

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

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.

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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

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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

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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 no 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.

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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 it 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.

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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.

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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.