



# MLN Connects<sup>TM</sup>

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services  
National Partnership to Improve Dementia Care in Nursing Homes:  
Improved Care Transitions  
MLN Connects National Provider Call  
Moderator: Leah Nguyen  
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## Contents

Announcements and Introduction .....	2
Presentation .....	3
Keypad Polling .....	3
Presentation continued .....	4
The Goals of Care .....	4
The Care Delivery Process .....	5
Coordinating Transitions in Care .....	7
Barriers to Effective Care Transitions .....	8
Open Communication across Care Settings .....	12
Four Pillars to Improve Transitions in Care .....	14
Successful Strategies .....	16
National Partnership: Next Steps and Future Goals .....	18
Question-and-Answer Session .....	18
Additional Information .....	26

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**Operator:** At this time I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you, you may begin.

## **Announcements and Introduction**

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the National Partnership to Improve Dementia Care in Nursing Homes.

MLN Connects Calls are part of the Medicare Learning Network. During this MLN Connects Call speakers will discuss the role of physician leadership in working with hospitalists to improve care transitions and the importance of open communication between physicians and nurse practitioners across care settings.

CMS subject matter experts will provide National Partnership updates, share progress of the Focused Dementia Care Survey Pilot, and discuss next steps. A question-and-answer session will follow the presentation.

The CMS National Partnership to Improve Dementia Care in Nursing Homes was developed to improve dementia care through the use of individualized comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual.

The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medication as well as other potentially harmful medications in nursing homes and eventually other care settings as well. You should have received a link to the call material for today's call in previous registration email. If you've not already done so, please view or download the presentation from the following URL, [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [www.cms.gov/npc](http://www.cms.gov/npc). At the left side of the web page, select National Provider Calls and Events, then select the August 19th call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

At this time, I would like to turn the call over to Michele Laughman, Coordinator of the National Partnership to Improve Dementia Care at CMS.

## **Presentation**

Michele Laughman: Hello and welcome. As Leah mentioned, our call today will focus on initiative updates, the role of physician leadership, and the importance of open communication across care settings to create successful care transitions.

CMS is grateful for your time, energy, and dedication to the mission of this partnership. These calls are an excellent opportunity to share new information about innovations in dementia care and to highlight successful care approaches that are being implemented around the country. We all share a common vision of truly person-centered dementia care in every nursing home. Together this vision is becoming a reality.

The success of this partnership, which is not always clearly depicted when just simply reviewing data, is the vision that we all have – the vision to provide care that is person-centered in a home-like environment for individuals with dementia who reside in nursing homes across our country, as well as all nursing home residents.

Currently, our efforts have been diverted to the pilot of a focused dementia care survey. Several states volunteered to participate in this focused review; however, only five states were chosen and trained to participate. Each state will be completing five surveys and the surveys are currently underway.

CMS is undertaking this pilot to more thoroughly examine the process for prescribing antipsychotic medications as well as other dementia care practices in nursing homes. In addition, we have been actively facilitating the grant solicitation process for a Federal grant opportunity. This grant will utilize civil money penalty funds to support and expand the National Partnership. The grant opportunity closed at the end of June and we are currently on schedule to make awards during the month of September.

Today we will hear from Dr. Leonard Gelman, current President of AMDA, American Medical Directors Association, the Society of Post-Acute and Long-Term Care, as well as Dr. Melissa Mattison, who is the Assistant Professor of Medicine at Harvard Medical School and the Associate Chief, Section of Hospital Medicine, from Beth Israel Deaconess Medical Center.

We look forward to hearing from those of you who are sharing your knowledge with us today. These positive efforts will create success in improving dementia care for people living in our nursing homes.

Now I will turn it over to Leah for a keypad polling question.

## **Keypad Polling**

Leah Nguyen: Thank you Michele. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today.

Please note there will be a few moments of silence while we tabulate the results. Selema, we're ready to start polling.

**Operator:** CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Once more, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Leah Nguyen.

## **Presentation continued**

Leah Nguyen: Thank you Selema. I will now turn the call over to Michele Laughman.

Michele Laughman: OK, I would like now to introduce Dr. Leonard Gelman. Dr. Leonard Gelman will discuss the role of physician leadership in creating successful care transitions. Dr. Gelman.

Dr. Leonard Gelman: Thank you Michele. Hopefully, everybody can hear me. I want to take the opportunity to thank CMS and the MLN Network to have this opportunity to speak to you all. And good afternoon for those of you on East Coast time and those of – Central – and good morning for those of you who are on the West Coast.

I was asked to speak about the role of physician leadership in creating successful transitions. So I wanted to talk about a few things. If you have my slide set with you there, I'm on slide 8 now, going through the agenda for my brief talk.

We're going to talk about the goals of care, the care delivery process, transitions, communication issues, barriers to effective transitions, accountability and the QAPI, the quality assurance and performance improvement, and how we can utilize that to help us in our endeavors.

## **The Goals of Care**

As far as the goals of care are concerned, there is a difference, obviously, between the goals of care that are engendered in hospitals as opposed to nursing homes. And hospitals appropriately are very disease-centered. Nursing homes are really functionally driven, quality-of-life, paradigm centered and it's important to realize that there is a difference there. And people get treated in hospital and they get sent to other places of service, including nursing homes.

But in the nursing home, even though the care is patient-centered and not really disease-centered, we still need to be cognizant of the disease process because it's quite – it's quite important, especially nowadays with more post-acute care. You know, the people are coming into nursing homes with many, many comorbidities and many, many issues that really need to be addressed and so it's something that we need to continue to monitor and be aware of, that there is a disease process, not just the patient-centered issues.

There are very complex treatment regimens. There are psychosocial considerations, functional considerations, as I noted, the increasing patient acuity. And one of the key parts in nursing home care are the gaps of family members and their knowledge about what nursing homes, what facilities – post-acute facilities – can actually provide, and sometimes there are expectations that are perhaps unrealistic, and this is something that needs to be worked on from all angles, especially from the nursing home side.

In general though, there really needs to be a greater physician involvement, both as an educator and also as a family mediator as well as, certainly, taking care of the medical needs of patients that come into the facilities. So this is really what I'm going to talk about in the next few minutes.

### **The Care Delivery Process**

I want to get back to a basic though, and this is something that – it's called the care delivery process and it's really a set of steps that all practitioners, physicians, nurse practitioners take to assess and manage the causes and consequences of illnesses and impairments. And the most important part – the most important word there is the causes. And I think we sometimes skip some of these steps and don't really have a full grasp of exactly what's going on with patients. And this in part comes from the transition itself, but also it comes in part because of the complex nature, as I've just talked about, of these patients. And so we really need to try to attain and maintain optimal physical functioning in the context of personal and psychosocial functioning. And these are the six steps:

- Recognition and assessment,
- Problem definition,
- Diagnosis/cause-and-effect analysis,
- Identifying goals and objectives of care,
- Selecting interventions and planning care, and
- Monitoring of progress.

And this is how I learned medicine 30 to 40 years ago. It seems like yesterday, but it really was that long ago. And we really need to be cognizant that these steps need to be performed in all settings of care and at all times, but unfortunately this doesn't happen as often as it should. A lot of times we try to skip steps. You know the classic skipping steps would be someone who has a symptom, for instance, a behavior. They get urinalysis done and treated with an antibiotic. And this is sort of your classic story of skipping important steps in the process to looking at what the cause of the problems are. And so I'm going to go into detail a little bit more about these six steps.

The first step is recognition and assessment. We need to gather essential information about the individual. The second step defines the problem, defines the problem in the sense of the entire patient. What are their risks? What are their issues? What are their other problems? And then – and only then – do we start talking about a diagnosis and a cause-and-effect analysis, identifying physical, functional, psychosocial causes of the risks, problems, and other issues, how they relate to one another and their consequences.

The next step really is identifying the goals and objectives of care, and this is a step that we also skip over quite a bit. It's not an easy step, it's difficult, but it really – we need to clarify, especially in our long-term care and post-acute care population, you know, what are the goals of care. Certainly, for the short stay patients who are there for rehabilitation, I think the goals are usually pretty clear.

But for those patients with dementia as we're talking about in this series, the goals of care may not be so clear and it may not have been discussed very in depth and so it's quite critical that we determine what these goals are, and I'm not just talking about advanced directives, although those are certainly a big part of this. But just in general, what do the patients want, what do the families want, what do they see as the objective of care, the goal of care? And it's a step that we need to really not skip because we really can't determine an appropriate treatment until we know what the goals of care are.

And then the next step, the fifth step, is selecting interventions and planning care. And this is, finally, after all of that, you determine what is best for the patient as far as an intervention is concerned and treatment is concerned.

And the last step is a monitoring of the progress. As time goes on, you know, what's happening to the patient, how are they progressing or not progressing, and this in essence is a quality improvement cycle because when you start monitoring the progress you start going back over the recognition and the problem definition, and the causes, you know, especially if things aren't working out the way you initially thought they would. This is the classic circle of quality improvement.

From a physician perspective, and especially in post-acute long-term care facilities, there is a medical director. The medical director is the person who is – a physician who is required by each facility to have and their role from a regulatory perspective is to implement resident care policies and coordinate medical services. And I've been a medical director for almost 30 years in addition to being an attending physician in many homes over the years and it is a very challenging role. And one of the things that we really have to be aware of is that the facilities need to rely on the medical director more than they are doing now.

I think it's an important role and it's something that I don't have time to go into too much detail at this point, but I really think that medical directors need to be more involved not only from a regulatory perspective because of their regulatory role but also from an operational perspective. And the key to that, though, is the medical director needs to be at the facility a certain amount of time.

Those medical directors that come and go in a very short period of time and just sort of pop their heads in and sign a couple of papers, well, that may not be meeting the needs of the facility, and certainly, may not be meeting the needs of the patients in the facility. So these are things that I know AMDA has been working on for many years and it's something that I feel strongly in that the medical director needs to be an active medical director and becoming – and become involved.

### **Coordinating Transitions in Care**

I want to skip over my next slide. I'm on slide 16, about what is transitional care, what is this definition of transitional care? Essentially, it's a set of actions designed to ensure coordination and continuity. It should be based on a comprehensive care plan and the availability of well-trained practitioners in all settings who have current information about the patient's treatment goals, preferences, and health or clinical status.

It includes logistical arrangements and education of patient and family. We can't forget about the patients at all and a lot of times – I'll go into it in a few minutes – we sort of put them on a back burner and they have expectations that are perhaps not being met. And there needs to be this coordination and this transitional care.

So what is this care coordination? It's a deliberate organization of patient care activities among two or more participants involved in a patient's care to facilitate appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources to carry out all the required patient care activities. And this is often managed by exchange of information among the participants responsible. But this exchange of information really is a key point that, I believe, Dr. Mattison will be talking about a little bit later in detail.

So what is the scope of this problem here? You know, why are we talking about this? It's certainly very common for patients in our long-term care community post the long-term care to be transferred from one care setting – one level of care or caregiver team to another. Unfortunately, it's also all too common for adverse events and avoidable complications to occur as a result of poor communication and coordination amongst all these caregivers.

I think people expected the computer, you have electronic records to help significantly in this, but they're bringing their own problems. You know, just because a, for instance, a medication list looks nice on a computer printout, it doesn't necessarily mean it's correct, and I've been in many situations where we end up with four, five, or even six different computerized printouts of patient's medications, you know, and the nursing facility – the nurses at the nursing facility kind of looking at it scratching their head, well, you know, what are we supposed to do? And so, these are issues that even though electronic record seemingly will help, you know, in some cases it's as much a hindrance as it is a help.

These communication deficiencies come about because we unfortunately rarely talk to each other directly. And I know, I've been involved with a number of facilities down in the New York City area where they are actually requiring physicians to talk to one

another. When a patient is transferred out from a nursing home, the physician needs to call the emergency room or one of the hospitalists and vice versa. There are some systems set up where that – the hospitalist needs to talk to a physician directly or a practitioner, and so these are things that are absolutely critical in helping us to avoid a lot of communication deficiencies.

Discharge summaries sometimes don't identify the appropriate care that was given in the hospital in specifics. I know a lot of discharge summaries are done somewhat briefly. When you do get a full discharge summary it's really a pleasure to read, but most of them are not. And one of the pieces of information that I always try to get when I have a patient that's coming from a hospital is the actual admitting history and physical and the emergency room evaluation. They really usually go into much more detail about the patient's past medical history.

And don't forget, these patients who are 70, 80, 90 years old have 70, 80, 90 years of history and it's rare that you really get a look at all that's going on with a patient because it's just so difficult to amass all that information. But if you don't know what surgeries the patient's had, if you don't know what medication the patient has been on and been unsuccessful, or what problems the patient's had, what specialist they've seen – if you just get a list of things that have happened in the past week or two, it's very, very difficult to continue care appropriately.

So these are important documents. Certainly discharge summary, but not only the discharge summary, history, and physical from the hospital, emergency department evaluations. And also I try to have the facilities as quickly as possible get records from outside physicians because even the hospital people don't know all of the ins and outs of what's happened on a local – on a local basis.

So, one of the issues that we come across here is that, especially now with all these silos that have been developed – there's hospitalist, there's a burgeoning SNFist, there's people who work in the office, the primary care practitioners – you know what's happening more and more are that practitioners, unlike myself and some of us older folks who work in all these settings, don't work in the other settings. There are many hospitalists who have never worked in primary care in an office. There are many primary care people who have never set foot in a hospital other than in their residency.

And so these are issues that really need to be addressed because a lot of the newer practitioners aren't familiar with some of the systems and some of the issues that occur in other facilities, and this leads to certainly a lot of miscommunication but also leads to perhaps inappropriate transfer of patients unsure of what the capabilities are in other – in other settings.

### **Barriers to Effective Care Transitions**

So I want to talk briefly about some barriers to effective care transitions. I'm on my slide 23. There are delivery system-level barriers, clinician-level barriers, patient-level barriers. From a broader delivery system level, each care setting, as I talked about, acts or

functions as a silo. And some of these silos lack any kind of a formal relationship with other care settings.

Even with the electronic record, very few hospital systems have records that speak with the nursing homes and the nursing homes are somewhat technologically challenged, although this is changing. They don't have systems that talk with many of the hospitals. So it's difficult to get this information back and forth, even at that level. The information systems just are in – the interoperability of the information systems is just not up to snuff. And I know some point maybe in the next year, two, five perhaps, this would be better. I know people are working diligently on it, but at this point it's still not very operable.

And there are, unfortunately, also financial incentives promoting transitional care. I mean until our financial incentives become more aligned. For instance, I know this is happening little-by-little, but there's still somewhat of a benefit for a nursing home facility to transfer patients to hospital because of the care issues – significant care issues that many facilities are unable to provide from a financial standpoint in their community. Insurance issues are certainly a problem. Hospice insurances, these are issues that are very difficult and until all of these systems become financially aligned, a lot of these transfers happen in, unfortunately, perhaps inappropriately.

From a clinician level, again a single clinician rarely provides continuous care across settings. I guess I'm kind of a dinosaur. I did this for many, many years, but even myself over the past 5 or 8 years or so, I don't go to the hospital anymore. I just – it just ended up that it was just too much. And I felt bad for patients – for my patients who I take care of in the office for many years, decades, that I'm not able to have the time to go to the hospitals, but I certainly do have the time in my practice to go to the nursing homes, and this is how my practice is set up.

There's also issues with specialists. Multiple specialists are now consulted on almost every patient and getting records to and from all these specialists is somewhat problematic. One of the things that we see a lot when patients are transferred out of hospital are followup appointments, which are not necessarily inappropriate. Certainly some are appropriate, but many may not be. Most primary care physicians should be able to take care of most of the issues that patients have in the nursing home; for instance, diabetes, COPD. We don't necessarily need to have specialists taking care of these patients. And so it certainly – we need to go back to what I was saying before about what are the overall goals of care and how can – how can we integrate that with the specialist care that is so prevalent in the hospital setting?

Care managers and social workers sometimes provide – in the past provided – longitudinal care, but now primarily associated with just specific settings and there's very little communication even at that level.

From the patient level, and this is what I alluded to earlier, patients and families presume, perhaps inappropriately, that their health care professionals will take care of their needs across the continuum. And often assume incorrectly that providers involved in their care

are sharing adequate and appropriate information. And as difficult as it is, we need to make sure that patients understand what the capabilities are of this information sharing. And we need to have long and broad discussions with families – and this really comes down to not just the staff in the facility but certainly, physicians need to be involved with this – with this task.

Older patients and caregivers are not adequately informed often about their disease process and the next steps in their care. Unfortunately, I've had a number of patients over the years who, you know, have an end-stage cancer who get transferred to the nursing home and they're not even aware that they have the end-stage cancer. It just sometimes is difficult, but these are discussions that need to happen on an ongoing basis, and the physicians and the staff in the facilities need to be understanding of that.

And it goes both ways. I think the hospital physicians need to be aware that of what – of all that's gone on in the nursing home, and that doesn't happen sometimes. Some of the information that we send to the hospital is somewhat cryptic at times. And the latest, certainly the latest studies and things, unless the hospital is keyed into the lab issues, they may not go with the patient or those goals of care that we painstakingly took care of in the nursing home for some reason don't get translated to the hospital and so we end up with miscommunication there. And I think our patients and families are assuming that we're having these discussions when in essence they're not happening as often as – as they should.

Patients need to feel empowered to express their preferences. I know this sometimes is difficult, but information that's given to patients needs to be accurate and especially expectations of what a nursing facility can do, what a hospital can do – you know these need to be very well defined. Issues come up more when there are – when there are a sort of a mismatch of expectations.

I want to just list a couple of factors that are considered by patients and caregivers in a study to be most valuable to them during these care transitions, and this isn't necessarily only a hospital and nursing home, but in general. But that is assistance with medication self-management, a patient-centered record owned and maintained by the patient to facilitate cross-site information transfer, timely followup with primary or specialty care, and a list of red flags indicative of the worsening condition and instructions on how to respond to them.

And these are sort of basic factors that patients and their families would like to see, and I'm not sure how often we're successful in helping patients have this list – checklist checked off. So just a way of looking at things that we need to remember that the patients are central here and in all of the transitions, people going back and forth to all the different settings, there's one constant and that constant is the patient and their family. And we need to understand that in all the information that goes back and forth, the families and the patients need to be primarily involved with this information.

From a transition standpoint and accountability, facilities perhaps should designate staff positions whose responsibilities include management of care transitions. Individuals in these accountable positions should be appropriately trained and empowered to develop relationships with their counterparts in the hospital, for instance, at sites to which the facility transfers patients and those that we get transfer from.

Perhaps a single individual should bear overall responsibility for ensuring that all the steps relating to a care transition are carried out in the correct sequence and in synergy with all the other performers in sort of a ballet kind of a process. Individual accountability for a specific task must be supported by a facilitywide culture that places a high priority on safe transitions and considers them to be everyone's responsibility, but having someone accountable to make sure that that happens certainly would go a long way towards improving these transitions.

Documentation, clear communication of appropriate information is the foundation of patient safety and good care transitions. And as I talked about, patient autonomy reigns supreme most of the time and patients and their families need to be aware of what the information that's going back and forth and to help make sure that it's accurate.

So, there is this QAPI, the quality assurance performance improvement, that the nursing facilities have been tasked with performing, even though a lot of the regulations haven't been dealt with yet. There's certainly a lot of information out there about quality improvement and the QAPI process, and this process of transition lends itself very, very well to delineating the different processes, the different subprocesses, of what happens in a transition and how well they are maintained, and it really goes very well towards the QAPI process. And so certainly, I know many facilities are working on these transitions in their QAPI meetings and their process in their facilities because it lends itself very well to it.

And so this is something that if you're not looking at, certainly, it's something that you should. The problem with the QAPI is, unfortunately, hopefully, this is changing as time goes on, is that there isn't a real deep understanding of how data is used. And you can't have an effective QAPI process without using data. In fact, that's the definition of it. It's data driven. And unfortunately, we still see a lot of people using two-point curves. You know – what happened last month, what happened this month – and we really need to get beyond that into dealing, into real root causes of where these processes break down. And so the transition process lends itself very well to dealing with the QAPI.

In the interactions with other facilities, the medical director and the physicians in the facility really need to take a key role here. A joint quality committee certainly is something that should be thought about between the hospitals that get, the people get transferred to most often, and the facility and the medical director needs to be a significant part of that. So at any level, again as I was saying before, the medical director needs to be involved with these issues.

So, I think that's all really I had time to speak about. Obviously, I touched upon many issues that are important. All these could be elucidated further, but I want to hold now and we will – I'll turn it back to Michele and we can go on with our presentation. I'll be available for questions.

Michele Laughman: Thank you Dr. Gelman. We're going to hold questions until the end, but next up we're going to have Dr. Melissa Mattison. Dr. Mattison will be discussing the importance of open communication across care settings for successful care transition. Dr. Mattison.

### **Open Communication across Care Settings**

Dr. Melissa Mattison: Thank you so much. It's my pleasure to speak with you today and to follow Dr. Gelman's presentation, which really hit on some very fundamental conditions, which I think are ripe for repair and, as he alluded to, quality improvement over the coming years, and I'm grateful for the attention this is getting by CMMS.

So in terms of conflicts of interest, I have none that are relevant. And I'm going to move right along to slide number 36, which outlines the agenda of what I hope to cover over the next 15, 20 minutes or so.

So Dr. Gelman spoke a bit about transitions in care and I'm going to talk as well about some of the complications therein. And I would pause here to say that underlying everything that we have been talking about – Dr. Gelman and what I will talk about – is that complications in transitions of care are common. They're very costly to society and individuals. They bring about significant morbidity and oftentimes are preventable.

I think I'll talk a little bit next about some of the pitfalls and the vulnerabilities that the nursing home population has in particular. Since this is a select population, we're not talking about sort of the average person who's admitted or discharged from acute care. I'll touch on some existing solutions and resources that are available today in 2014 to help us all improve care on our own local level. And I'll also speak very briefly about some innovations that are occurring.

On slide number 37 I've listed three cases that I think all probably ring true. They are cases that, you know, when I sat down to make this talk I was able to come up with off the top of my head without any bit of difficulty.

The first one is a medication problem that Dr. Gelman had alluded to. This was an 87-year-old man who had been admitted to the hospital, had been very sick, and was treated with, you know, fancy and expensive intravenous antibiotic ertapenem. And he was discharged to post-acute care – nursing home – for rehab. And when he went from the hospital to the skilled nursing facility there was no information in the packet that he went with commenting on how long he was supposed to be on the antibiotic, what sort of followup this gentleman required with the urologist, or if he even required any sort of safety monitoring lab while on that IV ertapenem.

The next case is one sort of in the opposite direction, not a patient going from the hospital to skilled nursing but from skilled nursing to the hospital. This is an older woman who had pretty severe COPD and was on chronic supplemental oxygen. And she showed up in the hospital with increased oxygen requirements and pneumonia. And she was confused, and yet there was no information that came with her about her preferred intensity of care, who her surrogate decisionmaker was, what her code status was – and that left sort of the acute care providers in a bit of a bind to provide the type of care that this patient would prefer.

And then, lastly, another problem of a patient going from the hospital to post-acute care was an older man who'd broken his kneecap and was put in a knee immobilizer and the information he went to rehab with was conflicting. In one part it said he was non-weight-bearing on his affected leg. And the physical therapist actually had said he was – weight-bearing as tolerated and the providers on the other end didn't know if they should be getting him up or not. As one can imagine, that's a bit of a challenge to rehab someone if you're not sure what their, you know, ability should be or shouldn't be in terms of weight-bearing status.

So moving on to slide number 38. Just to kind of set the stage with those three cases as we're thinking about transitions of care, I think it's worthwhile to pause a moment and define transitions of care. And the best definition I found was from Eric Coleman, who's really led a lot of work in this area. And he defines it as a movement of patients that they – a movement that patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

And he goes on to say – and I think this is actually a really telling quote, “Care transitions is a team sport, and yet all too often we don't know who our teammates are or how they can help.” And so, hopefully at the end of today's call, we'll all have some better understanding of who our teammates are and how we can work together to improve the care of older patients.

The next slide is number 39, and this is the same picture you saw earlier of an elderly woman. This is my grandmother, who at the age of 92 in this picture was quite vibrant and independent. But as happens too frequently, she fell and broke her hip and went to the hospital. And this sort of diagram on slide 39 illustrates the multiple transitions of care she had. And bi-directionally she went to first, after the hospital, she was not well enough to go home to her independent apartment, so she went to an A-plus sub-acute rehab facility.

And, you know, we're savvy consumers in our family, so we made sure we sent her to one of the best. But she – my grandmother – unfortunately didn't really like it there. She became depressed and delirious. She really refused to participate in rehab and ultimately did not improve enough to go back to living independently, so she had to transition to long-term care, which was not available at the sub-acute facility.

So she had to go to yet another place geographically, new providers. And there, of course, she continued her downward trend and became more depressed and continued to be delirious, developed pneumonia as well as C. difficile. And she had several more visits to the acute care hospital before she ultimately passed away about 6 months or so after she fractured her hip. And all along the way, at every single stop, there were challenges in the transitions of care. And I think this is the classic case. This is the case we see all the time.

So how can we improve the transition from the hospital to the sub-acute facility? From sub-acute facilities to long-term care? Long-term care back to the hospital? And sometimes, you know, sub-acute, obviously, back to the community, to independent living?

### **Four Pillars to Improve Transitions in Care**

On slide 40, you see the four pillars from Eric Coleman's Transitions in Care. And I wanted to address these because these are sort of widely cited in the literature as ways that we as clinicians and practitioners can improve the care of our patients across multiple settings.

So the first pillar is medication self-management. The patient must be knowledgeable about their medication and have a management system. The patient records should be dynamic and patient-centered. So the patient really needs to be able to help almost manage their personal health record.

There needs to be followup with primary care and specialists that the patient's able to schedule and complete. And similarly, the fourth pillar is the patient, again, needs to be knowledgeable about red flags, indications that their conditioning – condition is worsening, and how to respond. So, you know, I think slide 40, personally, is great and it would work very well for, you know, a middle-aged individual who is capable of doing all of this.

But on the next slide you'll see, what about the nursing home population? I mean, the burden of cognitive and functional impairment is significant. And it really undermines the ability of a patient to really participate a lot in their own transitions in care. And I think that this is really the lynchpin that's challenging safe transitions of care across all of these settings. You know, transitions are very common, very costly. Readmissions are, you know, up to a quarter of Medicare beneficiaries. There is often multiple outpatient specialists. As Dr. Gelman said, you know, if you lived to be 90, you have a 90-year-old – 90 years of past medical history and all the things that go with it.

Emergency and urgent care visits can challenge this multiple electronic health record, and paper records can challenge the record keeping. So we really have our work cut out for us.

On slide 42, and Dr. Gelman hit on this, patients that are transitions in care are really very important and important for all patients, whether you're young and capable of actively

participating in your own transition or whether you have surrogate decisionmakers or advocates in nursing home populations due to cognitive or functional impairment. I think that in terms of patients under transitions of care, we really need to focus for the nursing home population on these things.

What are the unique patient factors for each individual? So think back to the three cases that I spoke about initially. You can imagine the woman with supplemental oxygen-dependent COPD. You know, that's a unique patient factor. That's something that will somewhat dictate, perhaps, what her transitions in care might look like and what things she might like for her advanced directive.

Similarly, you know, can the accepting site sufficiently and adequately manage the patient's needs? I think that this frequently is a problem that I see when, you know, I work at a teaching hospital where the interns and the residents sometimes don't recognize the difference between the levels of care. If it's an acute rehab versus a sub-acute rehab, are they going to assisted living, are they going home with CNA, you know, can the accepting site manage the patient's needs?

Similarly, the accepting site and team need to be capable of managing the needs but they also need to know what those needs are. And so there really needs to be sufficient sign out in that regard.

And lastly, involving the family can be absolutely very, very helpful. And the surrogate decisionmakers in harnessing sort of their understanding, their advocacy for the nursing home patient.

There are challenges though, and I think that Dr. Gelman struck on a few of these. The ones that I think – that I see most in my daily activities as a hospitalist providing acute care and frequently preparing patients for discharge from acute care to sub-acute care, there is a tremendous amount of inertia where sort of, we've always done things this way and this is the way we will continue to do them. There's also this sense that, you know, the hospital doesn't or hasn't ever given us this information, so why should we start to ask for it now? Or we haven't historically partnered together and we've managed, so why should we change things now? And because there's very little communication oftentimes between the hospital and post-acute care, there can almost be an underlying distrust between providers because you actually don't know what their thought process was.

The post-acute care provider can wonder, what kind of doctor would send this elderly man to me on IV ertapenem and not tell me how long I should keep him on it? You know, who is that person?

Similarly, on the acute care side, who in the world would send somebody with oxygen-dependent COPD to the hospital and not tell me what their code status is? And a lot of that can be just poor communication across the sites that could really be broken down if maybe perhaps we had the time or the resources.

## Successful Strategies

I think the resources are coming and there are three strategies that exist right now that are quite well defined and available online. In the references section I have the – on the slide deck – have some of the websites. But if you just go to your Internet search engine and type in INTERACT, Project BOOST, or Project RED, you will see some of these more well-defined interventions and strategies one can use.

I will speak briefly about them. I'm not an expert in any of them and I have no interest financially or otherwise in any of the individual strategies. The INTERACT strategy, the INTERACT program was developed by Dr. Joseph Ouslander and is currently run by him and his team out of Florida Atlantic University. And it really, if you aren't familiar with it, is this quality improvement program focusing on nursing home patients, long-term care residents, and trying to improve either the communication from post – from the long-term care to the hospital or to just reduce the acute care transfers, you know, that are even required to begin with if a patient has a change or a resident has a change in clinical condition.

Project BOOST, on the other hand, is kind of the other direction. This is intervention that is funded through the Society of Hospital Medicine and I believe the Hartford Foundation to train and teach acute care providers around transitions in care best practices. It's a mentored implementation with mentors and experts guiding you and your team at your acute care hospital over time to implement quality improvement strategies to positively affect the process by which you and your facility, your hospital, are discharging patients from acute care to a post-acute care setting.

And lastly, Project RED is out of Boston University Medical Center. RED stands for Re-Engineered Discharge. And they have a quite complete website that sort of reviews what the good components are to the discharge process to try to reduce the needs for readmission, to make sure the patient's needs are all being addressed in a sort of checklist almost format.

The last thing I wanted to mention briefly are some of the innovations and I think this is where, hopefully, the folks on the line can sort of sit back and think about the local dynamics at their own site and think about what things might work locally that they might be able to participate in to positively affect change within their own clinical purview.

Locally here, at Beth Israel Deaconess, we do have warm handoff, which we define as a conversation. Dr. Gelman had mentioned he's aware of some places that mandate warm handoff for certain cases for the hospitalist or the discharging provider to pick up the phone and have a conversation with the accepting doctor. I think this has tremendous potential.

I think logistically, we have not been able to actually figure it out in a seamless way. Frequently we don't know who the accepting clinician will be at the post-acute care site and we have no way of, sort of, tracking them down in any easy – easy manner. And so,

until you sort of have each other's cellphone numbers, I think we're going to be struggling to logistically pull this off. But I think if you are in a – maybe smaller community where you have one or two post-acute care sites and you get to know each other, it might really have great potential. And if we can streamline things here and figure out better mechanisms to just get in touch with each other, I think that again it has significant potential.

And lastly, I just wanted to touch on something that we recently started back in September of 2013. It's ECHO Care Transitions, which is generously supported by a grant from the Reynolds Foundation. It's a predominantly an educational grant to teach medical residents about the major tenants in safe transitions in care. But it has a significant clinical component whereby every single week the hospital has a conversation through video, HIPAA-compliant technology with the skilled nursing facilities. There's about a half a dozen that participate that receive most of our discharges from the acute care setting.

The hospital, and I'm part of that, has a multidisciplinary team who has a conversation with these post-acute care sites and the clinicians there about the patients who were just discharged over the preceding week to make sure any questions, concerns, et cetera, are addressed. And because we're getting to know each other better, because we're getting to talk to each other every week, if things come up in the middle of the week before we have our scheduled conference, they know how to find us. They call us, they email us, and we're able to be kind of a bridge or a liaison back to the acute care world to track down the specialist or the provider.

So that if a person is discharged from our site and has an activity order that in one page says weight-bearing is tolerated and the other page says, you know, non-weight bearing, the skilled nursing facility won't hesitate to very quickly and easily resolve that problem. And then we can, on the other hand, feed back that information to the person who filled out the discharge paperwork to say, hey, you know, this is an opportunity where, you know, maybe we should double check things or we should realign the way we do our discharge paperwork so that there's not an opportunity to write in two different places the same type of information.

So with that, I think, I'm going to wrap things up. I do think that, not to be too much like Nike and say, "Just do it," but I think that on some level, we do just have to do it. We have to be not afraid to pick up the phone to call our clinical counterpart at a post-acute care site or the acute care site to talk about a particularly complicated patient or even a not complicated patient but someone on whom we have a question.

And I think we need to continue to work with the staff at our facilities to streamline the communication process to make sure we're sending the right information, not an overburden, you know, four different medication lists, like Dr. Gelman said, none of which seemed to match up. You know one list would be great if it was the right list. And continue to work on this and I think we're – there's a lot of work to be done and, hopefully, in the coming years, we'll have figured out how to do this in a much more

streamlined way. But there certainly are resources online and people who are already working very hard on this. And so some of it is just copying the good work that others have done elsewhere.

So with that, I will wrap up and take questions later.

### **National Partnership: Next Steps and Future Goals**

Michele Laughman: Thank you Dr. Mattison. I would now like to share some information about some of the next steps and future goals for the National Partnership. We are grateful for the efforts of so many people and organizations. Based upon some of the recent data, we have now seen a 17.1 percent reduction in the rate of antipsychotic use in long-staying nursing home residents.

CMS, along with many of you that are represented on today's call, have had extensive conversations to determine and establish a challenging yet achievable set of goals for the future. We've developed a press release and are currently moving this document through the clearance process. The goals selected are consistent with the important progress that's been made to date and express our commitment to continue this critical effort.

We thank you for your participation in today's call and we look forward to continued collaboration and partnership. I will now turn it over to Leah and Victoria for the Q&A session.

### **Question-and-Answer Session**

Leah Nguyen: Thank you Michele. Our subject matter experts will now take your questions about the National Partnership to Improve Dementia Care in Nursing Homes. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue. And we will address additional questions as time permits.

All right Selema, we're ready to take our first question.

**Operator:** To ask a question press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster. Please continue to hold while we compile the Q&A roster.

The first question comes from the line of Marvin Byard.

Marvin Byard: Hello, this is Marvin Byard, I'm a consultant pharmacist with Bishop Hodges Continuous Care Center in West Virginia and I was just wanting to see what the URL address should be for evaluating this program today. I tried clicking on the one on the screen and it takes me to the evaluation for a program that was last week sometime. So ...

Leah Nguyen: Hello, this is Leah Nguyen, I believe it will probably be live a little bit later on in the call. So if you want to just check it again, the evaluation for this call should be up on that link.

Marvin Byard: All right. Thank you.

**Operator:** The next question comes from the line of Nanci Wilson.

Nanci Wilson: Hi, this is Nanci Wilson. I'm with Plum Healthcare out in the West Coast. And I'm really not asking a question, I'm making a comment. I have participated – we've – we're on – participating on another initiative right now and have not been on any previous calls related to this initiative. I just would like to make a comment that the title of this call was a little misleading, and I think that what was delivered was wonderful in that it really helps in looking at effective collaborative communication. But I don't know if any call has really addressed how we enhance the skill set and the appropriate treatment and communication regarding the dementia patient at all levels of their disease process. And I just want to comment that I think that that would be extremely helpful, especially at the SNF level.

Michele Laughman: OK, thank you for that comment.

**Operator:** The next question comes from the line of Jeanette Fraser.

Jeanette Fraser: I – hi, I'm a clinical nurse specialist and have worked many years in the hospital setting, then now just began to move out to the outpatient setting and looking at transitions of care. I'm very familiar with BOOST, RED, and INTERACT. They've been around for quite a few years.

What I have noticed is that although community programs have a great amount of research behind them, some great data to support that they are effective, none of them seem to be taking off. And I was wondering if either of our speakers could address what they perceive or what they know to be the barriers in getting those programs enacted across the nation. What are we really facing that's keeping these wonderful programs from being implemented?

Dr. Leonard Gelman: Hi, this is Dr. Gelman. I can speak a little bit to the INTERACT program. I'm dealing with that in one of the CMMI projects to reduce hospitalizations from long-term facility. And I think that one of the biggest issues is, actually, just in the implementation and in the understanding of what the project actually is. And I know Joe

Ouslander has done many – he’s written articles and done many sessions and has helped from an education perspective to try to get facilities to understand what the issues are.

But it really comes down to being diligent about the – about what’s happening with patients and about the acute change or condition. And that’s really what it comes down to. And it’s just not easy to get everybody on the same page with that. So I think it’s just a matter – I think as Dr. Mattison was saying, just keep plugging away and eventually, it sort of – it does materialize into a well-oiled machine once you understand the basics of all of it. So it’s just a difficult thing in dealing with root causes is the key to it and try to find out, you know, why things are happening the way they’re happening is the real QAPI process.

Dr. Melissa Mattison: Yes, this is Dr. Melissa Mattison. I would agree with what Dr. Gelman said. I think, you know, change happens slower than anybody would ever really want. And, you know, just to get things reprogrammed within, speaking on a local level, if I notice something that I want to change across the board and I want to get our electronic medical record or our provider order entry system modified for a systematic improvement.

You know, there are certainly resources here, but I have to get it in queue. And it can take a while. And then, you know, if you really want to overhaul an entire process, it takes a while, it takes resources, it takes energy, it takes institutional commitment, and it takes local champions. And I think everything really needs to be lined up. And unfortunately, it’s only been a more recent phenomenon where there’s been financial incentive in my perspective to do this.

Previously, you know, I think Eric Holman was beating a drum, but people were not really paying a lot of attention to him or the issues that he and others were bringing about. But over time, it’s increasingly become more relevant from a financial perspective for providers and facilities to pay attention to this. And yet, even today things don’t fully align in terms of, you know, the readmissions and the cost therein and who’s paying for it.

Does the skilled nursing facility mind if a person is readmitted? Perhaps in an Accountable Care Organization, or shared risk model – financial risk model strategies, but not everything has come to fruition yet and I think over – hopefully, over the next, you know, decade, things will kind of lay out in a way that in the end the user, the patient or the resident, is going to feel the benefit of this.

Leah Nguyen: Thank you.

**Operator:** The next question comes from the line of Michelle Webb.

Michelle Webb: Good afternoon, can you hear me?

Leah Nguyen: Yes, we can.

Michelle Webb: OK, wonderful, thank you. I'd like to thank Dr. Gelman and Dr. Mattison for a wonderful presentation. I have a quick question regarding AMDA's courses or training for medical directors in relation to the care of patients with dementia. I wanted to know the doctors' feelings on those courses and if you would recommend any additional training or courses for medical directors who may not be geriatricians, who may need a little bit more education related to dementia and other forms of cognitive disorder or disease?

Dr. Leonard Gelman: Thanks Michelle. Yes, you know, obviously, in any one short course, you're never going to be completely comprehensive and learn all the issues that are needed to take care of patients with dementia. I think it's, you know, we have clinical practice guidelines on dementia in addition to some of the courses that we have out there. I think a lot of it just comes from experience and knowledge over time dealing with these issues and a diligence, again, into trying to learn about what – what – what there is to do for patients in this realm without medications.

And I think –this is one of the big issues that, obviously, this project is dealing with is, can we do something else besides just giving a medication to a patient? And I know almost every day when I'm in the nursing home, you know, I'm challenged with this. Nursing staff keep asking for something to do for a patient. And families are asking for something to do with their loved one. And it's very – its challenging to go away from medications and do things that, you know, that help without giving a medication.

And so it's just a matter of being diligent into looking at all these issues – and there are many educational opportunities out there across the board. American Geriatric Society has a lot of issue – has a lot of information, as well as do the geriatric psychiatrists.

You know it's a complex problem. Dementia is a very complex, difficult problem and it's not easily solved with, you know, a push of a button, a push of a medication. You know these are people who have a reduced capacity in some way, shape, or form and most times, in many ways, shapes, and forms. And figuring out what has to be done for each individual patient, it's a lot of just trial-and-error and a lot of it is just learning over time how to deal with patients.

Michelle Webb: Thank you Dr. Gelman.

Dr. Leonard Gelman: Sure.

**Operator:** Your next question comes from the line of Andrea Albaum.

Andrea Albaum: Hello, can you hear me?

Leah Nguyen: Yes, we can.

Andrea Albaum: OK. I am a dementia support group leader from the Alzheimer's – a facilitator from the Alzheimer's Association and also a health information manager. And

I really just want to applaud Dr. Gelman and Dr. Mattison for all they're doing. But I do want to tell you, you can – this is the first time I've heard this information and I'm going to share it when we have our next group. And I really think you do – you can take a two-pronged approach and if someone can write an article or even come up with some general guidelines what the families or those who are, you know, the medical powers of attorney need to know when these people leave the hospital, leave the nursing home. You have a lot of groups out there, especially the Alzheimer's Association has an eNewsletter and AARP that would really be able to then hold the people in the clinical settings accountable.

For example, we have people who are transitioning up and back and we're constantly saying to them, call for a care meeting. The families do not know what to do, what they should ask, what they should look for. So if you give them like change the four pillars, and say to the families when you leave a hospital, when you go in – this, that, and that – they will do it. The families are very hungry for information on what they can do to advocate for their loved ones. So I just wanted to, you know, to add that. It's something you might – you might consider.

Dr. Melissa Mattison: It's an excellent suggestion. I think there are some websites out there for families and patients. I've seen them through the New Old Age blog on *The New York Times*. They've put links to some sites that sort of explain to families how to best advocate for their loved ones as they transition from one site of care to another, what they need to know, what they should be prepared to ask, what information they should have with them, et cetera, et cetera. And I think those websites are invaluable for some of the patient families. I don't know the name of a website off the top of my head, but I can look right now and see if I can – if I can find it.

Andrea Albaum: So that would be great, but what I'm saying is if it's in the AARP eNewsletter, if it's in the Alzheimer's Association Dementia Newsletter, and then even if somebody just wrote up a little summary of the projects you're doing, you might have a lot of support from, you know, families out there and other people to help with your – with your program. 'Cause in our meeting we have a resource table. So then we kind of list out and we give to people, you know, if you have this interest, this concern, this is what you can take with you to help. And then it's kind of like it's a trickle down kind of thing. But thanks for all you're doing. It's great.

Leah Nguyen: You're welcome. Thank you.

**Operator:** Your next question comes from the line of Benjamin Bensadon.

Benjamin Bensadon: Hi, can you hear me? I'm calling from Florida Atlantic. So Dr. Ouslander is my boss. So I'm very familiar with INTERACT. I'm also a clinical psychologist. So I have one main question. At the end you have the slide on challenges and strategies. And one of the challenges is distrust of providers from other sites. I'm just wondering, you know, I think that's very vital, especially as a clinical psychologist, what sort of the strategy to sort of address that at this point – the distrust?

Dr. Melissa Mattison: Well, I think that all politics is local. And as I alluded to in my, you know, into what I was saying. I think that you have to sort of recognize what the environment is like where you are. And then work with your team to address the needs. So I can envision that things are very different in, you know, Boston with a large academic medical center and a large variety of post-acute care sites. How do you break down the barriers so that there's less distrust and so that people know each other and get to know each other and learn to talk to each other – providers across sites? That's very different than, you know, my family that lives in rural Illinois that has one hospital and like two nursing homes in the greater area. You know I think that we probably – we probably have to just work on different – different ways to address those challenges.

Locally here we have had – we've been fortunate to apply for and receive grants from various foundations to support some of the educational programs that we've done for the hospitalists here and have invited nurse practitioners and other champions from local sites to come and speak with hospitalists and vice versa. We – as a hospitalist and as a geriatrician I sort of have two, you know, one foot in each camp. And I feel like I can parlay my knowledge across the care continuum a little bit to assist my colleagues who are both hospitalists and my colleagues who are providing the care in the post-acute site. But I think locally, you know, you have to sit back and ask yourself, Who can I ask? Who could be a champion in this care setting? Who could be a champion in that care setting? How can we get the ball rolling?

And then once you get the momentum and, you know, there was a tremendous amount of distrust at one of our post-acute care sites in particular. And I don't know why, but the providers there whenever we would speak to them initially and talk about clinical care, there was almost this feeling of animosity. They didn't say anything, but it just – it didn't feel like a very happy conversation. When we would – we'd get off the phone and we'd feel like that just didn't feel right.

But it took about 6 or 7 months and finally they realized that we were all on the same side. And boy did the tone of the conversation change and the quality of communication changed. And so, I mean, I'm not sure what we can do, going all the way back to how we're training hospital clinicians versus primary care clinicians. I mean I think that that's a topic for another day.

How do we train nurses? How do we train physical therapists across care continuum so that, you know, people who are graduating and becoming nurses or becoming doctors know what it's like in different care settings and have respect for each other?

Dr. Leonard Gelman: You know I want to add – and that was exactly the word that I was thinking about is respect. You know, I don't know how many times, you know, we send the patients to the hospital and, you know, a family member comes back, you know, and you know, they have the comment, “Well, the hospital said this is the worst case they've ever seen,” of whatever it was and vice versa. You know, a patient comes back to the facility and people in the facility say, “Oh, they always start all those medications on this

patient, I'm not quite sure why," you know, or "We spent months and months trying to get them off of the antipsychotics and all the hospital did was put them back on it."

So I mean we have to respect the people's capabilities in the respective facilities and understand and, this goes to what I was saying about the causes, understand why these things are happening. You know, why is the patient being put on medications that the nursing facility painstakingly took off over months or years? You know, why is that happening, and back and forth?

And why is the – why is the hospital saying that this is the worst case they've ever seen? You know, what's happening there? And the best way to do that is not only respect each other but also communicate. I did mention about a quality committee, you know, across settings that should meet – that could meet periodically to help with this in a local community because I agree, Dr. Mattison, that, you know, all this is local. And you need to set up a committee with the facility that you spend a lot of time with sending your patients back and forth to talk about these issues and to go over all these things.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Lisa Parobek. Ms. Parobek, your line is open.

Your next question comes from the line of Stuart Gordon.

Stuart Gordon: Hi. To follow up on that last discussion, it seems to me that something else might encourage transition – better transitions is – are the incentives. So you've got the Medicare Post-Acute Bundle Pilot Program. If you reward transitions in some way within that bundle or in the readmission penalties if you can knock out a penalty, if you can show that transitions were appropriately applied or even if there were outcome measures that you can apply either in the post-acute setting or in the acute care setting, it seems to me that those would encourage providers to work together.

You know, I was at a – in December of 2010, I attended a CMS, a roll out of a transition, highlight, a CMMI transition pilot that involved acute care hospitals and community – based organizations. And I have to tell you that there was a lot of energy in that room. But I've yet to see or hear of any of the results that were outcomes that were found as a result of that pilot. And in fact, I was in conversation today with someone at CMS and we were discussing transitions for behavioral health providers from inpatient into the community and how it might be helpful to know what those findings were, but those findings as far as I know have never been disseminated.

So the issue to me is twofold. One, you know, if you're going to have all these pilot programs, you need to get results out. And two, if you want to have better transitions, you have to reward better transitions. Thank you.

Dr. Leonard Gelman: Yes. No. It's a great point, Stuart. You know, you hate to say it this way, but behavior follows dollars, you know, for the most part. Unfortunately, it's the way of life. I think as we become more shared in our responsibilities with ACOs and the like over time, you know, these responsibilities will be shared as well rather than just shunting people from one setting to another. I think it's unfortunate that it's been built up this way over time. Hopefully in the next few years, little by little, it will start to shift. And people need to take shared responsibility for taking care of our frail – frail elderly.

Leah Nguyen: Thank you.

**Operator:** Once again, to ask a question, please press star then the number 1. The next question comes from the line of Lisa Parobek.

Lisa Parobek: Hello. Can you hear me?

Leah Nguyen: Yes, we can. Do you have a question?

Selema, can we take the next question?

**Operator:** Your next question comes from the line of Marvin Byard.

Marvin Byard: Hello, this Marvin Byard and I'm a consultant pharmacist. I work both in the hospital and in a long-term care facility owned by the hospital, so I get to see a lot of things that are happening on both ends that need to be shared. And when we have a care manager – we have a couple of care managers in the hospital that provide free admission information to me, so I can get a head start on these patients that are going to our long-term care facility. But we never had a care manager or anybody that was really passing this information on to the next caregiver after they leave long-term care.

And as of a month ago, they – we hired another care manager. Now this care manager is going to take care of that. You know, there was always a question of, you know, whether systems – as far as a pharmacy recommendation, is there something we can take care of while they're here in this sub- acute care or is this something that we should pass on to the next caregiver and let them take care of this? And now we have a care manager and it's really rewarding to me and an incentive to do even more.

I'm just wondering what – how do other facilities – long-term care facilities handle, giving the patients from the long-term care facility to the home care setting again? Do they use a care manager? Do they use other health care workers? How does that happen?

Dr. Leonard Gelman: Well, they – just from sub-acute the care or long-term care, which doesn't happen quite as often, but certainly from sub-acute care – from the post-acute care I should say to home setting, that happens quite often. And what usually happens is there are local nursing organizations, visiting nurses, et cetera, that help with the patients. So again, you need to coordinate that with what your local resources are in your

community, however they're determined. You know, so that that helps in that transition from the post-acute care to home.

Leah Nguyen: Thank you.

**Operator:** The next question comes from the line of Mary Compton.

Mary Compton: Hi, my name is Mary Compton. I'm in Texas. I'm a nursing home consultant. In response to the woman that was asking about how some help in the article and everything, [medicare.gov](http://medicare.gov) actually has a discharge planning checklist for patients and caregivers. And if you go into [medicare.gov](http://medicare.gov) and just Google or search your discharge planning checklist, there's a great document there that can be used.

Leah Nguyen: Thank you.

**Operator:** And there are no further questions at this time.

### **Additional Information**

Leah Nguyen: Thank you. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release announcement in the MLN Connects Provider eNews when these are available.

On slide 48 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Please join us again for our future MLN Connects Call. Registration will be opening soon for the 7th – September 17th call on PQRS.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the National Partnership to Improve Dementia Care in Nursing Homes. Have a great day everyone.

**Operator:** This concludes today's call. Presenters, please hold.

**-END-**

