and hope to expand this to others over the next few months, a pre-arranged support package that provides the individual seven days of home delivered meals immediately, interim support six hours, two trips to medical appointments and we have now added escort to that, very often people can't go alone, and then a case manager and coaching for 30 days.

These services are being provided in this pilot at no cost to the individual and we are doing it through four participating hospitals. Our initial data, very promising, shows that it is running at \$400 per package and our admission rate just looking at those for a three month period how many people went back and that was 16 percent.

Then lastly just to mention to you that as an Area Agency on Aging, we have a far reach into the community and with Piedmont Hospital's help we have

developed a packet how to navigate through the health care system and through our senior volunteer program we have already trained 14 volunteers that are going out into the community, made 77 presentations to tell people before they go into the hospital, before they have an emergency room visit, what to expect, what questions to ask and how to handle the process.

I'll close by saying to you that we believe that it is critical that the community-based services system in the hospitals collaborate on the issue of care transitions to make it successful. We have to look beyond the 30 days, we have to know what are the support systems in place that will keep people out of the hospital. And I can tell you that aging network welcomes the opportunity to step up to the plate and be part of this system. Thank you.

Linda Magno: OK, we now have some time for questions for our panel, thank you for your very interesting and valuable presentations. We'll start as we did the last taking questions from the floor, from those present and then we'll go ahead and take questions by telephone. Our first question, over here.

Gayle Shier: Hello my name is Gayle Shier I'm from Rush University Medical Center. I'm part of their enhanced discharge planning program. One of the things we've found is that many of our readmissions are linked to non-medical issues. So I'm wondering if the panelists could respond to what do you when you find non-medical things that are bringing people back to the hospital?

Robert Pryor: I can go ahead and start. Our partnership is with the ADRC and we combine medical needs with social needs so that at the time of discharge we can tailor the needs of the patient, social needs and medical needs as well.

Jeff Critchfield: Hi, Jeff Critchfield of San Francisco General Hospital. So, Gayle, I don't know if you are at Cook County or not... some similar issues and what we've found is having the dedicated, we call them (inaudible) nurses, they have a little bit of extra time to surface those kind of things, the bedside nurses have a lot of things going on, our interns have a lot of things going on, the attendings spend on average two minutes per patient and those kinds of things, and so having the nurses being able to surface and once they do often it's a matter – that's the goal once it's surfaced and then they feed it back through our

multidisciplinary rounds, social services contacting the patient's caregivers, and then San Francisco has some fairly sophisticated case management systems in place and so we can feed it back. I think the biggest thing is that you are surfacing the issue and then feeding it back into whatever systems you have in place.

Jennifer Markley: One thing that Valley Baptist has done is that they are now in the process, and they just started that in the last month or so, they are spreading the RED interventions to the emergency department and they have put two case managers in the emergency department to work with patients who do come in and they're paying attention and they are able to flag those that are coming back within 30 days and one of the things that they're doing is they're asking the patients to complete a questionnaire to help them determine what went wrong, what brought you back, where did the system fail.

Matthew Schreiber: For me this stresses the importance that we need to keep reaching across the aisles to the outpatient world, and the community service world need to be reaching into the hospital and the hospital needs to be reaching out to connect to our community partners. So the first order of business is know that a problem exists, then the second order of business is know what resources you have and then try and connect those dots.

Linda Magno: Next question over here.

Allison Silvers: Hi, name is Allison Silvers from VillageCare in New York. I have just a quick comment. I wanted to underscore the idea of using motivational interviewing and this because I think some of this where readmissions come from patient non-compliance and their ambivalence about following up on plans.

But the second question I have is this was a hospital based panel largely and there was a lot of talk about partnership with the community but in skilled nursing facilities there is no resources to address some of these issues and I appreciate reaching across the aisle but what have people done to address the financial incentives for skilled nursing facilities where someone is doing more

poorly or has palliative care issues. It's just easier and a lot more cost effective to send them to the hospital.

Jennifer Markley: Well I can address that because we did work with skilled nursing facilities and if you'll remember looking at the slides, we started out with a 32 percent readmission rate and we're down to what was it? Low. Low. And they don't have, you're right, they don't have a lot of resources but there's a great tool kit that was developed by the Georgia QIO that has tools for skilled nursing facilities, the acronym for it is INTERACT and you can find those online. And it's a great set of tools for these skilled nursing facilities to implement within their facility and it's very effective in terms of reducing readmissions.

The other key part of this was in terms of working with the SNFs and why they came to the table, they had an opportunity through this project to sit down quarterly as a team with the home health agencies, inpatient rehab facilities, the hospitals in their community and talk about the barriers and the issues around transitions, the communication at transition, what they were receiving and what they were not receiving, what was going well and what wasn't.

And that collaboration community-wide, they were there, they've wanted that, they were eager for it and they came to the table for it.

Kristina Lunner: Good morning, Kristina Lunner with the American Pharmacy Association. I'm just curious, we're happy to see that medication use is reflected and integration of pharmacy in a lot of these programs, it's wonderful but building on this idea of transitioning and reaching out to the community partners, I was wondering if any of you have worked with community pharmacists or consultant pharmacists once the patient leaves the hospital?

Robert Pryor: Well, I can start. Part of our integrated health system is that we also help pharmacies. We have a large number of pharm Ds in our program that work with community pharmacies and we find that the community pharmacy, with our integrated medical record, our pharmacies know what our record is so when the patient gets there the pharmacist also can see what's going on with the patient. So, it's invaluable.

Matthew Schreiber: For me medication reconciliation is kind of the guerilla in the room.

Probably two-thirds of all readmissions have something to do with patients' medications and failures thereof. At Piedmont we have a Walgreens that's physically onsite and we've been working really closely to see if we can develop some innovative relationships to allow for bedside delivery which helps us figure out which medications can patients afford and can't they afford so we can get those taken care of before they leave. It gives us greater access to a good database of information. It gives us some ability to control and follow up with patients that return to the community. So I'm hopeful that that's a great opportunity for us.

Jennifer Markley: One of the hospitals, not this one that's here today, but another hospital that participated in the project in the community used the pharmacies to make the 72 hour follow-up phone call because of the issue around medications being one of the major reasons for readmission.

And they have a lot of pharmacies, that was a resource that they were rich in. And so, the pharmacists were actually doing that follow-up call to the patient after discharge and they were finding lots of problems with medications issues, as you would suspect. And so, hopefully, you know, through their process they were preventing readmissions as they straightened out those problems with medications.

Mark Williams: I think this brings up a great point that there just needs to be a terrific strong bridge between the hospital and the community and using people on either side. Whether its pharmacists or even community-based nurses for doing some of these follow-up calls. As hospitals, we critically see the importance of pharmacists, in fact, we have a joint statement from the Society of Hospital Medicine and the American Society of Health System Pharmacists because I think that this whole issue is it needs to be a team. We're not going to be successful unless it's a team caring for these patients as they go from the hospital to home.

Jeff Critchfield: I've got a comment Kristin, I'm going to go on and just make a request for you. I appreciate it. Project RED initially had pharmacists and we have a

shortage of pharmacists in San Francisco which is kind of a local issue and so work with nurse practitioners. One thing that I might ask and you've been a wonderful advocate of pharmacists and pharmacies today is, gosh it would be just great. We have a couple of pharmacies in San Francisco that give all their medicines in blister packs, essentially in basically premade medisets.

It's one thing to give people medisets but no one is in the home necessarily to fill them for them, it would be a wonderful thing to see pharmacies more broadly moving towards pre-made medisets. So in the advocacy from your standpoint, it would be just great, thanks.

Kristina Lunner: I will take that back.

Jeff Critchfield: I appreciate it.

Robin Jones: At Valley Baptist Medical Center in Brownsville, we've also included on our medication reconciliation a discharge list, we explain to the patient and we have it written in English and Spanish on the medication list. Make sure to take this list to your next doctor's appointment and take it to your pharmacy so they can have a list of all your current medication. We can encourage them but we can't make them do it, so...

Brian Ellsworth: Good morning, Linda, Brian Ellsworth. And I want to thank this panel for very interesting observations. I was intrigued most of all by the data from the Texas folks that indicated that admissions, initial admissions went down – and I'm wondering if there's been any attribution to the project itself in terms of that occurring and if so what they thought the mechanism was, and I also wonder if any of the other projects noticed that result as well.

Jennifer Markley: Well, yes, it happened in all 14 projects, not just in the Texas project so we know it's a result of the project. Dr. Jane Brock will be talking later on today. I'm not sure exactly when and she'll be talking about the 14 projects and she can address that for you. But we did see a 14 percent decrease in the community and 10 percent within this particular hospital and it was striking and it was across the project. Just fewer hospitalizations in general, fewer admissions and fewer discharges.

David Schulke: David Schulke with HRET. This is a fabulous panel. One of the problems that hospitals have is knowing about readmissions that occur at another institution, they don't go back to their own hospital but they go somewhere else. So there's a real need for timely data and there's a need for data that's not just from the hospital itself.

But one of those problems, the timeliness problem seems to me can be solved or is being solved by Robin, your work in calling patients afterwards, and the other project, I was surprised how often that this idea of calling the patient after discharge and very quickly after discharge and gathering data back of the experience of the patients, inherently patient-centered, very timely. And the question is how many of these projects are using that data beyond the project confines to give the institutional management and maybe even governing body information about how their institution is functioning and the other providers and the community information about how they're mixed together or falling apart as a result of those interviews.

Or is this all pretty much contained to these individual projects where we're including heart failure and telemetry unit functioning and not yet the data from these patient interviews flowing back to the other providers and higher ups in the institution.

Jennifer Markley: I can just speak for the care transitions project. Our data was community wide. So readmissions were counted not only if they were choosing participating hospitals but to any other hospital in the community or outside the community. If it was what we call a snowbird and they were rehospitized in Massachusetts but they had been hospitalized down in south Texas, that readmission was counted in our project, so it incorporated all of them.

And we had really good participation across the community, five out of six hospitals, two out of three inpatient rehabilitation centers, 11 out of 16 skilled nursing facilities, 30 out of 54 home health and hospices participated in the project. And all of those projects were receiving the data reports that we gave quarterly that gave them their data and also gave them community data, and they were discussed at the regional workgroup meetings.

Robin Jones: At Valley Baptist Medical Center Brownsville, all of our care transition project information goes up to our performance improvement resource committee which also goes to our med exec and our governing board.

Sealani Weiner: My name is Sealani Weiner, I am a Geriatric Care Manager with Transitions Geriatric Care Management which is in Maryland and D.C. And this is more of a recommendation.

You have people in all your communities, geriatric care managers which are generally social workers and nurses that can work with patients from the time they are before the ER all the way through the end. And that's an available resource that is not coming from the hospital and it's not coming from an agency so they are going to be really coordinating care and I just urge you all to think even if it's just for the most difficult cases, you may want to hire these individuals to deal with the more complex cases. It will definitely be cheaper what's happening now. Thanks.

Jeffrey King: Jeffrey King from Independent Living Systems in Miami, Florida. I appreciate the facilities presenting. You obviously get it. With our relationship with FMQAI, the Florida QIO, we got, we were involved in the national pilot and we developed those relationships with AAAs, ADRCs, and other community-based organizations but we still face the barrier of the hospitals not understanding, not being interested and just not committing to addressing readmissions.

So my question is what was the magic pill at your facility, what got you all to get it and how do we communicate that to the other facilities?

Mark Williams: I think health care reform is becoming the magic pill because there's now going to be a penalty, and I think also that there's funding changes such as payment for episodes of care and then also payment for value-based purchasing. There is no question, we previously were paid to do more to people and have them come back more to the hospital. So basically, spending time educating patients at the time of discharge and preparing them for

discharge was a failed financial approach unfortunately. It was good quality care but it cost you money.

I think the game has now changed with health care reform and hospitals that are ignoring this now are going to be facing big financial issues in the very near future.

Remarks by Kathy Greenlee

Linda Magno: I'm sorry I see that we've come to the end of our time and don't have time for more questions at this point. I'll encourage you to look for members of the panel or members of the CMS staff who might be able to help you with some of your questions during the break. We have a limited amount of time for a break but I'd like to now turn and welcome our next speaker Kathy Greenlee to the stage.

And Kathy Greenlee is the – Kathy Greenlee is the Assistant Secretary for Aging with the Administration on Aging. Of course it's the programs that she administers that are playing such a vital role in many of the communities around the country in developing models for care transitions, in training people, in working with hospitals and health care providers and others to make the kind of work you've heard about so far this morning a reality. So with that, I'd like to ask all of you to join me in welcoming Kathy Greenlee.

Kathy Greenlee: I'm the only speaker who is ever late to the podium because I was looking at the handouts from the last panel, so, and copying them. Good morning to you all. I think it's still morning. This is a great group of people that you have and quite literally I was looking through the PowerPoint. I don't have PowerPoint slides.

If any of you have ever heard me speak they would be so constraining for me that I would have to stick to something that I have written already, that I find them inhibiting. Thank you for introducing me, Linda, it's good to see you all. And I was sorry that I wasn't able to come up from Washington earlier this morning to hear Dr. Berwick speak. I've had the opportunity to do several things with Don, he and I met recently to talk specifically about the vision we

have at the Administration on Aging with regard to the interface between AoA and CMS.

Don and I recently did a senior event. Much as we love you all I think probably he and I like going out to talk to seniors the best. So we did a senior event to promote open enrollment this year for the prescription drug plan and we've done a couple of webinars. So, we hang out in the green room getting makeup sometimes as well.

So where ever he and I can appear together and promote the same things I think we should – so you can look for us one or the other or together as we continue our partnership. This is quite a talented pool of individuals. Some of you who just spoke I'm familiar with your work and just am here to cheerlead for you all a bit. It's Friday. I'm always glad when it's Friday.

I've been working now as a professional for two decades. So Friday for me means yes indeed I survived another week and TGIF, so happy Friday to you, Happy Hanukkah to those of you celebrating Hanukkah.

Fridays, I think, are significant, for all of us who are working. Fridays are also significant for another reason. All across the country this afternoon the phone calls will start because it's Friday. A daughter will call an Area Agency on Aging and say, “My mother is being discharged from the hospital now, what do I do?”

A son will call the local ombudsman and say, “The nursing home says my father can't stay any longer because his Medicare days are up. Now where does he go?” And for those of us in the field of aging it feels like all of these calls come at 4:30 on Friday or at 10 till 5:00 which is worse because at 10 till 5:00 you already have your coat on and you're turning off your computer.

And those of you who have done this and I can hear from your response know that this is true. And I don't have data, what I have is the truth of the reality of being someone who has received these calls by working in the field of aging. And Fridays can be difficult for people. They can be scary for people in hospitals and nursing homes and for their family members as they struggle

with the enormous decisions that they need to make with little time and lack of information.

Who do they call on Friday or any other day? They call me. That's who they call. I want to talk about the relationship between Medicare and Medicaid and the Older Americans Act. As we end 2010, it's been a reflective year because we have celebrated the 45th anniversary of these three laws this year. All three were passed and signed by President Johnson. And what you do not know because you don't work at AoA is that we're 16 days older than both of them. That Medicare and Medicaid finally showed up, two weeks later and we were glad to see them as critical, critical partners in 1965.

And those three laws are important to understand as all three of them, the triumvirate of those together with Medicare being of course the acute care support for seniors and people with disabilities; Medicaid which for those in this work has become the primary source of support for people who need long term supports and services and the Older Americans Act. The Older Americans Act was never designed to be an entitlement program. The funding at this point reflects that distinction. That's both a good news and bad news story.

The Older Americans Act from the beginning was envisioned to provide community-based supports to individuals to help them be healthy and independent for as long as possible. I did a public hearing on the reauthorization of the Older Americans Act in Milwaukee and one of the people who testified had this proposition that perhaps the Older Americans Act or the original home and community-based services – we have been around for that long. And all three of these were passed at the same time.

It wasn't until the early '70s, though, about seven or eight years after the Older Americans Act was passed that we developed this current national network that you're all familiar with, the national structure of the Area Agencies on Aging. And quite literally the piece I was pulling out of my materials for prior workshop was Cathie Berger's slide that describes the structure and the relationship because even though I don't have PowerPoints she did, of the

relationship between Congress and the Administration on Aging, the states and the AAAs.

That basic slide from her presentation, that structure has been in place since 1973. And when I present that slide it looks a little bit different than Cathie's because it's really an inverted pyramid. This is a very atypical Federal structure to have by design a small Federal agency at the top with tens of thousands of providers in the community. That's how it was always designed to work and we have been doing this work for a very long time.

For the past two decades CMS has been an essential partner with working with us. And CMS relies on this core network of Area Agencies on Aging to deliver four different but very important services. CMS is working with us and the area agencies in the network to provide home and community-based services waivers and since 1981 as we started to implement ACBS waivers, CMS has been relying on the network.

CMS relies on area agencies to implement the Senior Health Insurance Partners program – the SHIP programs. Two thirds of all the SHIP programs are area agencies. CMS works with us and our network to support (inaudible) the person looking for assistance for people living in any institutional setting who want to return to the community.

And of course the more recent and fabulous partnership with CMS and AoA for Aging and Disability Resource Centers. This is a combined partnership. These four things represent a significant investment by both agencies in developing a national network to provide home and community-based services.

So we're very happy to be here today to talk to you all about community-based care transitions because we've been around for a long time. I've only been around for about half of those 45 years in this work but I have seen all these transitions in care settings from the community to the nursing home, the nursing home to the hospital, the community to the hospital, the hospital to the nursing home or the community back to the hospital and the hospital to the nursing home, we all know these.

My proposition to you and the thing I want to impress upon you most today in terms of my philosophy is that none of these transitions is a medical event. And if you view transitions from the single lens of medicine and medical events you miss the large and essential picture. These are life events. They impact the person needing care, their family, their caregivers and their community.

Hospital discharge and hospital readmission cannot be solved or resolved by hospitals alone, and I know we have wonderful, wonderful hospital partners here and also listening in. Managing a successful transition involves all of us -- the medical people, the social service people, the long term support providers, their family, the caregivers and most essentially the person who needs care.

I am convinced that the aging services network, the network that we oversee at AoA and our community partners are essential to building successful transition care and that was evidenced by the panel before me and will be talked about this afternoon. There are three things that we do really well in our network. Information and referral, case management, and services.

And what's been hard for us over the years and I get asked about this a lot in Q&A, I was asked about this at my first national speech as assistant secretary. How do we tell people about case management and information referral? They have often been, in our world, undervalued but what we know about people and the supports in the community are what people need to know. It's what people know or need to know this afternoon at 4:30. Those are the things that we know, the kinds of questions that they're asking.

Where do I go? How do we provide these particular supports? Our goal at AoA is to support a person-centered approach to transitions by creating formal linkages between and among the major pathways that people travel while transitioning from one setting to another or from one public program to another.

I want to stop there briefly and give you a couple of other ideas on things that you won't necessarily talk about today as I don't think it's the main focus. But certainly because of the work that I've done both as an ombudsman and at the insurance department and as secretary in Kansas.

I believe that there are two more transition points that are not usually thought of, they weren't on the list I just read of all these different pieces. But that transition from Medicare to either Medicaid or private pay at the end of the skilled rehab Medicare days is a transition in care. That's not a necessarily transition in setting although it might be, you might be moved to a different place where you are in the same building or you may go home.

But that transition at the end of the Medicare skilled rehab days is a place where I think we need to do more work and I would like to put on the short list of future projects at CMS and our friends at CMS, because at that moment when the Medicare skilled rehab days come and people get this notice and they start calling or they don't. And maybe what worries me more is people who don't, who don't realize that when the Medicare days run out this is a transition point and we need to show up again with good information.

The other transition point that we all know about but don't talk about as much because it's not necessarily seen as a transition in care setting, is a transition to hospice, and when we go from the Medicare beneficiary benefit to a Medicare hospice benefit there's also a significant transition in care. And those of us who do this understand that different people show up to provide care. This is another significant transition and some place where I would also like for us at AoA and our partners in the network to work with you at the hospitals and CMS to talk about those two transitions as well.

The pathways that we work with on these other transitions and settings include pre-admission screening programs because of the necessary – the need to look at hospital discharge planning upon admission and pre-admission. We look at screening for nursing home services and we – these different opportunities really present to us the critical junctures where decisions are made.

And I've always seen transitions as the opportunity for a tremendous risk for individuals. And I usually call them consumers not patients because of my background I've never worked in a hospital setting and so they're just consumers to me; the transitions in care and that those opportunities they are critical for success or failure, that's why we're having this conference today, that's why the Federal government is investing more money with you as partners; tremendous, tremendous time of crisis for individuals, often done with lack of information based on a sudden change in someone's health status.

And this transition period can be determinative of the future of care for that person in a way that's significant when someone is old, especially if they move at that point to a nursing home when they prefer to be in the community.

I'm not an anti-nursing home person. I believe that nursing home needs to be there and present as a choice and a viable option. And that we should never look at community service as the ultimate goal and never set ourselves up in a dynamic where a nursing home admission is failure because I think we always need that option, but most people want to stay in the community for as long as possible.

And if we are not doing the work well, we are not providing options and someone goes to the nursing home early where they have other options. Those kinds of stories are the failures to me, not the fact that someone eventually needs to go to a nursing home.

Aging and Disability Resource Centers can play a pivotal role in those transitions to ensure that people end up in the setting that best meets their individual needs and their preferences, which like I said is often at home. Our staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their services and support options and quickly arrange for services.

I was working in Kansas with my friend and colleague who was the Secretary of Social and Rehabilitation Services. And he said something that we all know that sometimes someone else has to tell you for the light bulb to go on. He said, you know those nursing homes, what they have going for them is the

credibility of stability – that people are – that they're going to be there, there's that building. And we all know this about nursing homes. And in my hometown there is a nursing home there and there will be one next week and there be will one in ten years. That the bricks and mortars is the nursing home work and these buildings have been around long enough that consumers rightly or wrongly attribute good care and stability to the fact that that building exists.

And one of the challenges for those of us trying to do something new and show up is that, you know, the Clearwater nursing home in my hometown will always look more stable than ACME home health that someone hasn't heard of. And so, to catch up what we need to be able to do is quickly respond to services, to be open 24/7 like a nursing home is, and also be around long enough and have enough goodwill in our community that we can be trusted because not only are people making decision in a crisis, they only want to make this decision once. And so, we are going to make a decision we want it to stick and don't call us in six months and tell us that this home health company is not there.

So we have to develop the credibility and the stability. The partnership with the hospitals can help us go a long way in this regard because of the goodwill in the community and the staying power.

The work that we do with ADRC is in providing education and information to consumers can help them break the cycle of hospital discharge and readmission. It can help them when they're chronically impaired get the services that they need so that they can live sufficiently and live well in the community.

We first again this partnership with CMS and I told you that working on the Aging and Disability Resource Centers is a newer endeavor, we first began funding Aging and Disability Resource Centers in 2003. Since that time we've been able to demonstrate evidence-based models and I know that people from Central Texas. Scott & White were on the panel before me, they took that piece out of my speech because I was going to promote their good work as well and say thank you. We also know at AoA because we write it our

documents that you all are wonderful examples of the community partnership. This is how we've been able to model the Aging and Disability Resource Centers and use of Eric Coleman's model in the community.

We also have been doing work, and I know Mary Naylor is speaking this afternoon. The Delaware County Office of Services for the Aging is working with the Crozer-Keystone Health System, Taylor Hospital, the Crozer-Chester Medical Center, Springfield Hospital, the Delaware County Memorial Hospital and the Quality and Improvement Organization of Pennsylvania on the transitional care model. These are great, great collaborative efforts going on in Pennsylvania.

I said earlier that when you're wondering what to do and where people should call at 4:30 in the afternoon, they should call me. And by that what I mean is not to give them my phone number but to realize that this network that we built is an Administration on Aging for service and network supplemented with great partnerships from you and with CMS. When someone calls an Aging and Disability Resource Center they are calling me. This is the work that we do in the community and this is where people need to go to get good help.

One of the opportunities that we had earlier in the year with the passage of the Affordable Care Act was to look for some innovative ways to use the dollars that we have at AoA. The formula grants, the discretionary grants, the partnerships that we have with CMS and so we announced in September \$68 million that we are investing to fund initiatives to help people stay in the community and get long term supports. One of those initiatives of the four was focused specifically on evidence-based care transition grants. With those grants we funded 16 states to provide coordinated and comprehensive service to encourage evidence-based transition models to help older persons and persons with disabilities remain in their homes after a hospital, a rehab stay or a skilled nursing facility stay.

The objective I know of the conference today is to talk about what's coming next. What we've been able to do with our partnerships so far demonstrates that we're committed, that we're on the right path. Where we're going with

CMS is much reflected in the upcoming announcements about the additional investment in the community-based care transition program made possible through Section 3026 of the Affordable Care Act.

We will look for every opportunity to talk about what we can do in the field to work between ADRCs and the hospitals and the other community providers to support good evidence in the work that we do for transitions in care.

I believe that once upon a time we divided the world into two camps, the medical model and the social model. Medical care and social services. That's somewhat even reflected back in 1965 when we adopted Medicare and the Older Americans Act as separate acts. Social services and medical care. I think this division between the medical model and the social model is a false distinction, and with false distinctions come silly conversations.

I've been involved in some of these conversations. They sound like this, is long term care health care? It's a silly conversation. They also, these false distinctions, create false assumptions such as only medical services need to be grounded in evidence, and as we know the future is evidenced based practice in everything that we do. And we've been committed for the past decade at AoA to support evidence-based practice, this is not an enigma when we're talking about social services. We have to have evidence-based science on the social services component of holistic approach.

These distinctions, the medical model and the social model, have created tremendously complex systems for consumers to navigate. And really, the reason I think these conversations are silly is that they don't matter. The only thing that matters to a consumer, to a patient is who are you and what do you need and we go from there.

I believe the topic of care transition provides the opportunity to reset the frame for all of us, not to a frame of medical versus social. We are very, very much interested in the three part aim that CMS and Dr. Berwick have talked about of better health, better cost and better care and lower cost. And that we are value added to this process by investing in community-based services such as ours, that we are a good investment. By working with us and the Aging and

Disability Resource Centers and the experts that we have for the last 45 years been created in the system.

I believe we can provide integration, better health and most importantly support the whole person, that we have now finally this wonderful opportunity through the Affordable Care Act for tremendous intervention and innovation with regard to care transitions, that through this innovation we can finally have a holistic approach. I know this is the same approach that Dr. Berwick talks about; he talks about it – he talked about it this morning – his example of this 15-year-old patient. He says, you know, doctors and nurses need to talk to each other and then they need to talk to me. That it's all about being person-centered.

I look forward to more work with CMS and more work with Dr. Berwick and I wanted to close by telling you about this funny email exchange I had with Dr. Berwick last month. I had listened in when he was doing a presentation to CMS staff about the three part aim and where he's going. And after that I sent him an email, and the gist of the email was an attempt to get him to include some Jimmy Buffett quotes in his speeches. Now, you wouldn't think that's normally what we talk about but he used a quote and I thought a quote, a Jimmy Buffett quote was really a little bit better at that point.

So he and I had this email exchange about Jimmy Buffett quotes and he's onboard. So in honor of our new working relationship, I would like to point out it is 5:00 o'clock somewhere but not everyone can head to happy hour. Some of us have to stay behind and take off our coat and sit back down and help a distressed family member negotiate this complicated system of finding the right care.

Thank you all very much for your commitment to this issue. I know they had wanted me to save some time for Q & A, and so, I have done that and I also have wonderful staff here from the Administration on Aging that I would like to acknowledge. I'd like to acknowledge them now for two reasons, I forgot to acknowledge them earlier and we're about to do Q&A so I've got help. So do you all have questions or thoughts, other ways that we can be supportive to what you're doing in terms of care transitions?

I've given you the Jimmy Buffett quotes that I have written already in my speech. If he's providing more wisdom for us in this work, I'll let you know. Anything?

Female: My name is (inaudible) I work for Maryland Health Care (inaudible). First of all thank you, it was a great speech. There were a lot of points that I think everyone should have taken note. Two things that kind of emerged from the earlier portion, this concept of expanding the definition of transitions to other settings. I think that's very important to think about it and expand the idea of rehospitalizations or transitions to other settings so we could have a more coordinated care for the person.

And the other point that came out was that this fragmentational funding which was often these breaks in the transition process and from there my question is related to long term care.

In the previous sessions, you know, we saw that the patients' discharge from skilled nursing homes have higher readmission rates but if you look at where they are coming from in the beginning they are also coming from nursing homes. So I was wondering what kind of programs exist to improve the transitions in the nursing homes with the hospitals from the beginning because what I observed in the nursing home sector is there is this revolving door, patients are coming and going to hospitals so often that it seems to me that the nursing homes are also another place that we could actually impact readmission in the hospital. Thank you.

Kathy Greenlee: I absolutely – I absolutely agree with you with regard to the nursing home back to the hospital. I'm not a clinical person working in a clinical setting but I'm a lawyer so I can like spot the issues. And the ones that I know are about making sure that the records transfer, that one of the things that we've all talked about certainly from the hospital to the nursing home with regard to the meds, it's equally important that we have record transfer.

One of the things that I think we need to pay attention to is the growth of electronic medical records and the use of health technology. And I saw this

starting when I was a secretary in Kansas because I was making the Medicaid payments for nursing homes and I was also at a survey and cert agency in Kansas.

That we have started by focusing on electronic health records on hospitals and medical systems and somewhere in this concentric circle of health providers we need to make sure that nursing homes are there because as we build national systems for electronic health records, we right now have some very, very progressive nursing homes and nursing home systems, larger systems that can capture electronic data on kiosks and computers, and so, we have already building sort of in this other venue, people who are capable of coming to the table first as early adopters and partners to say, "Listen, this needs while we're transferring a person all of the information, the plans of care and so forth need to be sent back and forth electronically."

I think between those because, you know, so much of what we do is are these artificial distinctions that I talk about between the hospital and the nursing home, that one of the great opportunities to start trying to figure this out are the hospitals that are running long term care units that are a part of the hospital system. So, as we work on electronic health records that those I think could be some of the earliest people to say look this has to include the nursing home wing of a hospital for skilled long term care unit and then pick up the rest of the nursing homes as well. So that at least on an electronic basis we're doing a better job. And that's just one piece of the transition back and forth between.

Eileen Bennett: Hi, I'm Eileen Bennett. I'm a local ombudsman here in Maryland as well as the chair of the National Association of Local Long Term Care Ombudsmen. And it is Friday and you know where I'll be this afternoon. But I do want to really overemphasize the point that you brought up about the transition of, "Oh my gosh, my Medicare time is over while I am in this skilled nursing facility." It is probably one of the biggest issues that ombudsmen are dealing with that's the hidden issue because miraculously on day 21 somebody is better.

There are very few people who actually receive 100 days of Medicare coverage in the skilled nursing facility and it's the least known fact in the world, of my world. And that's what I'll relate it to, is my world. So there's also another scary part and we are seeing these observation days in emergency rooms and people not being admitted and I would like to just point that out since this is a group of people that can really be also monitoring that issue.

From the point I work in is strictly in nursing homes and assisted livings. I do not have a community-based portion in my own job description but there are ombudsmen in the community that are – I think there are 13 states that have long term care ombudsmen that actually follow people into the community. But we're seeing more and more people just being held in emergency rooms for observation so that somebody's magical numbers don't trigger something that doesn't look so bad. So I just ask you to pay attention to that.

Kathy Greenlee: And I will tell you that we are aware of that, I mean, the Washington Post did a big article about this a few weeks ago and have reached out to CMS directly so that we can talk to them about it and share our concerns.

Kathy Greenlee: Hello.

Amy Berman: Hello, Secretary Greenlee, Amy Berman from the John A. Hartford Foundation.

Kathy Greenlee: Hello again.

Amy Berman: Hello again. First I would very much like to thank you and the AoA for the remarkable work that you've done through the Aging and Disability Resource Center network and the recent awards that were made to build the evidence into those networks even further, so congratulations.

Kathy Greenlee: Thank you.

Amy Berman: Second, I just wanted to go back to your comments about the electronic medical record. I think that that is a very important area that is currently being built out but perhaps within the conversations that are going on nationally we're somewhat siloed. So right now here, we're having a

conversation about how to build in care transitions and within perhaps meaningful use, we don't hear that same conversation, so when the investment is fully done, will it be able to be supportive of the kind of care and the integration of medical and social supports and services in the way that we'd really like to see. I'd love to hear your thoughts on that.

Kathy Greenlee: You know, quite honestly I've told you as much as I can at this point and I think what we need – there are times that we can step out and say we want to make this investment. There are times we need other people to come to us as leaders as well to say, we see the same thing kind with regard to hospital records and nursing home records and help us figure out what the best role is that we can play. Because as you know there's a whole national initiative with office of the national coordinator and how do we then best bring to the table these particular issues.

So it may be something, Amy, that we certainly follow up so that I know how to articulate it because it's so massive and so acute care oriented that we may even need some guidance on sort of where to get in and specifically say, “Here's where you're not talking about transitions and here's what you're not thinking of long term care whether it's community care or nursing home care.”

Amy Berman: Just as one follow up, for the Office of the National Coordinator for Health IT, the Hartford Foundation in collaboration with the Gordon and Betty Moore Foundation in California, we brought in some of the leading experts that will be on the panel later today around care transitions including Eric Coleman to be able to help these beacon communities understand how to do a better transition.

But I'm still a little concerned that the meaningful use is not yet being addressed.

Kathy Greenlee: Right, and I think – when I listen to the conversations about health reform, there are so many things that sound similar to me like care coordination, care transitions and medical homes. They're all about the integration of a holistic approach, all of those, the meaningful use regs would have an impact on if they could fully be developed.

There are some challenges in our part of the world with regard to data. And that's another reason why it's important for AoA to make an investment because we started from such different places. The ability to track data on a granular level at the Area Agency is far different than what a hospital is tracking.

So, as we merge into systems that work better together, we have to have the ability to collect data and be able to transfer it from our side as well. And that requires investment and change from social services providers so that they understand. It's not just evidence that's important, it's the computer system and the data so that we can make the interface. And we're trying to help the network integrate those things.

Linda Magno: I think we have time for one more question.

Heidi Garland: Hello. My name is Heidi Garland. I'm a Director of Case Management of Memorial Medical Center in southwestern Pennsylvania, go Steelers. I'm very excited to hear this conversation. In fact, the first call I'll make when I get back to home is to the Area Agency on Aging because what I've seen over the years is a divergence between the community services and the acute care hospital based on finance. If there is an entity who is less financially viable than hospital acute care, it's not really skilled because you reserve the right to say no when you cost out the patient, it would be community-based facilities like Are Agency on Aging.

To give you an example, we'll try to get a patient set up for a waiver program, it could be six to eight weeks before we can get the service available. It just doesn't meet the immediate needs. So, I'm very hopeful that we can reconnect and make viable programs.

Kathy Greenlee: Thank you. Could I make a final pitch? And I know we're wanting to wrap up. I have another motive that I've not mentioned with regard to this, so I thought I should tell you that before. The integration that we're doing with regard to patients and their families must be paramount. But it's also important that we track the data and the investment so that we can show that

for every dollar we spent supporting an individual's health, this is the amount that should go to the social supports and the amount that should go to acute care, and this is the amount for long term care.

As we all get more and more successful in integration, we will need to make sure that we resource the community services well enough so that we have the resources. And the other opportunity right now with all of these innovations is to show better health outcomes, but also wiser financial investment. And when we do that, I'm going to show up with my hand out saying, buy some more of us please, invest more in us please because we are value-added and we provide good outcomes financially and for someone's health. So there are all kinds of reasons to do this together.

Linda Magno: Thank you, Kathy.

Kathy Greenlee: Thank you.

Linda Magno: Thank you. We're going to take a break. Now, we have 30 minutes for lunch. For those of you who ordered a boxed lunch in advance, you have a ticket indicating your lunch choice. It's placed on the back of your name badge. And please present this ticket at the applicable table in the foyer to receive your lunch. If you didn't purchase a boxed lunch, please consult the list of hotel restaurants and other options. And I hope you'll all be back here by noon in order to hear our dynamic lunchtime speakers. Thank you very much.

For those of you attending the conference by phone, remember you'll need to call back in using the same dial-in number. Thank you.

Quality Improvement Organization Support Center (QIOSC)

Linda Magno: Good afternoon. I'd like to ask you all to take your seats so we can begin with the afternoon's program. I know that was a hasty lunch, but we did have a very full-packed day and we only have the hotel for so much time. So, we had to push things together as much as possible. So, thank you for being very cooperative with keeping with the time requirements and recognizing the constraints on time for questions and answers.

I would now like to invite you to join me in welcoming our afternoon – or lunchtime speakers – Jane Brock, Chief Medical Officer; and Alicia Goroski, the Care Transitions Project Director, both of the Colorado Foundation for Medical Care.

Alicia Goroski: Hi. So what we're going to talk to you about is the lessons learned from the care transitions theme. So, for those of you who are not familiar, the care transitions theme is a part of the CMS 9th Statement of Work for the QIOs. This is the sub-national theme. We only – it was competitively awarded to 14 QIOs and each QIO is working in one community. So, you've seen this map before. Jennifer showed this. These are the 14 QIOs with the 14 target communities.

What I am going to start with is describing essentially the five steps that each QIO has taken to accomplish this work. So, the very first thing that each QIO had to do was figure out who is in your community. This is a population-based project. The QIOs defined their community by a list of contiguous ZIP codes. The QIOs, by contract, were then tasked with improving the care transitions and reducing readmissions for the Medicare Fee-For-Service beneficiaries who live in that community. So, they must reside in the ZIP codes that the QIO selected.

So, the next logical step is to figure out which – what providers care for the patients who live here. So, we've developed – and the QIOs have been really inventive and innovative with several techniques that tell us which providers to work with. So, we've looked at the overlaps. So what proportion of the beneficiaries who reside in those ZIP codes seek their care with your targeted providers?

We can also then use the Medicare claims data to show what proportion of all patient transitions are attributable to each of the providers you're working with. A few of the QIOs have used the social network analysis to actually visually depict those providers who share the most transitions and may or may not be working together or talking to each other. We also have worked with and developed a prototype of an interactive map by ZIP code, so you can click

on this map and it will tell you at the ZIP code level, the number of beneficiaries who live there, just incidence rates of 30-day readmissions.

So, the second step is actually recruiting and engaging those providers. So, the QIOs used a variety of techniques for this. Jane will talk a little bit more about that. But I will mention the one pivotal turning point in many, many of these communities was a community-wide in-person meeting. We have amazing stories from what came out of those meetings. Action teams were started instantly, work groups, calls to action. Some governors declared or had a proclamation, State Care Transitions Day associated with those community meetings.

So, next, the QIOs work with their providers. And I would also mention, we worked with all providers, hospitals, home health agencies, nursing homes, long term care facilities. Also, non-traditional health care providers, we reached out to senior centers, AAAs, a variety of the non-traditional partners in the QIO work. So this really was a unique and innovative project.

Then the QIOs worked with their community to perform root cause analysis. We needed to know why we have readmissions. Based on the findings, QIOs then assisted the providers in selecting and implementing evidence-based interventions, many of which you've heard about, heard from the developers, or will hear later today. And the final step is measuring all of this.

So, we not only measured readmissions. That was what we were tasked – tasked with. The QIOs worked with their providers. We hounded them for data and we – really, we collected three levels of data to show the effectiveness of the interventions which we implemented. The first level of data, we collected process measures. We had to know how many transitions is this intervention touching.

The second level of measurement, we call it the proximal outcome measure, it really – that measure needed to answer the question did the intervention do what we intended for the intervention to do. So, an example, for those QIOs that implemented the Care Transitions Intervention, did it actually activate patients, did we – can we show a measurable increase in patient activation.

And then the final set of measures, of course, the utilization measures. So, in addition to readmissions, we tracked admissions, emergency department use, observation stays, physician follow-up within 30 days. And we were able or able to show what this theme has accomplished.

So, this slide has a lot of information on it. But when we look at our results, I will also point out these are very preliminary results. This is calendar year 2007 compared to 2009. This project began August 1st of 2008. So, what you're seeing really represents just a year of the work. So, we started this project looking at readmission rates. So, of all patients discharged, again, it's population-based, so, for every Fee-For-Service bene who lives in these ZIP codes, how many discharges were there and then of those how many were readmitted.

What we actually started seeing early was that in some of these communities, that rate was actually going in the wrong direction. But when we dug down and looked at what was happening, some of these communities were reducing their denominator, reducing hospital discharges at a greater rate than the 30-day readmissions, which causes that rate to go in the wrong direction. But is that really a bad thing?

So, we developed these population-based measures, readmissions per 1,000 eligible Fee-For-Service beneficiaries who reside in the community as well as admissions per 1,000 beneficiaries. And as you can see, based on very early work, we now have another year-end to this project in which many more interventions have been fully implemented and spread.

We did see reductions greater than we saw in these 14 communities, greater than we saw for the national average. So, we also are calculating, looking at the cost savings associated with this. So, we, again, have access to the actual Medicare claims data. We can look at the actual cost paid. And associated with readmissions alone, again, very early in this project, we're seeing an estimated cost savings of around \$12 million for these 14 communities.

And, again, we did see that, nationally, there is a trend in lowering readmissions and admissions. However, these communities have achieved greater than the national average. And we're still working on finalizing these numbers. However, the cost savings associated with the reductions in admissions with this community are upwards of \$150 million at 17 months in

So, we continue – we will continue to measure this project through its conclusion, which is July 31st of 2011. And we actually expect to see just even greater reductions.

Jane Brock: So, I just want to go through a few of the nuts and bolts about how we did root cause analysis, what we found and what we know or think we know about community building. So, the QIOs did root cause analyses through basically medical record reviews and several types of process assessment. So, root cause analyses identified were vetted through group discussions with process owners. I want to point out though that almost every process involved in transitional care does not occur within a single institution. You know, your discharge process is somebody else's admission process. So, this work is not necessarily simple work.

Here's the way we're thinking about it now. If you ask why do hospitals have unwanted readmissions, it's because we have a system, we have care structures at the patient-provider interface that support unmanaged condition worsening, use of suboptimal medication regimens and return to an emergency department as a default way to seek additional care. And so we spend billions of dollars. Why do we have a patient provider interface that supports these type of things.

If you ask why again, it's because we have a system that in general has no standard and known processes for sharing patients. We have unreliable information transfer systems and we don't – until recently – have not put a lot of time into developing intentional mechanisms for supporting patient and family activation during transfers. But if you ask why again why is our system like this, the conclusion that we've come to across the board in the care transitions theme is because we really have no community infrastructure,

we've never thought about the community infrastructure that we ought to have in place for achieving common goals.

So I want to point out there are many evidence-based – well, a number of evidence-based interventions – that are targeted at this second level, system fixes. There's evidence like randomized control trial level evidence for a certain number of these interventions. And it is those interventions that 3026 funding can be used to support. A number of those interventions are currently things that were not supported through payments in the Medicare Program.

So, this is my favorite illustration of transitional care today. So, this is a game where you can be “it” without ever being tagged. So, you know, you have that cute little hospitalist back there who is lunging towards the recipient of medical responsibility with a great deal of vim and vigor. But you know, the receiver of care is not within arm's reach and also running pretty quickly.

So, we know that if she in the front is a primary care physician, the odds are less than 20 percent that he will actually tag her. Now, in the end, that doesn't really make any difference. She's still it whether she got tagged or not. And, of course, he can always go back to his office and fax her a note “you're it” which she'll receive within 48 of hours of discharge. And that's when she'll know that she's been it for 48 hours.

If she's with a home health agency, the odds are actually much better than 20 percent that she will be tagged. If she's a skilled nursing facility, she could have a nurse liaison go and put herself in arm's length so that she could be directly tagged. But we know even when that happens, often, there's inadequate transfer of functional information.

So, in terms of the interventions that are available, we published an early table of interventions. This is CMS' table of interventions. We had this table provided to us. We wrote our proposals after this funding so that we would say very specifically in our proposals what interventions we intended to implement. The QIOs have used a lot of interventions, most of us have used Eric Coleman's intervention. A number of us have used Mary Naylor's

intervention, a number of us have used BOOST and aspects of RED and that sort of thing.

This was published in the Remington Report as a sort of a working document. It is available on our website, which is in the tiny little print below. So, you can just – if really don't know what kind of interventions are out there for which there is an evidence-base, I would encourage you to take a look at that.

I want to say quite a bit more about how to build a community. So, when the QIOs got this funding, we thought about how to engage communities initially according to about four different ways, and most of the projects contain combinations of these ways. But some of us started with a multi-representative community-based steering committee.

Many of us aggregated our providers within the community into clusters, matching hospitals with their nursing homes and physicians and home health agencies. A number of us started by getting hospitals engaged together, nursing homes engaged together and home health agencies engaged together. And some of us just went for where the low-hanging sort of carrot opportunities. This SNF to this assisted living facility, this hospital with this SNF, that sort of thing.

But it was very quickly apparent and Alicia has already made reference to this -- that this really is a full-scale civic engagement project or you can certainly optimize the results by making it into a full-scale civic engagement project. So, I had the great opportunity to be part of a team from Colorado that very much helped write the Bennet Bill, which is now Section 3026 of the ACA. And several of my colleagues are here. Eric Coleman was one. Jay Want is here in the audience. I don't see Rohini Ravindran but I feel like we should all acknowledge the work that Rohini and Senator Bennet's office did to make this is a possibility.

But I would say that what we wanted this legislation to do was support three basic things. One was to create a sense that there's a population of people and that we all could figure out who lives here and what do they really need. We can view that by focusing on a population target. Secondly, there's a lot of tax

dollars coming into every community for the support of elderly, frail people. It's not just medical providers who take money from Medicare. QIOs take money from Medicare. We track all this data. We kind of know what's going on. We're not fully engaged in the communities. Area Agencies on Aging are actually in the communities, delivering many services that are similar, counties support housing authorities that can be helpful in ensuring people have safe places to go, recreation centers support senior programs.

I mean, there are just a lot of efforts that are already there, that are already paid for, and what we need is a hub to bring these people together and say we're all part of this solution. We need to target our population. We need to decide where to go with this. So, I would say the three factors underlying our success has been targeting the population, taking the community involvement perspective, and then I want to emphasize what's already been said about start with the gold standard, evidence-based interventions.

Now, truly, as they roll out, a lot of local communities need to make adaptations for local realities, but that's way different than importing a model that has been adapted by some other locality into your locality. So I think it was critical that we started with gold standard models and then modified them as they rolled out.

I have a list of things on this slide, but I don't have time to go through them, of where a motivated community could start. As we've gone around the county talking to communities about the work that we're doing and where we think are kind of the low-hanging fruits for, you know, early leverage, I use these slides. But now I'm thinking with the 3026 money being a reality, I would think of these things as things you could do right now to put into your proposal for 3026 dollars. And I told Linda that she can correct me later if this isn't what she had in mind.

But, you know, first of all, it's critical. You need to figure out, you know, where are your patients and who do you share them with at the very least there needs to be thoughtful consideration. I think that we should have forums in communities springing up for routine exchange of medical quality data, outcomes data, you know, who do I share patients with and how do they take

care of them. We should have routine discussions of readmission cases, you know, like tumor rounds, we should do transition rounds. I think that any community interested in doing this, should be reviewing very comprehensively your existence and your structures to referral to palliative care and hospice providers.

We only have one community that actually did this. Had their CEOs do cross-site exchange visits with the facilities that they send other patients to. I would think this is a very powerful and probably underused potential intervention. I think if you get started mapping your handover processes, these mutually interdependent processes that you share with other providers, I think that would be very powerful.

Certainly, at the very least, you should call and visit your AAA and see what they can do for you. They are specified in the law. I think it's time to meet those people. I would also include in this many of the other agencies I said. State survey and certification agencies. They know a lot of things that might be useful to this effort. QIOs certainly know a lot that would be useful to this effort. Counties, cities, housing authorities, all those things I already mentioned.

We think there's a tremendous value to intentionally supporting social networking, how well do you know the people that you actually depend on for shared care of the elderly residents in your neighborhood and we think these are the kinds of things that would make a more powerful proposal.

Thank you.

Linda Magno: Thank you, Jane.

We have some time for questions. This time, I think, in the interest of fairness, I'm going to start with questions from the audio participants in the conference. So, if the operator could please open the lines?

Operator: We will now open the line for question and answers. To ask a question, please press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state

your name and organization prior to asking your question and pick up your handset before speaking to ensure clarity. Please note, your line will remain open during the time you are speaking, so, anything you say or any background noise will be heard in the conference.

We have a question in queue from a participant whose name was not captured.

Please state your name and organization to identify your line to our presenters. Caller, your line is open. Caller, your line is open.

Female: (Inaudible)

Linda Magno: Excuse me. Can you start all over again and speak up a little closer into the phone please?

Female: We were wondering if possibly you could check the mic? We believe that the mic that's being used – that was used by Dr. Berwick and the last speaker might be the cause as why we're not being able to hear.

Linda Magno: OK. We're very sorry. We'll check those mics again, right now.

Female: Thank you.

Linda Magno: We'll take a question from the floor.

Female: Thank you. Dr. Brock, thanks for a great presentation and congratulations on the success of the work. As we in communities trying to basically take step one, know who your patients are, what are your recommendations for those of us who do not currently have Medicare data sets for taking an efficient stab at that? Do you have any thoughts for us?

Jane Brock: Well, my hope is – there's no guarantee – but my hope is that there's active intention at CMS to make this kind of data much more easily available. We hear rumblings. So anyway, I know that's not a totally satisfying answer but ...

Female: If I could – could I ask a follow up?

Linda Magno: Well, why don't I say something first. We have every intention once the program is up and running to be providing feedback data to hospitals and other – and community organizations about transitions in their communities.

But in terms of the start up since hospitals will have to look at their readmissions based on their own, you know, based on internal data and their readmissions to their own hospital, unless they can come together with and share data with other organizations, other hospitals in the community and other providers in the community because we don't have the ability to make community-wide data available, patient-level data available to applicants until they're actually part of the program. You had a follow up?

Female: My follow up was going to be just based on the data and your experience in the real world given that the Medicare data won't be available, thinking really specifically about these meetings, you know, and who's coming with what and we're going to have nursing homes, we're going to have home health agencies all of whom can bring to the table their own populations. Given that messy reality, any specific recommendations on how to use that data well?

Jane Brock: So our hope is that this entity that is a community-based organization can become a legal structure where providers can share cost-provider data. I mean, I don't know, it's not strictly specified in the law but I think there's a fair amount of acknowledgement that within a group of providers there needs to be a legal way to establish a data exchange forum, so that hospitals can know their arrangement.

Female: Thanks.

David Schulke: David Schulke, HRET. Great work on the project. I think one thing – one kudo to CMS that is deserved, in addition to the obvious, great work by hospitals and community providers and QIOs is that CMS and the design of the 14-state project allowed the interventions to be selected by the sites and that did not mean the QIOs, but the QIOs let the providers that they worked with figure out what they wanted to do and that's very powerful way to do things – it puts, you know, CMS was under some pressure to define the

interventions. So, this was a very, I think, courageous and smart thing that they did and I think it shows results at the community level.

People got to work on things they wanted to work on and the way they wanted to work on them. One of the things that the hospital community is concerned about and would like to see resulting from the national implementation of the 3026 pilot is sharing of interventions that seem to work.

So, of course there may be, I hope there will be a community of practice between the sites, but for everybody else, it's not in, I agree with you 500 million sounds like a lot but there's not that many sites compared to all the people that are trying to make a difference here and all that are subject to penalties potentially.

So do you have a mechanism in place for getting, pushing out intervention strategies as soon they start to show promise or are you going to start by promoting the evidence-based interventions strategies, RED and the Coleman and the other interventions?

Linda Magno: It's our intention – as Juliana mentioned this morning to have a technical assistance contractor who will cull the data from our monitoring of the projects to see where we think we're seeing early successes to bring the community of participants in 3026 together initially, to share those results, to learn from one another what's working, what's seems not to be working, how things can be tweaked, how things have been adapted to particular circumstances and to build on that and in fact participation in these collaboratives will be a requirement for participants in 3026 because our goal is to spread the learnings from this.

And then we are working actively with our colleagues in the Office of Clinical Standards and Quality – I can do acronyms but I like to pronounce for people who don't live in our world of alphabet soup. Anyway, we're working very closely with our colleagues to figure out how to take the information then that we develop from this project and use the QIO program in the 10th Scope of Work to begin to spread those learnings more broadly across the community

of hospitals and other providers so that we're not confining those learnings to ourselves.

And I think in combination with OCSQ and in combination probably also with our innovation center that we will be doing a lot more in the way of spreading the learnings from this project as well from other things that we're doing.

Good question. Thank you for asking.

Male: Hi, I'm not going to tell you who I am because I have yet another annoying logistical complaint request. The last, great presentation Dr. Brock, the last few slides however are not in our notebook and they were the best stuff including the web link to the evidence publications. So if we could somehow make sure we get that.

Linda Magno: If they're not already on the website fully, we'll make sure that any additions get added to the website.

Jane Brock: I think they are on the website because I got them.

Linda Magno: OK, they are on the website. Any other questions, do we have any other questions from the audio participants?

Operator, if you could open the phones?

Operator: Your next question comes from the line of Joanne Handy, your line is open.

Joanne Handy: Hello. I'm with Aging Services of California. I was – I'm really fascinated by your outside-in approach which I've contrast to the more inside-out approach that we heard in the earlier presentations.

I wonder if you could comment on two aspects. We heard earlier that it's all in the execution and the execution among so many different players is indeed difficult. What were your observations about the actual execution of the evidence-based tools in your projects? And did you observe that there was one provider type that often took the lead in the community coalition?

Jane Brock: So, let me answer the second question first. There often was a single provider – or provider type that would step up within each community, but I would say across the board we think there's many different possible models for doing this and that's why we say, I think the strongest strategy is to get your community together, figure out who is in it both in terms of who need services and who supplies services and negotiate that locally. I think, that in the end, that was almost our biggest learning.

In terms of outside in, I think, you're probably referring to the fact that we did this through community coalition work, is that right? If that's not right, correct me.

Joanne Handy: Yes, yes.

Jane Brock: And so, in the beginning, we didn't necessarily intend to do so, but within a couple of months, it was just obvious that that was going to be the best way to do it. And so, I think that's one of the reasons that this is being framed as community-based transitional care because we think that's what works. And we were so fortunate to go forward with visionaries at CMS who had a suspicion that it would go this way from the very beginning and it's just been very powerful.

Care Transition Intervention Model Implementation

Linda Magno: This now concludes Q&A session for the segment of the agenda. I'd like to thank Dr. Brock and...I'm sorry. I'm looking at announcing the next speaker and I lost track of myself here. Anyway, I'd like to thank both of you and I'd like to bring up our next panel.

Our next panel is comprised of Eric Coleman, Professor of Medicine and Director of the Care Transitions Program at the University of Colorado in Denver; Alan Stevens, PhD, Director of the Program on Aging and Care at Scott & White Healthcare, Naomi Hauser, RN and MPA, Director of Healthcare Quality, Quality Insights of Pennsylvania; and Tim Landrin, MPA, Director of Home and Community-Based Long Term Care Division of Southwestern Pennsylvania Area Agency on Aging; and Laurie Robinson, RN, Director of Quality with eQHealth Solutions.

Eric Coleman: Well, nearly two years in the making it's been very exciting for all of us to be here in this room and joining through the phone lines to talk about the Community Care Transitions Program. As Jane Brock mentioned, I had the privilege of contributing to some of the drafting of language as did Jay Want, (inaudible), (inaudible) and we're hoping that any minute Rohini Ravindran who provided outstanding leadership with Senator Michael Bennet's office to make this a reality.

Well, as one of the contributors, I would like to point out that our stated goal is not necessarily to be here to test new models but rather to find out new ways of developing meaningful cross-setting partnerships that are positioned to address the wide broad range of needs and factors that are contributing to hospital readmission rates.

And to build on Secretary Greenlee's point, I would like to offer an example that I learned about just this week, so if we could move ourselves to Winston-Salem North Carolina, Richard Gottlieb there is the president and CEO of Senior Services, he did something that I thought was very creative.

He brought his list of the clients that they served which numbered on the order of 2700 and sat down with the leaders of the two primary community hospitals there -- Wake Forest University Baptist and Forsythe. And when they compared Richard's list to individuals that had been touched in these hospitals, they found out that 2/3 of the individuals that were being served by Richard's program had recently been in the hospital or the emergency environment.

So I bring this illustration up to point out the tremendous opportunity we have. We know that hospitals do a terrific job in many respects but that they can't execute high quality care transitions on their own.

So, what we hope, the purpose of the CCTP is really to find new ways of encouraging these kinds of partnerships so that opportunities like the ones that arise in Winston-Salem can be addressed. Just to finish the story, Richard

shared with me that the two CEOs at the hospital have agreed to co-chair a Community Care Transitions initiative in that community as a first step.

Building on Dr. Berwick's comments, we attribute the entire success of our Care Transitions Program over the last 12 years. And each time we embark on a new endeavor, we listen. We go to the individuals that we are trying to help improve the quality of their care and try to understand from their standpoint what are the possible solutions.

One of the things I think that's unique and I cringe to say this a bit of a paradigm shift. When it comes to care transitions is the need for us as health professionals to step back and realize that in many respects even though we have all this training behind us that often the patients, the consumers, the clients have the answer.

We have done these types of exercises now in multiple communities across the country. It is remarkable how consistent the themes that come out of this are. We hear over and over again, people talking about the fact that they don't feel prepared. And on the surface, that has to do with what's coming up next and the fear of the unknown.

But when you drill down, it actually has everything to do with the fact that they're not sure what their role is in all of this. They talked about the fact that they get conflicting advice as they move across settings and that they're the ones who have to decide which of us they are going to trust.

They talked about the ability to reach the right practitioners, someone who's actually tuned in to what's going on in that very moment, who knows that you were supposed to have oxygen started; who knows that the traditional mask that might be used for that didn't fit your chin and that you are going to get a custom mask.

And the family caregiver is the unsung hero of care transitions, tell us about the fact that they're there to pick up the ball when we, as professionals, are dropping it. So all this to say, we've come to recognize that in many respects, individuals with chronic illnesses by default are put in the position of

doing a significant amount of their own care coordination even when they have terrific case managers, terrific home care nurses, terrific primary care physicians but by and large, 24 hours a day, seven days a week, a lot of this is falling back under them.

And yet they do this without any significant preparation or have the skills, the confidence, and the tools that they need to be effective. Many of you are familiar with the MacColl Institute's Chronic Care Model, summarizing the evidence for how we improve outcomes for this population. Many of you are also probably familiar with the fact that in that southwest corner there's that ellipse that says the informed, and activated patient.

Again, I would submit that in health care we're not entirely comfortable with that idea, hopefully, we're getting better. But we also know how integral this component is to eventually reaching the bottom of the slide to improve functional and clinical outcomes.

So what makes this model of care unique is that it is entirely focused on what the consumer or the patient's role is. It is essentially a self-care model. This is not another layer of care or another layer of professionals. This is about helping to produce informed and activated patient that even in the most highly integrated care system, we will continue to need.

With the continuous and generous support of the John A. Hartford Foundation. Pleased to have Chris Langston and Amy Berman in the audience with us today. We have set out to take this model from the point of listening to what consumers have to say. We also spend a lot of time listening to what financial leaders have to say about what makes for a model that they could adapt in a variety of community settings.

We realize it had to be relatively brief, relatively lean and mean. So a single home visit, three phone calls in 30 days. That's it. Patients and families helped us introduce the concept of the transitions coach. What's different and unique about this role is that the coach's sole purpose is to be the vehicle for imparting the skills and the confidence and the tools that individual patients need to be effective and to make sure they get their needs met.

The coaches do not fix problems. The coaches don't provide any skills services. We know that we can anticipate for most individuals what some of those challenges are as they go through transitions. I'll say a little bit more about those in the next slide. But we realize that if we can anticipate then maybe there's an opportunity to begin to prepare these individuals for future care transitions to start today.

So this really involves instead of coming in and fixing the problem, modeling the behavior for how you respond to common challenges as you move across settings, challenges like trouble getting a follow-up appointment, reaching the right practitioner, problems around what to do when certain signs and symptoms indicate your condition is getting worse and worse and what you should do about it.

We also know from adult learning that people learn best by practice, by rehearsal, by role play. All of us who are clinicians initially did some book learning which wasn't that exciting but eventually we got to do (inaudible), clerkships, we got out to interact with real people and that's where our learning curves took off because we were actually doing. We are making mistakes along the way and that was also part of the learning process. So in this model we respect the fact that our patients need to have a similar opportunity to learn.

We found that the key, one of the keys to engaging individuals is to find out what their goals are, have them identify a goal that they'd like to work on relevant to their health, but not exclusive to their health in the next 30 days. Interestingly in most cases, these goals have to do with symptoms, function, quality of life, feeling well enough to go watch their granddaughter play soccer, getting the swelling down in their ankles so they could put their good shoes on to be able to go to church services. Oddly enough, no patient has ever identified reducing their hemoglobin A1c or improving their injection fraction as one of their goals. Those are examples of our goals.

Also I appreciated a lot of the comments from this morning about medications and the role of pharmacists. It's been our observation and sort of back to

Joanne Handy's comment earlier to Jane Brock about inside-out or outside-in, we have learned it's extremely valuable to start with what the patient is actually taking and then moving into medication reconciliation from there versus starting with what we think they should take and trying to reconcile in that respect.

Well, the four pillars are those areas that consumers helped us identify were key for self management. Now I want to emphasize that converting the four pillars into a provider checklist is not something we would recommend.

These are the skill transfer opportunities that we see for the coach around self management, getting follow-up, red flags and taking some ownership over their information. We've done this using a personal health record, there's no magic to this, we didn't invent this. But really it's about individual's realizing that they have an opportunity to own some of their information.

In some cases this intervention begins in the hospital but not always. Not all hospitals necessarily are OK with people coming in and introducing a coaching concept, but that's really all we're trying to accomplish in a very brief hospital visit.

Introduce the program, why it might feel a little bit different, ideally schedule a home visit when a family caregiver is available. The home visit is really the essence of the model. This is where the opportunity for true coaching comes into play. And I distinguish coaching from patient education which also adds value but they're not the same thing.

Coaching involves skill transfer, it involves sitting on your hands, it involves letting go, it involves letting the person direct a lot of the agenda, the encounter. Again, not all things that we've been comfortable up to this point but highly effective.

The encounter begins around identifying the goal. The next question, "Show me what medicines you take and how you take them?" A very different question than holding up a discharge summary and asking the person "Is this what you are taking?" Because the answer to that is usually yes.

Modeling the behavior for how to address common transitions scenarios, generating a list of next steps, key questions, upcoming encounters that the individual can work on. We know from Judy Hibbard's work in patient activation we identify modest initial goals where people can have those small victories because those small victories then give them the confidence to keep trying.

The phone calls are usually timed around encounters with other professionals, the home nurse coming out, the physical therapy visit, the visit to the cardiologist. Revisit the goal. Revisit the four pillars. We have tools that can gauge how well this individual is making progress in their own activation. Back to that activated patient ellipse on the chronic care model and ensure their needs are getting met.

In the interest of time I'm not going to share the many studies we've not done of this model. I would rather – I'll try to summarize it. Remember that the intervention is one home visit, three phone calls, 30 days, that's it. We, of course, were very encouraged when we say that we could reduce 30-day readmissions, but that really wasn't what we were aiming for. We were under the belief that if you invest in self care, that that investment pays downstream dividends.

In another words, each time this person faces those similar transition related challenges instead of having somebody come in and address the problem for them, we coach them to know how to respond. They're going to be better positioned to get their needs met. And we have been able to demonstrate this out as far as our resources allowed us to measure.

Six months later, statistically significant differences in hospital readmission rates. On our website which is the last slide—caretransitions.org—we have brought on a number of smart CFO types to help us write the business case for the model. The one that we have on there right now is extremely conservative, we wanted to stand up to all levels of scrutiny.

We've been able to find that a typical coach with the panel size of 24 to 28 can reduce – excuse me – 24 to 28 over a 12-month period can produce a net cost savings on the order of \$300,000. We believe it's actually quite a bit larger than that, but that's the number that we start with for these conversations.

Since we produced these slides, we are now up to 367 adoptions of this model in 35 states. We would jump at the opportunity to find a way to partner with any of you here in the room or on the phone. When we had an opportunity to share our results with the Senate finance committee, I can tell you that the randomized control trials and the journal articles were not exactly what they were after. What they wanted to hear is on this slide.

Now, with over 300 plus adoptions, we have a lot of real world experience to share. So, I chose three examples, representing different parts of the country and different types of delivery organizations. John Muir is a large physician network in Northern California, already a very high performing system. In partnership and collaboration, we've helped them reduce their 180 day readmissions in half.

Health East in Minneapolis, again, a very high performing care system featured by the joint commission, featured by IHI. We were able to get their readmission rate down to single digits. Crouse Hospital in Syracuse, New York was really struggling with the negative margin around their heart failure patients. They tried a number of interventions and when we were able to work with them, we could get their readmission rate down again below 10 percent.

I'd like to end by just emphasizing how important the connection is between an evidence-based model, model fidelity, and getting ultimately the outcomes that we're looking for. It's so tempting at times to want to do sort of what we might do in the kitchen, you know, a pinch of this and a little of that and hope that everything is going to come OK.

And in our experience now again with over 350 adoptions we've learned a great deal about the factors that promote success. I have broken them down into four key areas around model fidelity, choosing the coach, executing the model, and then support to sustain.

So, under model fidelity, again, we've seen a number of different hybrids out there and we have recognized how important it is for the transition coach to have a dedicated role. It's been very tempting to graph the role of the coach on to an existing professional, home care nurse, or potentially a case manager. What it does is it actually confuses the consumer or the patient.

We also know that the coaches and I'll say a little bit more about coaches on the next slide but the coaching is focused on skill transfer as opposed to more traditional patient education who models the behavior rather than t comes right out and fixes the problem. And you're going to hear from Laurie about some of the impressive work they're doing in Louisiana.

I will share with you what Laurie's work – it's a little bit atypical in a sense of getting such promising results, our other partners who have bypassed the home visit and just did telephonic have not gotten as strong results. We're very confident, if you include the home visit, that you're going to be able to get the outcomes that you are looking for. We are far less confident if you decide not to do the home visit.

Our care transition program does offer a variety of training options. Again, it's caretransitions.org. You can learn more about those, you can contact us and we'd be happy to walk through those with you.

In terms of choosing the coach, in the early days this was all about the initials after their name. Since then, we've really moved away from that. We've been able to show the nurse practitioners, nurses, social workers, occupational therapists and emergency medical technicians have all been successful in this role.

But really, what distinguishes them again, are not the initials after the names. It's their ability to make this leap from being a doer who comes in and just fixes the problem versus being able to come in and coach this individual to be able to do more for themselves. It's the classic teach them to fish analogy.

We also know that terrific coaches have outstanding communication skills. Most importantly, they know when to stop talking. Bless our hearts, all of us who are health professionals want to believe that we're coaches and some of us are doing coaching, but we have found through our training program that these individuals who come in and pat me on my shiny little sweaty head line and say, "You know, I've been a coach for 35 years. This is not going to be worth my time." After the first simulated case, you see a look of transformation on their face. This is not the same thing that we've all been doing. And we realize that in our training program, that is our opportunity to help people understand and make that transformation and by and large most of them do.

On the execution side just, again, building on some of Linda's earlier points, the idea of organizational readiness has been incredibly important. We've created the readiness assessment tool. It's actually known as the RAT. And the RAT actually provides the organizations together to go through what really is required to make this model successful, to make sure that the coaches are going to have dedicated time to figure out what the workflows are going to look like, to make sure that the various stakeholders aren't just engaged in the standpoint of writing a nice letter on stationary, but rather that they are a true partnership.

And we are already providing ongoing community collaborative telephone calls for coaches who've gone through the training to provide that additional support for them after they've gone through the training and now they are out in the field again and they're learning new things to share with our program, we're learning new things to share with them, we're helping them understand what's going on at the national level and they're helping us understand what's going on in their communities.

Finally, in support of sustaining the model, this is, again, been a very interesting exercise in helping teams figure out not just what the important clinical outcomes are but what are the important outcomes. The decision makers in their organization need to understand in order to decide whether to sustain this approach. We recognize that the decision to adopt versus to

sustain are not necessarily the same decisions and that different information need at different points.

I mentioned earlier the ongoing revision of the business case as we see the environmental landscape changing has been an important part of this program. Everything we've developed you can access on our website caretransitions.org. It is a privilege to be setting up our next speakers who have been doing some outstanding work in this area. And I'm eager to learn from them as well. Thank you for your time.

Alan Stevens: Good afternoon. My presentation provides a case example of how a health care organization and a community-based organization formed a partnership to deliver Dr. Coleman's Care Transitions Intervention.

And the work I present today is actually a partnership of numerous groups primarily Scott & White Healthcare and the Central Texas Aging and Disability Resource Center and my colleague Richard McGhee is the director of the Central Texas ADRC.

The goal of my presentation is to demonstrate the tangible benefits of a partnership. At Scott & White, as you heard this morning from Dr. Pryor, at Scott & White, we believe that partnerships with the community-based organizations are essential to our vision of being a trusted and valued health care provider.

Formal partnerships help align the goals of care providers, activate health promotion in the community, and encourage patients to more fully engage in their health care. Furthermore, partnerships stimulate innovation, and innovation and support quality. Not just in the health care system but in our service-based organizations as well.

For example, the partnership that I will be talking about today began with a small grant from the Rosalynn Carter Institute that allowed our two organizations to work together on a program for family caregivers of dementia patients. From that early work, we shared ideas. We identified needs in the community. And that work has driven us to look more extensively into the

areas of care transition and providing other kinds of home – community-based and home-based long term care options.

These new services and new innovations that I'm speaking of are contained in our community living program which I'll give an overview of. And then, give some very specific examples of how we embedded Dr. Coleman's Care Transition Intervention within our larger focus of doing a community living program, and then also, how some of the strategies that we use to actually embed the CTI coaches within our health care system.

Our experience suggests that the innovation that is needed to develop new programs and implement these new programs are well served by a trusted partnership. In our community, the local ADRC began in about 2006 as an umbrella organization for 11 different community-based organizations that were a combination of social service and health care organizations that provided services to individuals from across the life span. They included agencies such as the Area Agency on Aging and the Independent Living Center.

Scott & White's Program on Aging and Care was included in the initial and the founding group of members based upon our goal of conducting very applied research and demonstration projects that target the needs of older adults. Within the ADRC, our role has actually morphed over time. With the Program on Aging and Care, now serving as a viable bridge between the formal health care system and our many providers in the community and in our hospitals with the diverse groups of individuals and service providers represented in the ADRC agencies.

The goal was – the program was co-designed – our community living program was co-designed by the ADRC partners including the Program on Aging and Care at Scott & White and the Area Agency on Aging. It was funded by the Administration on Aging to our state unit on aging which is the Texas Department of Aging and Disability Services who then contract with Scott & White and with the local ADRC for implementation of the project.

Our project targets individuals at high risk of nursing home placement and spend down for Medicare. These are typically older, frail individuals with multiple chronic diseases. And in fact, 90 percent of them have more than five impairments at the ADL. So, a fairly frail group of older adults who we believe to be at risk of nursing home placement.

We designed an intervention to target community living options for this population, and decided from very early on that transitional care needed to be a part of that intervention. Because we knew from our data that the more times an individual was admitted into our hospital it increased their chances of long term nursing home placement. We were able to know that from looking at the data in our electronic medical record.

We also knew that family caregivers were crucial to providing community support for older adults. And so we included components of another evidence-based intervention called REACH, Resources for Enhancing Alzheimer's Caregiver Health.

And we also were able – with the funding from AoA – to provide some tangible supports to family members who are caring for frail individuals in the community. Tangible support such as respite care and home modifications. The program provided this comprehensive support of transitional care support for family caregivers and tangible support as respite care over a 10-month period of time. And our initial findings suggest that the program has a positive effective not only on the frail older adult but also on the family caregiver.

What I want to concentrate on today is the care transition component of our intervention as you just heard described from Dr. Coleman. This is an empowerment-based intervention that – in which we are able to go into the home with a coach, a coach who is trained and certified according to the CTI intervention by Dr. Coleman's staff in Colorado.

So, we made close fidelity to the model as tested by Dr. Coleman. And we implement a hospital visit, a home visit, and multiple follow-up phone calls. There are 189 individuals who are enrolled in our community living program.

They were enrolled from both community and hospital settings. And 65 of these individuals actually receive the care transition intervention. Remember, this is a multi component intervention so, we're basically addressing the needs that family members have. Many of our patients were not hospitalized but those who were - were offered intervention.

For the process of – of importance to today's conference, I think, is the process by which hospitalized patients were identified and offered the CTI intervention and then enrolled in our community program. And that process is visually presented on this slide.

In this case example, a 65-year-old female with multiple chronic illnesses was identified by our case managers as being at high-risk for rehospitalization. She'd been back in the hospital three times in the prior six months. And she was also identified as being at risk of nursing home placement.

The case manager made an electronic referral – an email referral to a transition coach who upon getting the referral, went into to the patient's electronic medical record, reviewed some basic statuses about the patient, went to the patient's room, visited with the patient and the family and made that initial contact as Dr. Coleman described.

Not necessary, but we think a very valuable beginning to the CTI intervention. The following day, the patient was discharged two days later. The transition coach made a home visit to carry out this CTI intervention. Critical here is the activation of the four pillars and in working with the family and the caregiver – the family caregiver and the patient to record basic information in their personal health record, to do medication review, red flags, and to ensure that there was a scheduled follow-up appointment with a primary care doctor.

That visit with a primary care physician occurred the following week. We made a follow-up phone call the week after that. So, we are now about two weeks after discharge, I'm sorry, three weeks after discharge. We did a follow-up phone call to make sure that things were progressing as described.

We actually had to introduce a new coach at this time just to show that no matter how much you try nothing ever goes perfect, but you just keep rolling. But we had multiple individuals trained as coaches, a new coach stepped in to finish up the CTI intervention.

At that time we judged that the person was – had made a successful transition back to the family home, was still at risk nursing home placement, and the patient was then enrolled into the community living program to have this more extensive 10-month period of support that I described earlier.

So again, I show you this more as a – this is what it starts to look like in real life when you're working within the hospital to identify patients and then go into the homes to engage them in the CTI intervention.

Next, I want to highlight three strategies that we think support our successful implementation of the CTI. And the first strategy is related to access. That is, CTI coaches need access to case managers and of course to patients and families.

We knew this going in. We had been well-trained in our work with Dr. Coleman's group and had heard feedback from other groups saying that this was critical that we access patients in a timely way.

So, our implementation of CTI required both timely communications between the hospital case managers and the coaches and of course patients and families brought into that process. Our primary objective of the project was to provide CTI coaches with rapid access to the patients prior to discharge.

And we sought about achieving this by making sure that this project had joint ownership. Both philosophically owned by the community groups, by the ADRC, by our hospital and our staff as well as very practically owned by both programs.

We achieve this – one of the techniques we used to achieve this was that the ADRC contracted directly with Scott & White to provide funds that had been

provided to them by AoA to hire transitional coaches, they then contracted to Scott & White.

We were then able to hire coaches and make them Scott & White employees and vetting them within our system, making them the colleagues of the case managers, the colleagues of the referring physicians and allowing them access to electronic medical records so we could more properly and accurately track patients.

This also – we also then co-located some of these individuals, who are now, if you are following the story, Scott & White employees, we now co-located some of these people back at the ADRC because we wanted to have the continuity between the staff. Family members wanted to see a coach. They didn't care where that coach was being paid from.

Our second strategy was again, based upon timeliness, and timely identification of the target population. We knew that adoption of a new – of new programs like the CTI and the Community Living Program that we were putting forward would seldom occur spontaneously.

And that there would be some time before we got up taken by them. And so, we started with an aggressive education and outreach program regarding the new program that was really done to help communicate not only the spirit of the program exactly what we would be doing, but it was done in a way to cultivate trust.

Trust from the case managers, trust from the hospitalists that this new program was not a threat, was not being done because they were failing in some way, but rather this was an additional value that we were adding to the patient experience at Scott & White. So successful delivery of the CTI I think required this buy in. We were over time able to get it. I can't say that it occurred on day one. I can say it required a lot of time, working and providing feedback, and feedback really was the key here.

Both physicians and case managers wanted to know what happened with their people. What did we do? What did we do when we went on that home visit? What did we find in the home? And what was the status of the patient?

The third strategy is a bit broader, and focused at the level of culture. I think we have to know the culture in which we are – adopting – in which we are implementing new programs. And we believe that– that our innovative approach to transitional care could not be sustained without culture change.

We actively worked with our senior leadership and with direct care providers to help them understand what we were doing and, hopefully, demonstrate the value of our program to them. And specific outreach was made to standing committees like the Post Acute Services Quality & Patient Safety Council. Again, framing our program as not just yet another demonstration project that was going to go away in 10 months and they could wait us out if they needed to. But rather we were engraining ourselves into the culture and indeed we were related to quality and safety.

We also worked to understand the culture that we knew that for physicians to make referrals to our project, it had to be within their terms and in which they had done things so we arranged for there to be electronic consults provided from physicians to our program that we could follow-up on.

And again, provided ongoing feedback to leadership on our efforts regarding this project and our efforts to reduce unnecessary readmissions. If I can just say quickly that we started this project 2 1/2 years ago well before there was legislation that indicated the hospitals might be penalized for reimbursement and still our administration was extremely supportive for many of the reasons that you heard from Dr. Pryor this morning.

I think our early work has been beneficial to our community living program. But has also set an environment in which we are able to now take the lead on the Texas ADRC Evidence-Based Care Transitions Program which is one of the 16 newly funded projects by AoA that Secretary Greenlee mentioned this morning and it's co-funded by CMS and AoA.

The three goals of our new project is to embed additional CTI coaches within our Scott & White Memorial Hospital which is our slightly over 500-bed facility in Temple, Texas and replicate the model in a partner hospital on the other side of the county in which we are doing this work.

We will certify staff as CTI coaches within six additional ADRC partner agencies. So, we'll be reaching some unique populations including a pediatric population with the Children' Special Needs Network. And those CTI coaches will be based in our new children's hospital.

And finally, we hope to provide support to the wide spread adoption of CTI throughout the state of Texas by serving as a resource for ADRCs and the Quality Improvement Organization in Texas as they work to implement CTI in a number of other institutions.

And we're hoping that our experience can shed some light on how partnerships can be formed and the value of partnering between health care organizations and community-based organizations. Thank you.

Naomi Hauser: Good afternoon everybody, I'm Naomi Hauser from Quality Insights of Pennsylvania, the QIO from Pennsylvania, and it's certainly a pleasure to be able to talk about the program that we have instituted in western Pennsylvania.

Well, when we started the project, the Care Transitions Project as the same as all the other QIOs it was July 2008. And we were given the goal of reducing readmissions, but also to improve transitions of care as patients moved across the settings. That became the major focus of our work, and there were a lot of evidenced- based interventions that were offered up to us and obviously one that we wanted to definitely adopt was the Care Transitions Intervention.

And the question that we came up with was where do you get a coach? It was not something we were familiar with. We didn't know where there would be a resource to get a coach. And so, we approached the hospitals, and the hospitals clearly told us that they really didn't have a resource to be able to provide such a position out of their staff.

It was recommended to us that we approach the AAA. And that's exactly what we did. We did approach three AAAs. We presented the program, what our goal was and what our vision was to be able to move forward. And two of the AAAs said that they thought that they could actually do it at neutral budget, because they also were using their own already existing staff to be able to provide transition coaches.

So with that, we decided, OK, we're going to have to go to our next steps. And why did we go to the AAA? For obvious reasons as you heard today, because the mission was very congruent to what the project was looking at. And it was a sustainable model which was very important, because we wanted to make sure that whatever we put all this effort into would be able to be sustained in the community, and then in fact, it would be from resources directly from the community.

We chose to adopt Dr. Coleman's model and we really tried to have strong fidelity to the model. There were times where we had to flex that, but for all intent purposes, we really did stay true to the model. We approached the hospitals and the AAAs, we started getting them together and in all collaborative efforts, the first step is getting everybody to the table and talking about how we can do this collaboratively. And once we did do that, it really became a pretty smooth process.

There were some, you know, problems along the way, but nothing that we couldn't work out. And the QIO really was a facilitator to this process in the beginning, kind of laid some ground rules down, tried to get the nobling environment so that we had trust across the providers to be able to talk and really identify what some of these barriers were and be able to talk honestly.

So the QIO in setting the culture of collaboration made sure to include transparency, which was critically important, and to equal the playing field. Nobody had any more voice than anybody else. Everybody was important. It was important to identify workflow processes. Make that very clear and make sure that people understood what their roles were and to understand what coaching was really all about.

And, certainly, we had training from Dr. Coleman's team. They came to Pennsylvania. They trained not only the coaches from AAA, but also the staff from all of our providers. We had health agencies there. We had some of our skilled providers there. We had the hospital there and the QIO. So everybody got trained at the same time and I think that was very important to be able to have everybody on the same page. So nobody was at the head of the class. We were all learning together.

I'd like to share some of our outcomes. We were successful. I'd like to announce that. And some of the success measures that we looked at certainly were looking as if our rates of discharge went down. And they did. I will share with you that out of 500 – or 5,531 discharges we coached 418 patients. That was an impact of 8 percent on all the discharges in our community; and we had 53 percent of those 418 patients completed the 30-day CTI.

The reason someone might not finish it was because they were readmitted, because they left the community. There could be a variety of reasons, but 53 percent did in fact complete the 30-day transition program.

And as Dr. Coleman and everyone has told you that really the measurement of successful coaching is are patients activated. What we mean by that is how involved are they in their care. If they're more involved in their care, then evidence base shows that they are going to probably lower the risk of readmission.

So we applied a tool called a patient activation assessment. And what we did is the coaches would actually go in on the home visit and apply this assessment; ask some questions related to the four pillars. And the patients would answer and they would get a score. And then on the third call done by the coach after 30 days, the assessment would be applied again, or those questions would be reasked.

And we had a success rate of 73 percent improvement of scores from the pre to the post patient activation assessment. And that was an average of a 2 point increase for patients.

And the discharge rate for hospitals across our community was at patient's discharge from any hospital, not particularly our participating hospitals, but any hospital to any other hospital in the community readmitted was 20 percent. Our participating hospitals in our identified community that were readmitted to any hospital was 18 percent. Our coached patients in our community that were readmitted to any hospital was 14 percent. So that went from 20 to 14 percent.

Another measure of success, we decided that if the AAA staff and the hospital staff were working so closely and they really began working seamlessly with each other, we thought that that must have improved their relationship with working. So we decided to apply a questionnaire to both the AAA staff as well as the hospital staff.

And these are the results that we obtained and the questions that we asked. We asked the hospital staff and their response was 60 percent of the hospital staff felt that they had more contact with the AAA staff than they had before. And 66 percent said that they knew more about the services that AAA was providing. And 46 percent said they were more satisfied with the contact they in fact had with the AAA staff.

And from the AAA side, the answers that we got, 74 percent were more satisfied with the hospital contacts they had; 67 felt there were more AAA services that were actually provided; 60 percent said that the referrals were more appropriate; 53 percent said they had more contact with the referrals that were made; and 60 percent said they were more confident that the patients' needs were being met.

So we feel that that was a success, relationships were improved, services were increased, patients' needs were met. We couldn't ask for more than that, but to continue that and hopefully continue this process. So that's what I have to offer here today. And I thought what you really want to hear is what the AAA can talk about what they did, how they did it and what their outcomes were.

So I'm going to turn this over to Tim Landrin from Southwest Pennsylvania AAA.

Tim Landrin: Good afternoon. This is the short person session. As Naomi said, my name is Tim Landrin and I work the Southwestern Pennsylvania Area Agency on Aging, a three county section, surprisingly enough in the southwestern corner of Pennsylvania. Also, Ray DuCoeur who is the executive director of Westmoreland County Area Agency on Aging is here too. We are the two AAAs who provide the coaching in this project.

And we see it as an extension of our mission. You know, the mission of an Area Agency on Aging and also the AoA is to provide, to develop and to provide services to people to keep them in their home and to help them maintain their health and independence in the community. So, anyway, what I want to do is take you deep into the practical side of this. We are at the grassroots level.

We are an Area Agency on Aging. We work with people in the community. We work with our local hospitals there. We work with one hospital in our agency. Ray's organization works with three hospitals in his county. So we want to talk about – what I really want to talk about is how we got started and moving on in this endeavor and as coaching.

First of all, we first met, as Naomi said, we talked with Dr. David Wenner, who's a Medical Director of Quality Insights of Pennsylvania, the QIO in Pennsylvania. And we had also then had numerous and he talked to us about it and helped us understand how this could be a part of our mission and how this is part of our natural process as providing services to older people in the community.

There were numerous meetings with hospital, with the QIO, face to face, emails, phone calls, and those continue, of course. We developed a workflow process. We developed responsibilities, posters, handouts, the PHR, the personal health record, things of that nature. Whenever we identified staff, and these are part-time staff. These are folks who are already working full-time with our agency. So these are part-time staff performing these coaching

duties. But we looked at – well, two of them are nurses. Two of them are nurses. There are 10 altogether between our two agencies, registered nurses.

The others are human services workers. And we look for a very above average knowledge of medical conditions obviously. They need to be flexible and they had to have good organizational skills. The roles, whenever we looked at roles both with us and with the hospital and this was very important. We wanted to do respect the policies and the limitations of each organization. We needed to be open each other's comments and suggestions. We needed to compromise. There was a lot of compromise as Naomi said.

We did run into some problems, but that's OK. We worked things out. And we were honest with each other as far as working through the issues, the concerns, and those types of things. We did attend, as Naomi said, Dr. Coleman's training. I attended as an administrator. Ray also attended along with our coaches, so that was done. And we felt that was important from the standpoint of, the administrative standpoint that we have that strong administration support and involvement.

OK, the implementation process, and a lot of you have heard this already, but just to go through it one more time, we were following the same criteria. We began coaching actually in July of 2009. So, we were one year, this QIO was one year into the project. The target population is the Medicare Fee-For-Service beneficiaries. We identified folks who were alert oriented or a caregiver who met that criteria, who was alert oriented. People who were able to understand the concepts of the program. They could follow direction and have a potential to take control of their medical situation. The diagnoses we looked at were congestive heart failure, COPD, and a few other diagnoses such as diabetes. We also transitioned the coaching, or excuse me, we coached folks who were part of the ZIP codes. So there were target ZIP codes as mentioned before in the project so that was the other selection criteria.

Some lessons learned. The QIO role was vital. They were able to, with their project coordinators, work with us with Naomi's help and just vital in helping us understand and the communication between us and the hospital, also

understand the whole concept of the model and what we were working with. We had worked with a hospital for many years. Both of us had. Both of our agencies had done that. However we were able to better understand what the hospital staff was going through, understanding their major concerns, their relationships with patients. We also, the coaches were, as we moved through this, the coaches became part of the hospital family. They were accepted into that. So, they go there and I'll tell you in a second exactly how we worked this, but it was a part of that and what bears it out as Naomi mentioned, the questionnaire that was done, there was improved involvement and there was value in that collaboration with the hospital.

The value of the onsite hospital visits. What we do, the coaches go there one day a week for a few hours to meet the patient. These are referrals coming from that hospital. The coaches then make contact, make that initial contact with the patient, possibly the family is there too. They develop a rapport. There's very consistent follow up. Whenever we are on the phone, we are making that home visit, there is a lot of, you know, there is a rapport. They know us. They know who we are. The AAA is known in the community. We walk in, our coaches walk in and say "I'm from the Area Agency on Aging" and they say, "Oh yeah, I know who you are. Thank you for being here." And so we have a recognition in that area. Moving on.

Limitations. Resources. We are very committed to this project. Both of our Area Agencies on Aging. However, our AAA, neither one of our AAAs receive any type of additional funding to provide this coaching. We feel that due to those funding constrictions, that only 8 percent, well, we know that only 8 percent of discharge patients were coached. However, hopefully with increased funding, we feel that we could, would hire more coaches that could be trained and thus, we could lower the visits, or excuse me, the risk of rehospitalizations back into the community.

Couple of success stories. And just very quickly, because I know I'm running late. Quite honestly, as I said, this is part of our mission. So, not only were we coaching, we were also receiving referrals. A lot of these people were already known to us. So a lot of the people who we saw we may already know and

may already be providing services to them. People that may not be known to us we were able to very smoothly transition into the provision of services. Monitoring them, keeping them and providing other services. Taking referrals. Couple simple examples, and I think the doctor from San Francisco mentioned this this morning... about transportation. That's happened a lot. Where a patient says, well I'm not sure how I can get home from the hospital. That's a very simple barrier that we, well that's a barrier that we can simply resolve within our agency. But, anyway, those were parts of the... a couple of stories. We've had a number of stories. One of them being with a person with anemia who was in there.

They were able to identify their medication. They knew they had to go to the doctor. However the doctor, she had not called the doctor yet. The coach was able to convince her and help her, coach her to call the doctor. The coach also identified an over-the-counter medication that was – that she was taking that her physician wanted her to discontinue. So we were able to do that.

Just simple things like that, but very important things like that. Things that we were able to do become second nature to us. And we learned from coaching also. And the training was excellent. The training was excellent so. So that's pretty much what we're doing. And I know as we have questions and answers, we may be able to provide you with some more information. Thank you.

Laurie Robinson: My name is Laurie Robinson and I'm from Baton Rouge, Louisiana. And we're going to tell you a little bit about what we're doing. OK, great. I've listened today and this whole week about our projects and transitioning care and not calling this discharge planning anymore and all these wonderful things. And I've heard a lot of things today that I've written down that I want to be able to touch base with everyone on because I think they're critical pieces.

The first being skill transfer with this coaching process. That's pretty critical. We're trying to transfer the skill to the patient and the caregivers. Modeling behavior, that's how people learn by doing and empowering them to do. So

that's pretty critical with coaching. Selecting the coach, this is one of the most important aspects of implementing this intervention. You got to like people and you got to be patient and you got to be a listener and you have to be able to sit on hands.

The coach is a safety net when all the other interventions don't work. We can rearrange discharge and we can change all these processes, but on occasion, processes aren't 100 percent. The coach kind of is that little safety net for the patient in the event the process is broken. I heard the compliance and patient adherence, and I'll talk a little bit about that, but we don't even say those terms in that process anymore.

And motivational interviewing, that's pretty interesting stuff as well, but we use some of that when we first get to know the patient but don't use it really beyond there. So let's talk a little bit about us and we're going to start kind of with our objectives. I'd like for you to be able to identify barriers to smooth transitions by the time I get done here today. Maybe just a couple that resonate with you. Also, to understand the role of the coach and the role of the patient in the coaching relationship, I think that's critical, before you embark on something like this in your own environment.

I'm going to start with a story because I think it's real important. Some of you may have heard this story. It's not the same story from yesterday or the day before. But I have a couple of real live patient experiences that as a nurse and a case manager and a caregiver and a patient in the past that has struck me as one of those Aha! moments. I may have been doing this wrong for 25 years, but anyway.

So we start coaching in a smaller hospital. This was like the third hospital to come onboard with this intervention. The coaches in our project are employed by the QIO, so we go in and we do this kick-off rally. And the first thing that we are there to do is to be the solution to the revolving door patient. We're going to, you know those frequent flyers that have lost their name and identity because they're the frequent flyer, which is not always what we're there to do but it's part of the what we got to get over to get the project started in a hospital.

So we go in and the first patient they select for us to take is an intensive care, which is not a great place to learn or coach a patient. But we say you know, maybe we ought to wait until she moves to telemetry and, oh, no, no, she's just there because we don't have a bed. And the other side of me, the utilization nurse, says, oh god, please don't tell me this. But, anyway, so we say, OK, we'll go in.

And they give us the down and dirty on the patient. And she's a 45-year-old Medicare patient who basically, dual eligible, who they basically said, you know, if she would just quit drinking all that Diet Coke and eating all that salt, she wouldn't be back in the hospital. She has congestive heart failure and she just really is non-compliant. She doesn't manage her disease.

So, OK, well, we'll go meet with her. Well we go in to the ICU and Ms. Kaye is in the bed, a lovely lady. She's 45 years old. She's disabled. She has CHF, COPD, hypertension, diabetes – I mean I would be in the fetal position under the bed if I had to manage all those things myself, and I'm a nurse, OK – insulin independent. She is raising two of her grandchildren because her daughter as she put to me “loves crack more than she loves her children.”

Her husband has died two years ago with COPD and was in hospice at home when he passed away while she was raising two children; and has a daughter who is in her mid 20s who has a closed head injury, so she's a walking wounded. OK, she might need to drink a Diet Coke every once in a while. So, anyway, so I walked out of that ICU cubicle thinking what have we all missed here?

So she transfers to tele and we continue to follow her in the house and it becomes very apparent to me that the coach is really struggling to get this whole warning signal across to her. And, you know, I'm just observing this and thinking, gosh, this lady, why are we missing this? So I just start to quiz her a little bit about her heart failure to see what she knows – absolutely nothing.

She's an end-stage heart failure patient that doesn't know that her heart pump is not going to get better. We have missed the boat, OK? Nobody has established the "why" for all of this treatment we're giving her and all these things we're demanding that she do, OK? So, we start to work a little bit more with her in that respect. She transfers to skilled care to beef up her walking and all the other things because she's got to care for herself and all these other people so they transfer her to skilled care.

And we go in on a Monday after a weekend. And she is leaning over the bedside table in visible respiratory distress. The coach comes running out and she says, "Oh, my god, Laurie, something is really wrong." Like what is going on? She said, "She can't breathe. She can't breathe." And I said, "Wait a minute. We are on skilled and we are fixing to get ready to go home. We should be doing our coaching discharge session. What's the deal?" So, I go in there.

She visibly is having some struggles. She tells me her weight is 9 pounds over what it was on Friday. And they keep turning the oxygen up but it's really not helping. Well, anyway, so, I turn my nurse hat on at that moment and I go out and speak with the charge nurse. And one critical piece the patient tells me. "You know that water pill you all are teaching me about? They haven't been giving it to me. No, they have not been giving me that. I've been watching my medicines every day like you told me to. And they're not giving me that water pill. And that's why I think I've gained this weight and I can't breathe."

Now, she was getting warnings signals whether we knew it or not, and so sure enough I go out and look at the medical record and the lasix had not been continued over. So we talk to the charge nurse. She assures me she's going to call the doctor, and so I figure that is settled. We go back to the patient. I said, wow, what a great opportunity for this patient to talk to this doctor in this controlled setting and we can maybe get a good, you know, success out of this.

So we role played with her in the house what she was going to say when the doctor made rounds. I said, "Can you do that for me? Can you talk with him

about this lasix situation?” “Sure I can.” Knowing that he was going to know when he walked in the door because the charge nurse was going to handle that. The charge nurse did not handle that.

The doctor walked into the room and the patient handled it with the doctor. And the doctor challenged the patient and the patient challenged the doctor back. And the doctor went to the medical record and the doctor came back and said you are right. That patient – that experience for that patient of the treatment team telling the patient “you are right” was incredible. I just can't tell you how she felt the next day when we got there other than she was really angry that she spent all night in the bathroom. But she was nine pounds down and she could breathe. She totally in a controlled setting saw the relationship between her warning signs, how she felt, how to interact with the treatment team was successful. And what a great story. Now, that wasn't good for her heart or her physical condition, but patients do not activate in the hospital.

For those of you who treat patients or have been in the hospital, you know they become very submissive to us as the treatment team, our secret society that we don't let them into. So for her to do this and have the confidence to do this was incredible. And I attribute that to coaching and the relationship that a coach establishes with the patient which is trust. The end of the story, she was discharged. We did follow her outpatient. She did readmit, but not in the 30 days. But when she readmitted, she did talk with the social worker about other options. And she said, “You know, you told me about this hospice stuff and my heart was not going to get better and I cannot take care of what I need to care of in this hospital.” And she opted hospice and hasn't been back in the hospital.

And from what I appreciate, is improving. So our CMS project is in the Baton Rouge community. We collaborate with hospitals on process redesign as well as partnering with patients and caregivers and we provide patient tools and hospital tools and we track our success. So here's what we've identified are the drivers of rehospitalization in our community. And as we've work with the other 14 QIOs, and we all talked together about these things, they're pretty much not unique to us, OK?

So fragmented patient information. So we've already talked about data going back and forth, right, between provider care settings. Inappropriate end-of-life care, recognizing that, talking to patients about their options and getting them plugged into appropriate end-of-life care resources. Medication issues, we don't have to go any further on that one. At risk patients are not being properly identified at discharge. We're not doing our due diligence in the hospital to say these patients have risk factors that we need to talk to somebody else about.

Lack of post discharge follow-up, only 50 percent of our patients were hitting the mark. And getting that doctor visit, you know, you can make the appointment, but if the claim doesn't hit the system, it didn't happen. Lack of disease specific protocols. In hospitals, care maps have kind of gone away in some hospitals. I was amazed because I was in the hospital 25 years ago when we had to write all those things. And I got back to the same hospital and said, "Where are the maps?" "What maps?"

OK, that was a lot of work for nothing. And then there's no protocol in the downstream provider, so there's no seamless care map. Patient adherence to the care plan, sometimes they choose to do that and that's an A-OK thing. Patient knowledge deficit, what I just talked about with Ms. Kay, her not really knowing what was wrong with her. And that impacts them being able to make decisions. And then certainly lack of community awareness that we had a problem.

What does the coaching intervention drive to do? How does it address some of those drivers of readmission? Certainly, patient fragmented information. The single common thing in this whole thing is that you have to have a patient to have an admission, right, or discharge or readmission or doctor's visit. And if they have a portable record in their hand that's relatively updated with their medicines and what their diet is and how much fluid restriction they're on and what their – when they were supposed to stop their antibiotics and what their weights have been, wouldn't that be wonderful if they showed up to us with those things?

Medication issues, medication reconciliation form is critical. The patient writes it in their own handwriting. You know, it's not something that the treatment team prints and hands them, right? It's the patient taking that at the moment of discharge, we take the discharge instructions and they write it in their handwriting however they want. If they want to write water pill for lasix, they can write water pill, but they write it in their own handwriting so that they can have a document that's theirs, that they own.

Lack of post discharge follow-up, you know, a lot of folks are stepping out there and making those appointments for patients, but what we're finding is that that doesn't secure the – that doesn't guarantee the patient is going to go to the appointment and so it's critical that the coach help to drive for that patient why it's important. What we've also noticed if the patient has to invest in making the appointment and the coach helps them to do that that they go to the appointment. You know, getting through the gatekeeper is difficult. I have terminology as a clinician that I know how to get through the gatekeeper. I just insist on the nurse and if I don't her than I insist on the doctor calling me that afternoon. The patient is quite comfortable with that, so we help them with that.

And then help them with adherence to the care plan. If they can't do the fluid restriction, OK, tell the doctor. He needs to be able to know that that's what you've chosen to do, so that he can help to maybe make some modifications that make this all better. And then address the patient knowledge deficit with tools.

If I can drive nothing home to you, the different track is the person that is, you know, hired to do just this job. We know what happens when case managers that are utilization review nurses and also have to do discharge planning and also have to do what happens. That this gets diluted and then it's not effective. So the coach needs to be the coach.

The coach empowers and encourages the patient to self care. The patient and the caregivers in this relationship are the doers, not the coach, right? If the patient says, can you call the doctor and tell him that because you said it so well. No, actually, you know, if they have questions for you, I can't answer

those. So let's go through it one more time and then I know you can do this for me. You can do this.

The coach reinforces the discharge plan. The coach doesn't determine what the plan is. The treatment team does. The coach is just a complement to the treatment team. And we do this through a series of hospital visits and telephonic follow-up. We get our patients from hospital management teams and from case management teams. And we go on the units and we work with those guys to get these referrals. I'll go through this quickly.

We have Fee-For-Service Medicare beneficiaries. These are the diagnosis, AMI, COPD, CHF, and pneumonia that we cover. We added COPD because our hospital said you're really missing the boat if you don't add it. And we do it disease-specific because we have a tool that we give patients that are warning signals, right, when to call on yellow rather than red.

So if you're CHF, that means a 2-pound weight gain and then we realize that the hospitals weren't telling the patients what they weighed when they left. So when we said, OK so what's your target weight to call the doctor on? Well, I don't know. I don't know what I weighed when I left the hospital, so the intervention had to change again. But the key there is that there are specifics to each diagnosis that are critical for the patient to be watching. So we created tools that were specific for those.

And we want to be able to engage with caregivers as well. You know, the patient has a network that we've talked a whole lot about this week. And if you can engage the network as well as the patient, so the patient's network, you're going to be more successful in coaching. Just a little bit about our process, our hospitals push back on us really hard, you know, we agree with it. We're drinking the Kool-Aid, but we are not going to fund this. So figure out a way and we'll be happy to work with you. So the QIO say we'll resource the coaches.

For sustainability purposes, because I'm going to tell you I truly, truly believe in my heart that a home visit is the way to go to see patients in their environment. The hospitals told us we cannot sustain that, not with the 600

beds in this house and 75 percent of those being Medicare. So we said, OK, what's something you could do? If we leave here in three years what can you continue to do because we want to be able to keep going? They said we'll consider telephonic. So that's why we went to a hospital and telephonic model, to look at sustainability.

I can tell there are home care agencies in our community that want to do this as well. They've trained in the model, but have not been able to pull the trigger for whatever reason. I think part of the difficulties, you got to see it on two tracks. You do have to see that coach separate from their home care nurse. We do our telephonic follow-up, 2, 7, 14, 21 and 30-day. Two-day because home visit would have occurred in that time. But two day because the patient that didn't fill their prescriptions, you're going to catch them at that time. Too much time had not lapsed for them to have a boo boo if they've interrupted their antibiotics.

Seven-day because you're either fixing to have that doctor visit or – fixing to have – don't you love the Louisiana phrase? Or the patient is getting, has just come from that hospital visit and you need to reinforce those changes that need to occur on that plan of care, if medication changed or diet has changed or something has changed. Fourteen days just makes me feel better. I just think that if you go seven days without talking to folks, they're going to say I'm done. I'm, you know, throwing in the towel.

Twenty-one days, most people who have changed, their diet is slipping and they're starting to see, make some changes in their plan of care that they're not really confiding in you about, they start to have some physical changes. And 30-day because that's when we do our follow-up to say how did you like this program. You made it, you know, would you recommend this to other folks?

We are doing a 45-day call because after 30 days people started in it, well, what this is about. The minute we stop calling, they start going back to the hospital. At each interaction, we focus on those things I talked about. The plan of care, post discharge plan of care, medications, discharge follow-up and any other follow-ups that need to occur with specialists, warning signals, the portable health record or personal health record and the patient-centered goal.

The patient-centered goal is the why. And when they understand what's wrong with them and you tell them connect treatment and adherence to treatment, to go into that soccer game to be able to watch it from the field rather than the car, going to church, going to the mailbox, going dancing, then it all seems to fall into place.

These are some of our results. We have one, two, three, four, five hospitals – hospital D had a huge C-suite overhaul in the very beginning of their coaching. And it was very labor intensive for them to keep up that intervention in their hospital. They agreed to some of the other interventions we had put into place, but you'll see their referrals were low and relatively, you know, when you have 10 coached and 4 readmitted, your readmission rate is not going to look so good.

And hospital E just came onboard, but you can see that hospital A came onboard first, we've had the most referrals from that hospital, and they actually have hired a coach and have reaped the benefits and see the benefit and their patient satisfaction scores with regards to discharge, satisfaction with discharge and medications have also soared. Good stuff about coaching, can't say enough about it, can't say enough about how the patient is the solution to this problem. Thank you.

Long Term Care Transition Models

Linda Magno: OK, thank you. I'd like to thank all of our panel. And I'm being signaled that in the interest of time and moving the program along, we really don't have time for questions at this point. So I'd like to ask you to join me in thanking our panel and hope you have an opportunity to ask questions later.

I would now like to invite our next panel up to the table. And this includes Dianne Richmond, RN, MSN, the Theme Lead for Care Transitions and Patient Safety from the Alabama Quality Assurance Foundation, and Sara Butterfield, RN, BSN, Senior Director of the Healthcare Quality Improvement at IPRO.

Dianne Richmond: Good afternoon, everyone. I'm Dianne Richmond and I am the Theme Lead for the Care Transitions Project in Alabama with Alabama Quality Assurance Foundation, which is the QIO or the quality improvement organization for the state of Alabama.

We are part of the 14-state sites for the care transitions demonstration project. And I want to share with you a little bit this afternoon how we are using INTERACT to reduce 30-day readmissions in our project. This toolkit of interventions was actually developed by our sister neighbors in Georgia, Dr. Ouslander and Mary Perloe and their team were very instrumental in getting this intervention toolkit available.

It started out with the CMS special study and then it was later updated with funding by the Commonwealth Fund. What we do know about acute care transfers is that they do occur commonly. It can be quite disruptive to the nursing home residents and that there's a great potential for medical complications when the patient is transferred to the acute care facility resulting in delirium, incontinence, inappropriate use of Foley catheters, pressure ulcers and polypharmacy.

We also know that this is very costly to our residents. In the original study, they did discover that of the 200 patients that they reviewed through medical record review that 68 percent of those were potentially unavoidable readmissions. They were able identify the top 10 admitting diagnoses of which informed them on what to focus on as a developed targeted interventions that are now included in this toolkit to improve care and reduce cost.

The goal of the INTERACT toolkit is to aid in the early identification of resident change of status and to guide the staff through a very comprehensive resident assessment when a change does occur in the resident. It is also designed to improve the documentation around the resident's change in condition and to enhance communication between care providers.

The INTERACT toolkit is organized around four dimensions – communication tools, clinical care paths, advanced care planning, and then the

quality review tools. The early warning tool is used for the non-licensed staff. And it was designed specifically for them because they spend a lot of time with the resident. They develop these very trusting relationships and are sometimes even viewed as family or extended family to the resident and they are more likely to be able to pick up on any changes that these residents experience.

There is a mnemonic stop and watch that is used, the cues the CNAs to be able to determine whether or not this patient is experiencing a change such as they seem a little bit different than usual or that they have – they're not eating as much or their weight has changed. So they are able to pick these up very quickly. They use this form to communicate those things or document that they've communicated those things to the nurse.

Another communication tool is that – was developed is the A to Z listing of signs and symptoms of changes in a resident. It also directs the nurse as to whether or not these are things that should be reported immediately or if it is non-immediate or if it is routine, meaning, that they should pick up the phone immediately and call who is on call or wait till the next day or to the next routine visit or call to the doctor.

Another communication tool is SBAR. And most of you are familiar with that tool. What SBAR does is helps the nurse to organize their thoughts around the information that needs to be transferred to the next care provider who would make decisions about the patient's care. With SBAR, you are going to be looking at being able to determine what the situation was, what the background information related to that resident is, what is the possible assessment or what is going on with the patient and then to either provide or seek recommendations from the care provider regarding what the next step should be for that patient. Ideally, this tool, if the patient requires to be transferred to the acute care facility, should also accompany the patient during that process.

The clinical care paths are algorithms. What they did with this toolkit is to identify six care paths which represents the most common reasons why residents are transferred to the hospital and they develop these algorithms to

guide the nurse decision-making along that process, so that the nurse understands when to notify the doctor, or what assessments should take place and then there are decision points along those algorithms that would guide her actions regarding whether further assessments are due or whether the patient, whether you're to call the physician now or whether you're to get additional assessments and then whether or not the patient ultimately to be managed at the facility based on the capabilities or be transferred to the hospital.

Another tool is the advanced care planning tool. And the advanced care planning tools help start the discussions around “Is it time to seek hospice or is it time to do palliative care, is it time to do a do not resuscitate, is it time to do a do not hospitalize?” and these tools were designed both for the staff and for the family.

Then the quality improvement review tool is designed to be used with every case that results in a transfer to an acute care facility whether it is admitted to the nursing, admitted to the hospital or is just assessed in the ED.

This tool looks at background information of what was transpiring at the time that the patient was transferred, who authorized the transfer to the facility, was it actually necessary for the patient to go to there, did we have the capabilities at the nursing home to actually manage the patient here as opposed to transferring them to the hospital.

What happened in one of our facilities was that the hospital Chief Medical Officer actually noted that two particular nursing homes had a spike in admissions and wondered what was going on with the nursing homes. He wanted us to meet with the Medical Director at the nursing home to try to figure out what was going on there. What we discovered that the readmission rates from the nursing home was consistent with what the physicians were experiencing at the hospital.

So we met with the Medical Director there who thought that others on his staff, of course, were responsible for all of these readmissions. So we went to the nursing home and we sat with them and they had fully implemented INTERACT and as you can see where they had been up to about 30 percent

and for some reason went up to about 40 percent on their readmission rates had come down sharply to just over 10 percent, but then there was a rise for some reason.

So we had the opportunity because they were using INTERACT to go back and do a 12-month look back and what we discovered on the 12-month look back and I know that's very difficult for you to see if you haven't printed out the handouts, but what we found out with the 12-month look back is that we had seven patients who were basically responsible for about 26 transfers. And of those 26 transfers, 25 of them actually resulted in rehospitalization. And the Medical Director was responsible for about 46 percent of those transfers.

We also were able to discover by doing that look back because they were collecting these data even though they were not acting on it, they were collecting the data. So the data was available for us to aggregate and we were able to see that a patient was most likely to be readmitted in that facility on a Monday and they thought it was a Saturday or Sunday, but Saturday and Sunday are not innocent.

They do seem to have a lot of transfer around that time so they were able to try to focus what can we do on Saturday, Sunday and Monday to try to prevent these transfers. They also discovered that the transfers were happening more on the second shift, because they thought it was happening at the night shift. But actually it was on second shift where these were happening.

They looked at all the capabilities that they had at the facilities and they were able to determine that what was needed to manage the patient at the time that their condition was declining was available at the facility. So, there were no changes needed in that area.

They also were looking at those clinical conditions that prompted the patient to be sent to the hospital and they found out that fever and altered mental status were the primary reasons for the patients going to the ED.

They also looked to see if there were some communication problems related to these transfers. And most of them seemed to be in the other category, which those of you who are in long term care know that there are some pressures from family members that say we want them there.

And so, they found out that that was one of the biggest pushes for patients getting into the – getting back to the hospital. They also looked to see what proportion of those patients already had – do not hospitalize or do not resuscitate orders and 44 percent of them did have those, but it gave opportunity to look back at those others and say who are those patients that we now should start those discussions around do not hospitalize or do not resuscitate.

And they also discovered that majority of the patients that went to – or the majority of those transfers, the patients ended up in the medical surgical unit, which gave them an idea that now we can narrow it down to who we need to talk to and who we need to communicate with.

They also discovered that as far as days out from readmission that the majority of those – the majority of the patients were admitted between the 16th and the 30th day at 75 percent. But they had 25 percent of the patients who were readmitted within seven – three to seven days of discharge from the hospital.

So, with that information, they were ready to start looking at what they can do to actually impact that. One of the things that they did start to do was to look at those patients who might be ready for advanced care planning. They also looked back at their staff because they had had some turnover over the period of time since the original training for INTERACT and looked at those staff who might need to have training so that the algorithms could be more fully used.

They also, in our referral – hospital referral region, we had established a relationship or an improvement team where there is what is called a nursing home – a hospital nursing home improvement team where you have persons or key stakeholders from both of those settings, meeting to talk over issues.

And one of the things that we have recently started to talk about is to have person-to-person telephone contact at the time that the patient is being transferred to the facility so that they can understand that perhaps when the patient arrives in the ED and they see the mental – the altered mental status that this is not the reason. This is the baseline altered mental status and is not the reason why we're sending them to the hospital and perhaps they could stabilize and send them back, and it does not result in an actual hospital admission.

So, because that graph that you saw earlier – on the graph that you saw earlier – let's see if I can get back to that. Because that process does not appear to be stable, we're hoping that once these tools, once they start using the information that the tools provide for them that we can stabilize that process and that these patients will be less likely to end up back in the hospital. Thank you.

Sara Butterfield: Good afternoon. My name is Sara Butterfield and I'm the Project Leader for the IPRO Care Transitions Initiative. We're one of the 14 states selected by CMS to focus on care transitions.

And I'm going to talk today about the home health side of reducing readmissions and improving transitions of care and the experience of the patient and caregiver. And we're going to look at interventions and strategies to help travel down the yellow brick road.

We have been privileged to work with our home health – Medicare-certified home health providers in New York State since 2000. We were one of the pilot states selected by CMS to train our home health providers at that point about – over 200 of them in outcomes based quality improvement.

And you can see that our New York State home care providers have been working on initiatives to improve patient outcomes along with us for the last 10-year time period. In 2003, home health providers started having their acute care hospitalization rates, emergent care rates, improvement in medication management, improvement in pain, outcome measures publicly reported.

And since then, they have been working to improve acute care hospitalization and emergent care. So, this is something that has been engrained and they've been working with right along.

What I'd like to share with you today is some of the interventions and strategies that have proven successful for our community and also kind of crosswalk those two – the Home Health Quality National Campaign, HHQI, that is a CMS-funded project and has abundant tools and resources online for you to access. Now, if you're not a home health provider, it does not mean that these tools and resources don't apply to you. As you'll see from Dianne's presentation, there's a lot of crosswalk over for some of these tools and strategies that are applicable to all of the provider settings.

So, we found within our target community some of those drivers of readmissions that you've heard a lot of people talk about, is really lack of a cross-setting – and that's the key word here – lack of cross-setting, care coordination, communication, even providers within the same health systems really have never sat down to really talk about what's happening as patients are shared between and transition between their settings. Lack of a medication reconciliation cross-setting process.

Everyone has developed an excellent reconciliation process for their siloed setting but not sharing that information as patients transition from one setting to the other. Patient, caregiver activation and self-management you heard in the previous session, very, very important.

Assessment of patient and care goals at the time of transition and really letting go of that, we're discharging the patient and what can we do now to make sure that they're successful in their next level of care, provide that provider with the information they need to prevent them from having to be readmitted to the hospital. Then, certainly, lack of a formal cross-setting information transfer.

And what we've found as the foundation of success for our program is really partnering all of the provider settings together. I mentioned before that home health has been working on acute care hospitalization and emergent care for

the last seven-year time period. And many of the home health agencies did demonstrate success in reducing those rates.

But what was loud and clear and we were able to identify in those first stages of the program was it is not something that one provider setting can do alone. It has to be the community. It has to involve all of the cross-setting partners.

So those partnerships, we partnered folks together, all of the provider settings by community to actually talk about what's happening to patients and caregivers as they're moving from one area to the other. We made sure that we used a patient-resident focus and not blaming any one setting for the gaps in communication and information and care coordination that were occurring.

We helped each of the organizations really do a self-assessment, much like you heard before, not specifying that these are the interventions you're going to do, but let's look at what the particular issues are for your organization and let's look at what strategies to improve those.

Multidisciplinary involvement, important to have that senior leadership buy in but also to have that direct care staff involved in what's being planned and implemented. And also shared learning, and lots of celebration of the improvements. I think in health care, we don't tend to do a lot of celebrating of even the small improvements.

I mentioned before the Home Health Quality Improvement Campaign. And this is a national campaign that home health agencies have been invited to participate in. The first stage of the campaign started back in 2007 and supported a lot of the work that we did with home health providers in the 8th Statement of Work.

The campaign was reinitiated in 2010 and is currently up and running. And you see on the screen there the website access to be able to look at the tools and resources. And truly what you see there is a real community patient-centered focus that really touches on all types of providers and including the community stakeholders.

And what you will find on that site is online resources, most of them, and lots of tools, most of them in Word that you can customize for your organization. And again, they do not just speak to home health care. They are applicable across all settings.

And as I talked to before about some of our drivers of readmissions, I just wanted to touch on some of the tools that are on that website and some of the strategies that our providers did within the Care Transitions Initiative that have helped them.

On the Home Health Quality Improvement Campaign site, there is an acute care hospitalization risk assessment tool. And one of the things that is important is as you start to do your work, is to be able to identify who your high-risk patients and populations are so that it will enable you to do something different for those populations.

So, this tool was particularly helpful because it was based on individual case mix. You could customize it for your organization. It crosswalked to the OASIS questions. It's used at start of care, resumption of care as patients come back out of the hospital or come on to service. And many of our providers hardwired that to their electronic health record system so that folks on off shift, those people covering on the weekends, could really identify who their high-risk patients were.

From there, looking at front-loading visits. We know that most of our rehospitalizations from home health care in pretty much all settings are within that 7 to 14-day time period. So, front-loading visits so that the home health care providers are in there during that critical time period to get these patients settled.

We've had great success. One, with our home health providers on the care transitions initiative has implemented telehealth for their heart failure patient population and has significantly decreased their heart failure readmission rate.

And one of our home care providers also implemented a palliative care program for their COPD patient population where those patients are being

more intensively case managed with excellent success in keeping them out of the hospital.

On the communication gap piece, Dianne mentioned the SBAR tool. And again, that's a cross-setting application. But, we actually have some of our home health providers that are using that as a reporting tool as one of the – as the disciplines report to the patients that they're handing off within their agencies so that all the critical points of the care of that patient are covered.

The stop and watch tool, very important to be involving the CNAs , home health aides in the care of their patients. They're the ones that are there in the home with the patients and patients confide in them and they know more about what's going on than the clinicians that are in there for maybe one or two hours per day.

Emergency department report, encouraging providers to call when sending a patient into the emergency department to give the staff there some insight on why that patient is going in. We found that in some instances the emergency departments are very willing to work with that home health provider to prevent that patient from having to be readmitted if they know they can be seen the next day and there can be an intervention.

And also cross-setting readmission review teams which was mentioned earlier. We have a few of our providers that are actually sitting down and talking about on a monthly basis which of their patients that they shared were readmitted and why, and what can we do different next time. And if they are one of those frequent flyer patients, who else can we bring in to this, can we build a contract with the patient, what can we do differently.

For medication management and reconciliation, this is one of those bigger drivers for readmission, those adverse events. For our coached patients that are receiving the CTI intervention, we found that 82 percent of them had at least one medication discrepancy as they transferred from one setting to the other.

So, we do have a best practice in our community where we have a hospital that has a pharmacy-based – pharmacist based on the unit. That pharmacist reviews the medications, prescriptions, what that patient was in the hospital for, reviews what they're being discharged on, looks back to see what they came in on, and what they were taking at home. And that's reconciled before they go out of the building.

The home care nurse, when she goes in then to open the case and if she identifies any discrepancies as far as what she's seen in the home and what the patient is actually taking, she then can reference back to that pharmacist and have that discussion of what occurred and reduce the time element that's being required for reconciling medications in the home.

The Medication Discrepancy Tool monitoring, which comes out of Dr. Coleman's work, really, we found that providers were identifying medication discrepancies; there were med errors that were happening all of the time. But no one was documenting them. Were they patient level or system level errors? How long is it really taking to resolve those issues?

And then the biggest piece, the important piece of this is sharing that information back with the sending provider so they can start to track and trend and put some preventative measures in place for those discrepancies.

Beers Criteria, you'll also find that on the HHQI site as far as medications that are high priority for adverse effects for seniors; as well as potential interaction alert systems, ways to simplify medications.

Most of the folks that we see can be on anywhere from 13 – we had one last week that was up to 21 medications. So, is there any opportunity, to look at what they're on, how often they're taking it a day to really simplify? And there's an export tool on the website that supports that. And then also the medication management care planning tool.

A few questions earlier today about partnering. We've had great success with our home health agencies partnering with our area college of pharmacy. So, those pharmacy interns go on site to the home health providers. They also

accompany the nurses out into the homes with the patients, look at what they're taking at home as far as what's prescribed, and also assist with the education of staff and patients.

And this is not unique just to New York. All of the interns, really, are charged with looking at this type of support. And there's been great success with this. We also have some of the pharmacy interns doing follow-up phone calls to the patients to see if their medications that they're taking them, they have any issues, side effects.

Starting to do some community pharmacy collaboration and looking at those pharmacies that – and encouraging patients and caregivers to use one pharmacy, but looking at those ones that are able to meet – best meet the patient's of that community's needs.

And then, cross-setting patient educational tools – and this isn't just specific to medication management. We were able to identify that sometimes patients were receiving two and three different types of heart failure educational tools that all provided different guidance.

So, our providers are working together with the hospitals so that they have one tool, it contains the same information, and the home health provider is able to see what the patient has learned once they come out of the hospital, so they can pick up the teaching and the education from there.

As far as patient activation and self-management assessment, we have had our home health providers – actually all of our home health providers implement the CTI model with success. And I'll share some of their readmission rates with you.

It's important to note that our home health providers really implemented a number of different interventions, but very successfully the CTI model. And they did have some struggles as far as how to differentiate that between the coach and the home health provider, what the difference was. And we had some struggles but we're all successfully up and running with that program.

Personal health records, again, part of Dr. Coleman's work – the red-yellow-green zone tools that provide guidance to patients and caregivers, all, again, posted to that website. Also in different languages so that you can access them and use them for your different populations. Some of them are diagnosis specific, some are symptom specific. So, very helpful.

Emergency care plans, reviewing of the teach-back model and the tools associated with that, and also, we've had great success with beneficiary outreach and really meeting with the focus groups of patients in our target communities and getting their perceptions of health care and what needs to change; again, going back to listening to your patients.

For assessment of patient and care goals at transition, we talked about the cross-setting teaching tools, assessments of learning. We have had success also. A couple of our providers implemented a hospital based case manager liaison that's actually based in the emergency department.

So, not only is she able to work with the emergency department if one of their patients comes in to setup care to prevent a readmission. But she also has that unique opportunity to meet with the patient in the family to see what caused that readmission – did they consult with the home health provider before they came in to the emergency department.

Nurse-to-nurse verbal report, we're trying to get folks back to this. We found that there's lots of communication being done by fax that contain patient information, but let's go back to where we actually nurse-to-nurse give reports. And then cross-setting referral teams where they're actually talking about different patients and sharing information.

Information transfer – we developed a universal transfer tool that we're starting to get providers to utilize and also supporting through work with our regional, our RHIOs, information transfer on electronic mechanism. And if they can't – some of the providers can't do that but can we get into a fax system when we absolutely need to.

Now, I promised to share some of the improvements that we've been able to demonstrate. So, you see here a comparison for calendar year 2007, '08, and '09 for the five home health agencies that are involved with this in the project. And you can see a significant decrease for most of them – or all of them in comparison to 2007, 2008.

We have a combination of provider settings here where we have two of the home health providers in urban settings, two of them are in rural settings, and one based within the city. And you really do see fluctuation as far as those patient populations, but success in implementing the program.

And this gives you a perspective of their actual percent reduction and the number of returns to acute care for their particular settings. And you can see anywhere from 29 or the 37, 45 percent reductions to 9.20 percent reductions. So, they've all been successful with these particular strategies.

So, I would encourage you to visit the Home Health Quality Improvement website. There are best practice intervention packages there. There are leadership tracks. There's just a quick reference, but there is abundance of tools and resources there, as well as success stories.

And you'll find our home health agencies in New York success stories embedded in many of those best practice improvement packages. So, you can get some information and thoughts about how to apply these tools and how they did it and how they had success with that.

Also partnering with your community referral sources, you've heard a lot of that discussion today. We approached that by getting the providers from all the different settings around the table to talk about what's working well, let's make a list of those, what's not working well and what's on your wish list to improve the next six-week time period and let's look at those strategies and get them in place.

And also, designing and documenting an implementation plan – so that something is in writing to guide that work. And with that, we've had success.

In the May-June edition of the Remington Report, you will find more detail on each of our home health providers and what they did as working on the care transitions projects. And that incorporates some of their strategies, their challenges, some of the barriers and how they worked around that. So, I would recommend – you can find that link on our website, which is listed on the caretransitions.ipro.org.

So, all these tools are there, a link to HHQI is there, and to that Remington Report, and happy to answer any questions.

Linda Magno: Thank you very much, both of our panelists. I'd like to go ahead and ask the operator to open the phones and we'll see if we have some questions out in the world of the audio conference.

Operator: At this time, if you would like to ask a question, please press star followed by the number one on your touchtone phone. Please state your name and organization prior to asking your question. To remove yourself from the queue, please press the pound key.

And your first question comes from the line of Roland Erika. Your line is open.

Roland Erika: I'd like to ask Sara Butterfield. She was referring to a website. Can she give me the website because we don't see it on the screen?

Sara Butterfield: Sure. It's www.homehealthquality.org. And that's the website the National Home Health Quality Improvement Campaign. Is that the website you're referring to?

Roland Erika: Yes.

Sara Butterfield: OK, great.

Roland Erika: That's homehealthquality.org, correct?

Linda Magno: Homehealthquality.org.

Roland Erika: Thank you.

Linda Magno: Yes. We'll take a question from the room while we're waiting for the next question to queue up.

Andrew Koski: Hi. Andrew Koski, Home Care Association of New York State. I just want to congratulate Sara and the work of IPRO, doing a great job with a lot of our members. You sort of alluded to the issue about how there were some – I don't know how you put it, but maybe some issues between the coach and the home care agency. And I wonder if you feel comfortable talking a little bit about that.

Sara Butterfield: Just as Laurie was describing before, the home care providers, and as a nurse, you're used to going in and providing skilled clinical services, so you're doing, you're assessing and you're tending to do more for the patient as compared to the coach role, which you heard people talk about - sitting on your hands.

So, within the coach role, you're not there to do, but to get to patient to understand or the caregiver how to do. That's been a challenge for some of the home health providers, because it's a different role for them and it's different – it's difficult to switch off that hat where you are used to doing and solving and feeling comfortable leaving knowing that you left the patient and the caregiver, with some follow-up to do.

It's different. You have to get adjusted to that. And we've had some struggles with that. One of the other struggles I think we had from the home health side is sending the coach and the home health clinician in on the same day.

That was not really – it did not work well for the patient. It overwhelmed the patient and it really confused them as far as what was the difference between the nurse being there and the coach being there. So that didn't work really effectively.

Andrew Koski: One follow-up, was the coach part of the home health agencies?

Sara Butterfield: Yes.

Andrew Koski: He was? OK.

Linda Magno: Do we have another call on the telephone? Hearing none.

Kristina Lunner: Good afternoon. Kristina Lunner from the American Pharmacists Association. I want to commend the work of the last two panels to address medication use issues.

Two comments based upon feedback we're starting to hear from our over 62,000 members. And that's I greatly appreciated hearing that – it sounded like the description of your Med-Rec program was beyond just pure reconciliation. There's a real concern that looking at the medication usage is just making sure there's an accurate list as opposed to making sure that the patient is on the right medication to begin with.

And there are, as we all know in this room, errors in that regard. So, I fully support what your work in that area. Additionally, I've – we're starting to hear some sensitivity. It's wonderful that pharmacists are – community pharmacists are, I think, getting increasingly asked to engage as consultants with nurses or case managers who are doing home visits, but there's not a formal relationship.

And there's some tension that I think is building up. It's great to hear that one of the programs you described had a pharmacist that that was their role and the person doing the home visit could go to that pharmacist. But just know that they want to be engaged in the community, but there's a sensitivity as these sort of random calls are coming up, —“Can you help me with this issue I've just discovered,” when there's no formal relationship or business relationship.

So, I just raised that as something to be aware of.

Gail MacInnes: Hi. My name is Gail MacInnes. I work for the Professional Healthcare Institute. So, you may be familiar with our work, but for those who aren't – we work to improve the quality of care by improving the quality of the jobs of the direct care workers who are delivering the care.

So, really, my aim was just to give you a comment and compliment you on recognizing the role that direct care workers play in helping to facilitate successful transitions. And I just wanted to encourage everyone in the room as you're working on implementing care transitions to consider the role of the direct care worker and the powerful role that they can play.

Linda Magno: Are there any other questions on the telephones?

Operator: There are no questions from the phones.

Transitional Care Model Implementation

Linda Magno: OK. In that case, won't you join me in thanking our panelists, Dianne Richmond and Sara Butterfield.

And I'd now like to invite our final panel up to the podium. And that consists of Mary Naylor, PhD, RN, the Mary Ware Professor in Gerontology and Director of NewCourtland Center for Transitions and Health at the University Of Pennsylvania School Of Nursing; Andrew Miller, MD, MPH, Director of Physician Services, Healthcare Quality Strategies Inc.; and Louis Colbert, MSW, LSW, Director, and Denise V. Stewart, MSW, Deputy Director of Long Term Care, Delaware County Office of Services for the Aging.

Welcome to all of you and we're going to hear in this panel about the transitional care model implementation.

Mary Naylor: Well, I can't tell you how thrilled I am to be here. For those of us that have been working in this field for a long time since we were 10, this is quite a day. This is an extraordinary day.

So when I received the invitation and I was – I had a little bit of a conflict this morning. I said there's just no way I'm going to miss this opportunity to be a part of a beginning of a movement around care transitions for beneficiaries,

doing what Don Berwick talks about and that is figuring out how it is that we will deliver better care, better health and reduced cost at the same time.

And so I've had the great fortune for the last 20 years to be part of a team, based at the University of Pennsylvania, that's been focused on this issue and to see 3026 of the Affordable Care Act and all of the provisions that are really in that Act that provide a road map to achieving what our Medicare beneficiaries and all that we serve deserve is really extraordinary. So I can't tell you how excited I am to be here.

I'm going to talk with you about the transitional care model and I know you've been here all day. And I can actually ask you what transitional care is, but because we all have a bit of nuances on these definitions, I wanted to make sure that you understood how it is that our team has been thinking about this work.

And by the way, we didn't start out this way. It has evolved over time. We've been thinking about transitional care and transitional care environments as those opportunities to target high-risk populations who really need more than we're currently providing, to assist them as they navigate an increasingly fragmented health care system, to really promote positive outcomes, assure continuity of care and prevent all of the things that we now know are preventable and you've heard a great deal about them over time.

We view transitional care as complementary to really excellent, advanced primary care. And so it's not one or the other, but rather a part of a system that really assists high-risk Medicare beneficiaries achieve their goals.

I had the great fortune a couple of years ago to work on a national quality forum group that began to think about how is that we can reframe the way we think about health care delivery and began to think about communities and populations at risk and how it is among those at risk people targeting those that are navigating increasingly our care system.

And so we talked about people moving from acute care through sub acute to the primary care network. But we recognized immediately that not everyone

navigating that is the same, that there are individuals who have an acute heart attack who are going to be fine if we give them the right information, the right support like good handoffs in terms of transfer of information, et cetera.

But increasingly, we are serving a population of people who have multiple complex chronic conditions often complicated by all of the social and other issues you've heard about today—cognitive impairment, lack of willing and able social networks to be available to support them during really vulnerable times, depression as coexisting conditions. And we also have a growing population of people who are using the acute care system who are really need to be in better palliative or end-of-life services.

And so we began working 1990 on the quality cost transitional care model. And right from the outset said we want to be able to demonstrate higher value, improve care and at the same time figure out how we can increase efficiency of the value of the investment that we're making. And we knew right from the beginning, that meant targeting people at highest risks for poor outcomes, the top 20 to 25 percent of the Medicare beneficiaries consuming the 75 to 80 percent of our expenditures.

We also knew long before it was named or framed that the only way to get from where we were to where we could be was by engaging the people, by engaging patients, by engaging the family caregivers, by engaging the community resources that are essential to long term success.

We began to understand pretty quickly that not everybody is on a great care management plan so that we couldn't start by saying we're going to move towards self-management, but rather had to figure out how to work with all the providers and all the players and again, especially directed by what people's goals were, what family caregivers' goals were on coming up with a streamlined, rational plan of care. We know from science that many of the people we serve are on way too many medications, often not the right plans of therapy, et cetera.

Once we get a great plan of care in place and everybody onboard with it, then we can begin to promote the kind of self-management, the early identification

that someone's running into trouble, the prevention of the risk factors that contribute to poor outcomes.

The rest of the model is guided by everything that we learned in nursing, in social work, in pharmacy and every other health discipline. It's going to take a village. It's about teamwork. People care a great deal about continuity, about coordinated care that's not just connecting the dots, but integrating care in a way that creates efficiencies and it is all built on a foundation of trust.

The unique features of this care model as it evolved is that that care is both delivered and coordinated by masters prepared nurses. The same nurse who begins to work with the patients at hospital admission continues to work with the patient throughout the hospitalization. If the patient is discharged for a period of time into a skilled nursing facility or rehab facility, they're there within 24 hours helping to make sure that everybody is onboard in terms of the plan of care and they follow the patients into the home substituting for traditional visiting nurse services. So there are not many players going into the home, there's this provider.

Seven day per week availability and you've heard about the importance of that, all guided by evidence – that which we know happens in the hospital to create the risk for poor outcomes or happens within 24 hours after discharge.

We know, for example, from following people 7 to 10 days, post discharge, they are at a low ebb functionally, physically, emotionally. It becomes a really important outreach time. So this evidence-based protocol guides the work of the team. And our focus is on long term outcomes.

What is it that we're going to be able to do today to interrupt a chronic illness trajectory, to interrupt the multiple hospitalizations that are resulting in people becoming increasingly deconditioned, increasingly vulnerable to risk going forward?

So this is something you can't see, but let me just stop there. Mr. Smith is admitted during a given hospitalization and immediately offered this service. An advance practitioner, if Mr. Smith agrees, comes in and does an

assessment of what the priority issues are, that if unabated, if not interrupted will result in poor outcomes for Mr. Smith.

The nurse will begin to work with all the players involved—pharmacists, social work, whatever the priority issues are, will engage the team members in helping to solve the problem, does outreach not just to the physician who's admitting, but all the physicians including the primary care practitioners because they know a great deal about what's going on and essentially uses the hospital time to really get somebody who has been not well, manage better position for better outcomes after discharge to prevent some of the seeds of readmission that sometimes happen during hospital admissions.

Is in the home within 24 hours, goes to the first visit with the patient and family to the primary care provider not just to position the patient and family to how to maximize on a 20 or 25-minute time, but also to establish the collaborative relationship with the primary care practitioners so that two weeks later, three weeks later the nurse is in the home and the patient is running into trouble, they can collaborate with each other. There's a trust established and there is a better opportunity to avoid unnecessary acute utilization.

And the nurse will continue to work with the patients and family caregivers until they are no longer at risk for poor outcomes. In our work, that's been shown to be an average of about two months, but ranges from one to three months.

So what are the core components? This is a holistic approach. It recognizes that there are many person and family and system factors that contribute to poor outcomes and we need to be thinking about how it is that we're going to focus on the individualized needs but within the context of knowledge that it's going to take more than just looking at medical management.

It is a family-centered approach because we recognize the central and critical role that families play in assuring. And families, in this case, broadly defined—it could be a neighbor, blood relative, et cetera, whoever is going to

and willing to get involved in the care in order to contribute to positive outcomes.

I should also mention, it's a community-based approach because these nurses are capitalizing on community resources to assure positive outcomes. It's nurse-led, but it's team-based. It capitalizes on the skills and expertise of every team member. It is protocol-guided. A principle is streamlining the plan of care for many people whose regimens are way too complex, a single point person throughout the acute episode with information systems and a focus on increasing value in the long term.

So across multiple clinical trials, NIH funded, we've demonstrated consistently the capacity of this approach to care to delay first time readmission or time to first readmission, to improve health, physical function and quality of life, to increase the satisfaction with the care experience, to decrease total all cause readmissions and in doing so, decrease total all cost. And we look at all costs except out of pocket and cost for medications.

So this gives you a sense of what the first three randomized clinical trials demonstrated in terms of reductions. We started where many people do. Could we have an impact on discharge planning and immediate post discharge follow-up? And we showed we could, but it was short term. We then said, "Could we affect change by adding a home care component, targeting high-risk individuals?" And we showed that we could reduce readmissions through six months by more than 50 percent.

But we then had the opportunity to look and say, "Did we do it well for all of the diagnostic groups?" And we found that we did not do as well with patients with heart failure who are in many ways emblematic of the complexity of challenges people face today, multiple chronic conditions, multiple other risks and on a downward trajectory path. And that became a focal point of our latest reported clinical trial where we showed reductions in all cause readmissions, all cause readmissions through 12 months.

This shows you the impact demonstrated in terms of savings in these clinical trials with the latest reported trial demonstrating a mean savings per Medicare

beneficiary after accounting for the cost of the intervention of \$5,000. And again, this is all costs. We've looked at home health, skilled nursing, acute care visits to physicians, emergency.

So you would think with these publications in the right places, right journals, great reviews that you all would be saying, "Let's do this." And we learned that it takes more than just publishing papers in order to accomplish meaningful change. We had to begin the work of working in partnership and collaboration first with the managed care organization, then with health systems, all funded very generously by a number of foundations listed here and some represented in this audience to help say what's it going to take to move evidence into the real world of clinical practice.

We were very fortunate to have a fabulous project officer also sitting here who said, "Have around your table, everyone, representatives from all of the groups that you ultimately want to influence, the people who measure care, the people who pay for care, other insurers, the people who deliver care, et cetera." And so we were very fortunate to have an outstanding advisory group including an individual represented at the table.

I'm going to tell you briefly about our work with Aetna since that's a completed project. We were testing the transitional care model in a defined market. We had an independent consultant say, "What are the facilitators and barriers to having something like this happen in real life?" We provided the basis for ongoing advisory committee input. Our commitment was to present our findings to Aetna decision makers and obviously, to widely disseminate them.

In the process, we learned a great deal. It's very different to run a clinical trial than it is to make things happen in the real world. We had to build tools of translation. And so we had to take what we knew and create patient screening and recruitment tools. We had to position nurses who are not traditionally prepared to deliver this kind of approach with web-based modules. We had to build a documentation and quality monitoring system. We had to figure out what is the quality improvement system that will be needed in organizations using root cause analysis which was the way that we've done all our work in

the clinical trials; how could we make that happen on an ongoing basis and obviously we had to rigorously evaluate all of this.

So the findings with Aetna, despite the fact that we ran into very significant adaptations of the transitional care model, including, at that time, a legal ruling that we couldn't implement the hospital component which has since been changed. We demonstrated improvements in all of the quality measures.

And at this point, the quality measures are not Penn's team's quality measures, they're what Aetna and Penn together determined were really important quality measures—symptoms status, functional status, quality of life, et cetera. We demonstrated improvements in patient and physician satisfaction, reductions in rehospitalizations through three months and cost savings that extended through a year.

So a very important question emerges along the way. Up to this point in time, all of our work has been with high-risk, cognitively intact older adults. And we received a call from the Alzheimer's Association saying, "You have chosen an easy population." We're like, "Are you kidding? Are you kidding? This is extraordinarily high-risk." They said, "No. You need to really focus on people who are coming into our emergency rooms and hospitals who have cognitive impairment as a coexisting problem."

And I cannot tell you what the first grant for which we did not have to write a proposal yielded. But it yielded a passion in us to deliver on the promise of having a large scale study. And we're very fortunate last week to report at GSA some of the findings from the study for the first time.

We're very excited that we were able to demonstrate. And in this case, we were not comparing the transitional care model to standard care. By now, we have convinced all the reviewers that standard care is not what we need.

Now, we had to compare it against a low dose intervention where we simply told everybody involved in the team that people had cognitive impairment and we told them exactly the nature and what we found. A second intervention, we prepared nurses via web-based modules to better both assess and manage

patients with cognitive impairment. And in the third, we tested the transitional care model which enabled us to follow these patients throughout an acute episode.

So the preliminary findings, and these are final in terms of these findings, we demonstrated as the result of this that the transitional care model compared to these other lower intensity interventions, increased time to first readmission or death, decreased all cause rehospitalizations through six months and decreased the total number of hospital days through six months.

Our next biggest venture is to really tackle what some of you have already been talking about, which is how do we connect the acute care sector more efficiently and effectively with the long term care sector.

And when we went to approach this in our traditional way, we realized that we did not have a very good understanding of what it is that we were working toward. There are very few data out there to help us to understand what is a good outcome for the long term care population. We have lots of studies that tell us what points in time might be, but not a sense of what the care experience is like for this population, their care trajectories, and how it is that their care difference varies over time.

So we have enrolled about 500 English and Spanish speaking individuals and we are literally tracking the transitions from the point they enter long term care until they die. And part of this experience is to really help to get us to understand from their voice, the voice of the older adults, what are the changes in health and quality of life that they're experiencing; how does that vary over time; how does that vary based on whether or not they start receiving long term care services in their home, assisted living facilities in nursing homes and so on.

But we're also able to track the impact of vulnerable transitions on their health and quality of life. And so this will be very important to us as we begin to approach application of the model with this group.

So in summary, the transitional care model focuses on the needs of high-risk, cognitively intact and cognitively impaired beneficiaries across multiple settings, designed specifically to increase value over the long haul. It has been successfully translated into practice. And it was recently recognized by the Center for Evidence-based Policy as an innovation that meets the top tiered evidence standard.

This is a nonpartisan group, funded by the MacArthur, McConnell Foundations. And that is a group that basically says innovations, if scaled, could have a major impact on society. So such recognition is really extraordinarily humbling and we feel very privileged to be among this group.

But mainly, what drives us, what keeps us excited every day are stories like the one that was published in the Washington Post about a Mr. Lynn who for the few years before we were involved in his life, was homebound. And that means, only time that he got out of his home was when he was taken by the emergency – by the ambulance to the emergency room for yet another hospitalization, and his wife of 50 years who was watching her beloved husband go through this experience.

And the picture in the Washington Post was a picture of Mr. Lynn in his garage where he had this fabulous wood working shop. And his goal was to get back into the garage and do the things that gave him quality of life, meaning in life, et cetera. His wife's goal was to get Mr. Lynn out of the house.

We met both of those goals and it was – it is that opportunity to deliver better care, to achieve better health and to do it more efficiently and achieve the cost savings that will become – that are important today and will become increasingly important on January 1st when the first baby bloomer hits 65 and so on.

So we are really privileged to be a part of this movement and to try to help communities that are interested in joining it, to know what works, what doesn't work, to begin with that which we know and begin to adapt according to your own needs.

So thank you for this extraordinary opportunity.

Andy Miller: I am Andy Miller from Healthcare Quality Strategies which is the New Jersey Quality Improvement Organization. And I'm the Co-leader for the New Jersey Care Transitions Project which is one of the 14 QIO Care Transitions Project that you've been hearing about today.

What I'm going to talk about is the implementation about of Dr. Naylor's transitional care model in a community setting. This slide shows a picture of the New Jersey care transitions community. It's the green area. And I just wanted to point out that just to the left of the green area is the city of Philadelphia, not totally coincidentally like what you're talking today.

Our main partner in this project has been the Virtua Health System. It's a system that includes four acute care hospitals, two nursing facilities, two home health agencies and a number of outpatient physician practices also.

And at the beginning of the care transitions project, CMS invited us, the 14 states together, and we got to hear a presentation by Dr. Naylor and her team which includes a number of really talented and committed people. And we got to hear the unabridged version of the model and how it works. And we thought, "This is great. And it's just across the river in Philadelphia, about a half hour from our community. We've got to do this."

And so we went back to Virtua and asked would they be interested in working on this. The Virtua home care people which is a part of the system that operates the home health agencies was really excited about it and from the beginning, very committed to implementing the transitional care model.

For them, this was great. It's the nursing model. A number of people in the home care agency and throughout the Virtua system were graduates from the University of Pennsylvania, School of Nursing. So they appreciated where this was coming from. Some of them were aware of the model specifically and Dr. Naylor's work. So we didn't have to do a big job selling this program.

However, right from the beginning, they said they needed to be, not just they wanted it to be, financially feasible and sustainable after the project ended. And like some of the other QIOs, resources were an issue and we said we could help fund one or more of the nurses. And they said, “No. That's not going to help us. When this project ends, we want to do this in a way that we can continue without outside support.” And so I will come back to that.

Dr. Naylor's team provided the training and support for the program. Mary, herself, came and gave a number of presentations to Virtua's leadership. And I think this was really key in, number one, making the people in the home care program feel good that this was something that was supported by the system. But also, the leadership of the system really got a chance to understand the model and how – what a great opportunity it was and how it's fit also into a number of the other initiatives that the system was putting into place to improve coordination of care throughout their system.

Mary talked about the training modules, the online modules, Virtua hired transitional care nurses. And they went through that training that was reviewed by the Penn team. They made a site visit to Philadelphia. They got to do a home visit with one of the transitional care nurses and managers went along through this site visit. And the Penn team provided ongoing case conferences for the transitional care nurses and the managers who were involved in the program.

Now, as I said, one of the issues was the home care agency said this has to be a sustainable, financially feasible project for us. And so a number of adaptations had to be made to the model to make it that way in a system that is – or in the community that's primarily Fee-For-Service Medicare and pre-Affordable Care Act interventions.

So – and Laurie Robinson talked about this. It's an issue for our home health agency. Alright, how do we provide these services in a way that they're going to be reimbursable?

So the first was we need to make these visits and these a billable service for the home health agency. So that's number one. Limits this to only patients

who are eligible for Medicare home health. They had to be homebound and they have to be in need of medically necessary services. So that limits to a certain extent who's eligible.

They said, "We can't afford APNs." They had no problem with the idea of using advanced practice nurses, but said, "We can't afford that based on what we're paid for a home health visit. So we're going to have to use baccalaureate level nurses."

Fortunately, the Penn team had dealt with that before and that was not a major barrier to get past. They also said, "We can't do the first visit in the hospital by the transitional care nurse – the home health nurse because that's not a home care visit. It's not reimbursable. But we have home care nurses. We have our intake coordinators in the hospital and they will do that visit."

They said, "We can't do that visit that's part of the transitional care model along with the patient to the first doctor's visit," which you know that makes so much sense and they realize that, but they said, "But we can't do it. It's not a reimbursable visit."

And they said – they found that, occasionally, patients even though they were screened in the hospital, either refused services where they said, "You know, I had home care before and I want my old nurse back." "Well, but we can provide you a better service with another one of our nurses." "No. No. I want my own nurse back."

Or, occasionally, somebody would slip through the screening process and not be picked up as being high-risk and in need of this service, so the agency said, "We can enroll patients after discharge from the hospital." So a nurse would go out to the patient's home and determine, "Wait a minute. Here's a good candidate. Here's somebody who would really benefit from transitional care – the transitional care model." And those patients were enrolled.

Because the nurses were not advanced practice nurses, the agency put a lot of effort into training them and getting them to the level where they would be comfortable and they would be capable of providing the services through the

model. So they were trained in management of patients with COPD, CHF, with diabetes. And about the resources that are available in the community in which they work for patients with these conditions with other needs.

The program started out and still is a small pilot within the home health agency, but the ultimate goal is to spread it throughout the agency and integrate it into all the care options that the agency provides.

Right now, there are four transitional care nurses who between them work 2.4 FTEs. And they don't spend all of their time in the program. But anecdotally, the program has had a spillover effect within the agency with regard to increasing awareness about care transitions among the other nurses and providers within the agency.

The agency decided after about nine months working with the program that it was really – that it was different enough from the transitional care model and that it was their program, their own program. So they gave it a separate name and called it Transition to Care Program. And Dr. Naylor was extremely gracious about this. And she put it – you know, I didn't think of it that way, but she did, that really, it was a good thing, that the agency wanted to take ownership of this.

They had put a lot of effort into doing it. They had a lot of pride in how it was working. And they wanted to take it on as their own. They've continued to do this – they've continued – instead of having sort of case conferences now provided by the people from Penn, they run their own case conferences, but they're continuing to follow the model.

Now, this gets back to something Dr. Coleman talked about earlier. Now you're starting to make changes. Dr. Naylor emphasized this is an evidence-based model. This has been shown over 20 years in randomized controlled trials to work and now you're messing around with it. You're taking out pieces, they may be the key pieces. We don't know that and we're not – and we're taking them out not because evidence shows that they may not be as important. We're taking them out for financial reasons. So, you know, this is

a problem, the potential loss of fidelity with the evidence-based, evidence tested model in any time you do this in implementing within the community.

Now the good news is, I hope you can see that in the back, the outcomes really have been good. The program has really been up and running fully for a little more than a year, so we don't have a lot of data yet. But you can see there's been a significant reduction in the number of hospitalizations. This was not a controlled trial, so we didn't have a controlled group of people who needed the program and didn't get it. So, we compared hospitalizations for patients who were enrolled in the 30 days before they enrolled in the program, versus a 30 days after and then also for 60 days because as Dr. Naylor said, this is designed as an average 60-day program. And as you can see, there was a decrease in hospitalizations both over the 30-day period and the 60-day period.

We also looked at – at the numbers and again, the numbers of patients is small. Those readmission – readmission rates by quarter of the program and we were very happy to see that in the first couple of quarters the nurses were getting used to this. They were getting up to speed. They were learning. As time went on, the readmission rates have dropped. Now, you say, “Well, those readmission rates are not low yet either,” and we can't say what the readmission rates would have been without this program. As Dr. Naylor pointed out, these are patients who were at really high risk of repeated readmissions to the hospital. And so, we hope that the rates will continue to drop, but they are certainly moving in the right direction. And this is just a graph showing those same readmission rates.

Just a few things for people who are thinking of doing this. It says on the slide and I really think it is as good a model as Dr. Naylor says it is. It's worth investing the time and resources necessary to identify and train the transitional care nurses. It was said earlier today how important it is to have a coach. In this case, to have a transitional care nurse who really understands the program, who's committed to it, who has the feel for – for working with patients. But it's worth the time finding and training those people.

The model does work very well in a community-based setting. And an important part, point is to build in at least a simple evaluation system right from the start. Not just outcomes but is the process being followed and, you know, anybody who's been listening today or if you've worked in any health care system, just because things are supposed to be done a certain way, doesn't mean they happen. Not because people aren't trying. But so did that initial visit happen in the first 24 hours after discharge, did the patient make it to the follow-up visit to the physician for one reason or another and did that impact on the readmission rate for these patients?

I just want to mention the role of the quality improvement organization in this project and to encourage you to work – to reach out to the quality improvement organizations in your state if you're are thinking of doing any of these projects that have been talked about today. When we, as I said, made the home health agency aware of the transitional care model, there were some people around who were - at least somewhat aware of it. But we brought it to them as this is something that you could do and we could work with you to do in your agency.

The facilitating role, bringing the agency together with Dr. Naylor and her team, assisting with implementation, one of our quality improvement nurses has been a member ongoing of the steering team that oversees the program for the agency. Providing funding support as I said, they didn't want us to pay for nurses, but we were able to provide support for providing the training for the – for the nurses. And analytic support in terms of looking at outcomes, this is a sophisticated health system, a sophisticated home health agency, but didn't necessarily have access to – well, certainly not to the claims data outside of the system that the QIO could bring to this and I think we were agreeable to helping them also. Thank you very much.

Louis Colbert: Good afternoon. I am Louis Colbert and I am the Director of the Delaware County Office of Services for the Aging which is the AAA. One of the objectives of the conference is to make information available regarding how best to lay the foundation for successful implementation of care transition interventions. And so, what I'm going to do is take a couple of moments,

about three or four minutes and share with you the foundation that we have laid in Delaware County. Denise Stewart, my Deputy Director for Long Term Care Services will come after me. She's going to actually describe the model. And we have in the audience with us, Barbara Looby. Barbara, raise your hand. Barbara is our partner. She's the Administrative Director for Senior Health Services at Crozer-Keystone Healthcare System.

Opposite to Tim who was here earlier, we're on the southeastern corner of the state. We are a department. Our AAA is a department of local county government and I think we're fairly typical of an AAA. We provide some of our services through contracts such as senior centers and nutrition, and legal, and senior victims, volunteer and primetime health. And then there are services that we do directly such as our long term care assessment, our Medicaid waiver programs, family caregiver support program, protective services, ombudsman and we have the state funded care management system.

Crozer-Keystone Health System has been an invaluable partner to us for the last 10 to 15 years in everything that we do. They are a system that operates four of the six inpatient hospitals in the county, beds totaling 750 plus. They are a trauma center, they are a regional burn center. Crozer-Keystone has a dedicated specific senior health department, which is the department that Barbara Looby is responsible for, and that department spans all of their hospital systems. So, we've been very pleased to be able to be in that situation and again, I think it's part of what has been successful in laying the foundation for us.

For some time, we have been working with them to impact the positive change in the culture between the acute care setting and the AAA supported system. This is very key to us. Many people that that I find when they figure out what I do, I become their personal care manager whether it's in church, in the grocery store, in the ACME, in Wal-Mart, wherever it is, they're asking me to kind of interpret what's going on with their mom or what's going on with their spouse. And often times, I think we in the aging network, we forget how complicated this system is. Every time I have to fill out my mother's reapplication I have to go to Denise and ask her to translate for me. And I'm

often sensitive to the fact that your mom could be healthy one day and end up in the hospital the next day, and they go from hospital language to insurance language to home care language, to AAA language to county assistance language and they're just changing hats. And so, therefore, I think this whole day has been very exciting because it's going to mean hopefully that some of this translation will be easier for people.

The partnership has been very key and we've had a history. One of the things that we found that while we've been talking to Crozer-Keystone is 42 percent of all the patients discharged from that particular system were over 60. That represents almost 40 – I mean 20,000 people a year. And a significant percentage of our referrals to the AAA come from our hospital systems. It's also very important to us because we – I mean the reality of it is, is that we've found that the health care systems and our AAAs traditionally have not really had positive perceptions of each other. And so, to be able to be in a partnership with a major health care system like this, it's phenomenal for us and we are very excited.

The perceptions sometimes are hard to change, but we felt that as this transitional care opportunity came along, it was a wonderful time. It was a perfect time. It was the perfect fit for us. We were excited to be able to have the opportunity to implement Dr. Naylor's model in Delaware County. So it's consistent with the national trends and we were able to build on our existing foundation.

We've been working with Crozer-Keystone Health System, as I said, for probably about the last 10 years and for us when you think about our agency, it's 35 years old, that's significant. Because you figure the first 25 years, we just kind of went about our ways and we didn't really talk to each other, so this is monumental. We started probably I think it was about in 2001 when we realized that we have primetime health funding but yet, we weren't really good at it and so we went to Crozer-Keystone and asked them, "Can you come into our senior centers and begin working with our seniors around primetime health and disease prevention and education?" and that was the beginning. We have several sponsors for our older Americans month celebration in May

and again, Crozer-Keystone is one of our major sponsors. They're excited to step up to the plate and we appreciate that.

In 2006, Delaware County was designated by the Pennsylvania Department of Aging as one of what they consider a Community Choice County. And Community Choice is Pennsylvania's description for people who are in an acute care setting and are ready to be discharged but the community piece is not there. And in the past, this particular individual may have ended up in a skilled nursing facility and with Community Choice, we are able to go in, do an assessment and put services in the same day.

In 2008, the state implemented a nursing home transition program and that simply is self-descriptive. People who've been in nursing homes and want to transition back in the community, we work to do that. We were very successful in 2009 and very excited that we were able to get an ADRC grant in the county and so now, we are the lead agency for the ADRC team in Delaware County. And early part of this year, Crozer invited us to become a member of the heart failure transition team and for people in the health care system, they meet like quarter of seven in the morning and it was like, "You people really meet this early?" I was like, "I don't know if I'm going to stay on that committee or not."

So late in 2009, Barbara and Crozer-Keystone came to us and they said, "You know, out of our hospitals, we have one particular hospital that has a significant number of people who are 60 and over." And that was a hospital called Taylor. And so we began talking to them about what we called the Taylor Hospital Discharge Project. And when we first began, we were talking about looking at consumers who have four diagnoses -- CHF, MI, COPD and pneumonia -- and those particular consumers would be referred to the Senior Health Services by either the hospital discharge staff or the emergency room staff.

And quickly as that project began to unfold, what we realized was that it was really larger than just those four diagnoses. We realized that there were people out there with minimum family support or no family support. There were people out there that they were seeing who are considered poor

historians and then there are patients with ongoing recidivism. So, all those were included into that group and what happens is that they were referred to Senior Health Services. Senior Health Services then talks to our assessment office and there's a combination of Crozer-Keystone Senior Health Services following that consumer as well as the AAA put, doing the assessment, putting services in and the consumer is followed for a certain amount of time. They're followed for I think three months from Senior Health Service, but from AAA, they now have a care manager so they're in our case load forever.

So the foundation was laid and when we had the opportunity to apply for the transitional care grant, it was just all perfect and I think as we described, all the pieces kind of fell in place, the stars were aligned. And so, as we begin our project because our project began October 1st, we still have an opportunity to learn from all of you today and make whatever adjustments that we need to make. But I think we're in the right place and I think we're at a good beginning.

For us, I think it was just so critical and so key when we work with the Crozer-Keystone Healthcare System. At the end of the day, we really believe strongly that we have a collective responsibility for a single patient, that we share the responsibility of the seniors in Delaware County. And I think that's also the reason why our project will work so well. Denise is going to come and describe our project. Thank you.

Denise Stewart: Good afternoon everyone, I'm Denise Stewart and I'm the Deputy Director for the Delaware County Office of Services for the Aging. It's a test. It's the end of the day. It's Friday. It's not moving it along.

OK. All right. First of all, the slide, thank you very much. The slide is there. I want to thank Kathleen because Kathleen had worked with me, the person who initially sent the slide, sent an error, so you will on the website, you will need to go and get the one that I'm going to be referencing today. But we needed to look at this one.

First, we're going to have, obviously the patient is going to be admitted into the hospital and will identified within 24 to 48 hours and when that happens

then, and again, I want to make note to Dr. Naylor, we adapted the model that she showed earlier to this. The patient will be screened by the advanced practice nurse based upon the program criteria and the risk factors. So, the advanced practical nurse will contact the Senior Health Services triage clinician for additional patient history and that clinician, the triage clinician, is actually in Barbara Looby's office, and what she does, she is like the point person that is able to access that person's history for all the hospitals and that person, any doctor's office within their system that they are seeing so that that will assist us with knowing what's going on, when they've been hospitalized that they didn't come to Taylor Hospital, maybe another hospital in their system that were in as well as what kind of patient history when they were – what was going on with that person at their last doctor's office visit.

The advanced practical - advanced practice nurse is also going to determine the patient's eligibility for the transitional care model and enroll that patient in the model. Also, at the same time, working together in partnership will be the COSA -- and that's the abbreviation for my AAA -- COSA assessor will be determining the eligibility for the CBO program. And a couple of things, we are and are required to do a mandatory eligibility for aging waiver and with that and Louis spoke earlier about Community Choice, we work as a partner as well with our county assistance office and that allows us to get a response back from the county assistance office about the eligibility for someone in the aging waiver program within 24 hours or less. So, we can then move that – that information and start that piece ahead of time.

Also, if we – we have thought about if the patient does not – is not appropriate for one of the CBO programs at that time, we will have that person as what we call a care management only case, meaning that person will be assigned a care manager. So, whether they go into a specific program or not, they will have in the community a care manager that will be working with them and their families to follow and see what their needs are as well as my boss, Louis Colbert has spoken with the state and asked them about people who do not potentially fit into any program about any special funding that may be – from the state that they may have for us to able to help serve that person. Again, the goal is to keep them out of the hospital.

The next is the advanced practical nurse visits the patient in the hospital within 24 hours of the enrollment. The Crozer-Keystone Health System has developed a risk assessment tool that that nurse will be using to determine. And also, at that same time, the advanced practical nurse will be conducting a comprehensive assessment of the patient and the family caregiver's goals, needs, their initial – the collaboration with the patient's physician and their PCP. So, all of that will be working together with the APN.

The APN will visit the patient daily during the hospitalization, to include the health care team and identifying the protocols that are needed but on our health care team it consists of our APN as the lead, patient, the family, the COSA assessor, the attending – the PCP and the discharge planner. Also, the advanced practical nurse will work with COSA's care manager to design and coordinate a transitional care plan, a discharge plan and arrangement for the COSA services for whatever that patient is eligible for.

The advanced practical nurse will visit with the patient at home within 24 to 48 hours post their inpatient discharge as well as the advanced practical nurse will be available seven days during the week which will include a weekly one – at least a weekly visit during the first month, a weekly telephone outreach throughout the intervention. Then the advanced practical nurse and the COSA care manager will implement the actual care plan since that patient is home, continually reassessing the patient's status, the plan with the patient, with their caregiver and the PCP. We expect this entire average length of the intervention to be at least two months post their hospitalization.

The advanced practical nurse will then continue to initiate at least that monthly telephonic outreach to monitor the progress and to communicate regularly with the care manager to see if there's any kind of changes that need to be made to the care plan whether it's an addition or a deletion of a service or replacement of a service.

As we continue to move forward, the advanced practical nurse will provide additional intervention to the patient that they see is at a high-risk with poor outcomes. And again, this is where the care manager and the assessor will be

working with the APN to go over what are their need – what other service needs are required to help maintain that patient to remain at home as well as if there is a change then that actual assessor or the care manager will have the ability to do another assessment and actually from that, it may mean there may be a level of care change for them, it may mean a focus of care possibly. But at all times and what is most important is the communication between those two as well as our systems to help keep that patient out of the hospital.

In keeping with Dr. Naylor's model and she brought – she spoke on it and it was one of her slides earlier around the core components which she expressed very vehemently and I agree when you talk about the family-centered, person-centered approach that it is very important to have that the nurse-led team, the single point person, all of that. And again, that information and communication flow among the systems is very important. And then to conclude for me around the barriers, just the barriers, and again this is something that Dr. Naylor had spoken about and I'd seen her earlier at another presentation, she talked about the regulatory barriers and one of the things that we found just for us in our systems working together with the hospitals around HIPAA and what you can share and what you can't share and if it's a protective service case that's one thing, but if it's not, what does that mean and how do you – how do you keep that confidentially. But again, service that patient so that patient does not get rehospitalized.

Another point was the lack of the quality or financial initiatives and getting grant funding to be able assist with that. Looking at organizational changes and how we do it currently versus what needs to change in order for us to serve our patient well. The culture of change, trying to make that change as well as thinking at the end of the day that we share that responsibility to provide quality care to our patients. And the key that I see in our model is the continued partnership that we have had with the Crozer-Keystone Health System, with the other community-based organizations, as well as our local county assistance office to work together to try and keep our patients, our consumers in the AAA world out of the hospital, in the community where they're best served and where they're happy and where they want to be. And

again, like I said, we're all serving the same patient or the same consumer and we need to work together to make that work.

That's it. Thank you.

Linda Magno: We have time for a few questions. If you would like to step to the microphone, please do so.

Male: Hi. Could you – could you identify the assessment tool you're using to identify the high-risk patient?

Barbara Looby: I'm so sorry. I just got up to ask a question.

Male: I can wait.

Barbara Looby: Well, that's OK. The assessment tool is something that we created internally and I can email it to you. I have it on my iPhone.

Male: Great. I'll come give you my address.

Barbara Looby: I'm Barbara Alexis Looby. Dr. Naylor, please allow me to tell you how impressed and how passionate I was sitting there hearing you talk about the role of social work. Guys, I may be in health care administration but I'm a social worker by profession. OK. Once a social worker, always a social worker, and I know when we met at the (inaudible) conference, I did ask you that question regarding the role of social work even though I know this is a nurse-led model, I am just excited to hear you actually mention the role of social work.

When we started developing this program, one of the things we quickly found out was the fact that we're going to have a difficult time based on the dollars and cents from the grant hiring a nurse practitioner or hiring an advanced practice nurse, the New Jersey model stated that you were very comfortable ma'am with having a BSN or MSN actually assume this role, have you seen any difference in outcomes based on the qualification of the nursing staff?

Mary Naylor: So, we have an ongoing project with Kaiser Health System in which part of the goal is explicitly to say can you accomplish, now that you have all the tools in place. We also have a high-risk screening which I'm sure they'll be a lot of common ground and we can make that available to anybody. But now that you have the tools in place, you have the evidence-based protocol, you have the technical assistance, quality monitoring, quality improvement systems in place, could you achieve the same outcomes using different level providers and that is an explicit goal of our work – ongoing work with Kaiser Health System.

That said, you know, *carpe diem*, this an opportunity for us to think about using existing resources and existing and available evidence. How do we position highly qualified professionals to be able to achieve these goals? And so, I would say if what you have available in your system are baccalaureate prepared nurses who have experience and knowledge in care of complex chronically ill people and you're willing to make the investment which you will need to make in their orientation, in their preparation, in their ongoing investment in quality, in quality improvement and quality monitoring, then that is – that becomes your starting point because at the end of the day as you describe, it's going to be the patients and the families to help us guide how we're going to make needs and it's going to be all of our team members that are going to help us accomplish these goals. So, that's – that's my response to you at this point.

Barbara Looby: Thank you very much.

Linda Magno: I see nobody else standing, I've asked the operator to open the line to see if there's any – any questions from the folks participating by audio.

Operator: If you would like to ask a question, please press star followed by the number one on your touchtone phone. Please state your name and organization prior to asking your question. To remove yourself from the queue, please press the pound key.

Your first question comes from the line of Linda Noelker, your line is open.

Linda Noelker: Thank you very much for the presentation. My question is has any one got any information on referral rates versus enroll rates and drop out and failure to complete these programs?

Linda Magno: May I have to ask if you repeat the question? And slowly into the phone please.

Linda Noelker: Hi. Thank you. I was wondering if anyone has any information on from among those who are referred to these programs, how many actually enroll and then how many actually complete them versus drop outs?

Mary Naylor: So, this is Mary Naylor and we have those data published in our papers actually but now, also have this as a service in our home health agency special service line currently being reimbursed by local payers, Independence BlueCross of Philadelphia and Aetna. I believe the contract has been signed. So, the numbers of patients - when we screen the number of patients who accept the service is very high. I don't have the exact data, but it's very high. You know, as long as they fit within our geographic region, et cetera. People really – it resonates when you talk to about these issues and people really recognize how important it is to have the continuity of care, the access to someone during this very vulnerable time. It resonates just not – not just with patients, but with family caregivers. So, that I – you know, I'm happy if you want to email me, I can give you the actual acceptance rate but I feel very confident in saying people are really interested in this type of a program.

Closing Remarks

Linda Magno: Next question? In that case, I'd like to ask all of you to thank our panel for a very fascinating presentation. Before I let you go, I feel that I have to make a few remarks and acknowledgments of what went into today's conference. First of all, I'd like to acknowledge and thank Steve Jencks, Mark Williams and Eric Coleman whose New England Journal article really helped to put readmissions on the national health policy agenda. It's been critical, it is now a clear focus of the Centers of Medicare and Medicaid Services. Other parts of the Department of Health and Human Services are also tracking readmissions and I think you'll see a number of activities roll out above and

beyond those established in the – in the Affordable Care Act in Section 3025 and 3026.

In addition, I'd like to acknowledge Joanne Lynn, Paul McGann, Mary Pratt, and Traci Archibald who were here today. They are with CMI – CMS' Office of Clinical Standards and Quality and they have been playing a significant role in shepherding the care transitions subnational theme through the QIO's 9th Scope of Work, and they've also been very helpful to my staff in helping us build upon that foundation to develop the community-based care transitions program that I hope we'll be announcing very shortly.

In addition, I'd like thank Juliana Tiongson, Kathleen Connors de Laguna, Diane Merriman, Kathy Pirotte of my staff, and our research and evaluation colleagues in Tim Cuerdon and Susannah Cafardi for all of their efforts in helping to bring this conference together to get the information out to all of you. And then I'd like to thank all of you who spoke here today and shared your knowledge and insights about developing and implementing care transitions models, to the funders whose generosity has contributed to building the evidence base that's now giving us so much material to work with and then to all of those of you who took the time to attend today's conference either here in person or with some of the handicaps, by audio conference. We're very appreciative of your interest and of your participation in today's conference. We hope this meeting has been helpful to you. We're very excited that Congress has made the resources available for us to undertake this important work over the next several years.

And now as Jimmy Buffett says, "It is 5:00 o'clock somewhere." It's almost 5:00 o'clock here so we know from Kathy Greenlee earlier today that some of you will soon be taking phone calls from anxious sons and daughters and neighbors of Medicare beneficiaries who are being discharged from the hospital this afternoon. For the rest of us, it's almost happy hour. Thank you very much. Have a good weekend. Safe travel home.

Operator: This concludes today's conference call. You may now disconnect.

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