

**Centers for Medicare & Medicaid Services**  
**National Conference on Care Transitions**  
Friday, December 3, 2010

**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.

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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 carrying 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.

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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

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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

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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.