

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

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

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

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

because we really have no community infrastructure, we've never thought about the community infrastructure that we ought to have in place for achieving common goals.

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

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

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

If she's with a home health agency, the odds are actually much better than 20 percent that she will be tagged. If she's a skilled

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nursing facility, she could have a nurse liaison go and put herself in arm's length so that she could be directly tagged. But we know even when that happens, often, there's inadequate transfer of functional information.

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

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

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

Many of us aggregated our providers within the community into clusters, matching hospitals with their nursing homes and physicians

and home health agencies. A number of us started by getting hospitals engaged together, nursing homes engaged together and home health agencies engaged together. And some of us just went for where the low-hanging sort of carrot opportunities. This SNF to this assisted living facility, this hospital with this SNF, that sort of thing.

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

But I would say that what we wanted this legislation to do was support three basic things. One was to create a sense that there's a population of people and that we all could figure out who lives here and what do they really need. We can view that by focusing on a population target. Secondly, there's a lot of tax dollars coming into every community for the support of elderly, frail people. It's not just medical providers who take money from Medicare. QIOs take money from Medicare. We track all this data. We kind of know what's going on. We're not fully engaged in the communities. Area Agencies on

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Aging are actually in the communities, delivering many services that are similar, counties support housing authorities that can be helpful in ensuring people have safe places to go, recreation centers support senior programs.

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

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

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

she had in mind.

But, you know, first of all, it's critical. You need to figure out, you know, where are your patients and who do you share them with at the very least there needs to be thoughtful consideration. I think that we should have forums in communities springing up for routine exchange of medical quality data, outcomes data, you know, who do I share patients with and how do they take care of them. We should have routine discussions of readmission cases, you know, like tumor rounds, we should do transition rounds. I think that any community interested in doing this, should be reviewing very comprehensively your existence and your structures to referral to palliative care and hospice providers.

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

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

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cities, housing authorities, all those things I already mentioned.

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

Thank you.