# Care Transitions Forum
# November 9, 2011
# Meeting Summary

Participants

Peg Ackerman, Commonwealth Care Alliance
Lindy Alves, HVMA
Mary Meade Ambrefe, Pharmacy Consultant
Zoe Barber, Massachusetts Health Data Consortium
Kate Bones, Institute for Healthcare Improvement
Kathryn Burns, Elder Service Plan of the North Shore
Christopher Chue, Institute for Healthcare Improvement
Mark Craig, BON HealthWatch
Donna Curran, MassPro
Keren Diamond, VNA Boston
Cheryl DiPaolo, Emerson Hospital
Peter Eggleston, SBR Health
Louis Freedman, Group Insurance Commission
Amy Goldstein, Medical-Legal Partnership Boston, Boston Medical Center
Apurv Gupta, AltaVentiV
Laurie Herndon, Massachusetts Senior Care Foundation
Kirsten Hinsdale, Boston Medical Center
Emily Kearns, Greater Lynn Senior Services (via phone)
Vic Kingsley, Medical Resources
Patrick Littlefield, JPL Ventures
Barbara Lund, Massachusetts eHealth Collaborative
Amy MacNulty, Community Care Linkages
Kelly Magee, Caregiver Homes of MA
Janice Masi, Seniorlink/Caregiver Homes Network
Cheryl Pacella, Caretenders
Janice Romagnolo, Southcoast Physicians Network (via phone)
Ronnie Rom, MA Department of Public Health
Craig Schneider, Mass. Health Data Consortium
Helen Siegel, Home Care Alliance of MA
Madhvendra Singh, BHMA
June Stark, Tufts Medical Center
Deb Sylveston, Commonwealth Care Alliance
David Young, Seniorlink
Elisabeth Zweig, Harvard Vanguard Medical Associates

## Summary

**Announcements**

We would like to congratulate Laurie Herndon of the Massachusetts Senior Care Foundation and Terry O'Malley, MD of Partners Healthcare for being awarded by the Massachusetts Medical Law Report as Honorees of the Rx for Excellence award.

The Consortium's next major event is the Fall Workshop on payment reform. The event, "Payment Reform: Innovation for the Nation" is on December 14 at Babson College. There will be four morning keynote presentations and two rounds of interactive workshop sessions in the afternoon, with four topics to choose from. The presentations and workshops are designed to address the emerging issue of how to make a successful transition from fee-for-service to bundled payments. This event is expected to sell out, so please register soon to secure your seat! A flyer with more details is attached to this document.

**Caregiver Homes Initiative**
*Kelly Magee and Janice Masi, Senior Link*

SeniorLink offers deep expertise in serving consumers with complex physical, behavioral, and medical needs. The Caregiver Homes service model, available to Medicaid beneficiaries in Massachusetts, Rhode Island, and Ohio, offers 24/7, dedicated at-home, person-centered care for frail elders and persons with disabilities. Clients live with a professionally supported, technology enabled, paid caregiver. **(Please see Handout)**

Discussion:

Q: Is care done at individual homes or group residences?
A: Caregivers work with clients in individual residences, with up to 3 patients per Caregiver.

Q: Is a Medicaid Waiver needed?
A: Enhanced Adult Foster Care program regulations permit this with a Frail Elder Waiver. Many clients are more comfortable living at home with a trusted caregiver.

Q: Is this program related to the ASAP network?
A: It is not directly related, but there is a lot of communication with ASAPs.

Q: Are there programs to teach caregivers how to cope with stress? Are there respite services?
A: We offer support groups for caregivers and opportunities for stress management and relief. We coordinate respite services and people who can provide alternate care.

Q: Is there a process that care team members would do a face-to-face evaluation to avoid a re-hospitalization?
A: We do an initial assessment so that the plan of care is targeted toward the problem areas. This is updated monthly as well as reconciled with daily notes from caregiver. Extra visits are done as needed, which gives an opportunity to share, discuss, and monitor.

Q: How do you handle a situation with urgent care? How do you do triage?

A: The caregiver is responsible for giving notification by phone if there is an urgent problem. Daily notes also reflect irregularities. Caregivers are trained to respond to an emergency. We have 24/7 tele-triage support.

Q: Describe nature of the population, including eligibility criteria, and geography
A: We exist all across Massachusetts and have managers and teams that cover different geographic areas. Patients are 16 years and older, with MassHealth or CommonHealth, must have a chronic condition and require assistance with upper and lower body functions. About 20% are under 65, 1/3 over 80, 10% over 90 and 60% are dually eligible.

Q: Is there any kind of early warning tool?
A: Teams utilize notes longitudinally and monitor symptomatology. We push training out and reinforce training on monthly visits.

Q: Where do the patients go when discharged?
A: 60% of our patients die, some go to skilled nursing facilities, and others move out of the state. Most however, are in the program until death.

Q: When patient is transferred, what is the arrangement for transferring relevant patient information?
A: We have semi-annual communication with the Primary Care Physician where we do updates on client, physician summary form, and plan of care. We also conduct follow-ups after a patient is seen by a doctor and have discharge planning meetings. Teams are always alerted when a client is sent to the hospital.

Q: What is the interaction with the PCP regarding patient status?
A: We have semi-annual meetings and encourage communication. We will meet more frequently if it is necessary. Caregivers will always alert PCP in a necessary situation.

Q: What is the Case Manager Capacity?
A: This depends on the assignment, but 35 clients per month on average.

Q: Do you do root cause analysis of re-admission?
A: We have 1 million notes in the database and we aggregate the data but haven't yet devised a way to analyze it. It seems that clients with one issue, always go back for the same issue, for example respiratory problems are re-admitted for respiratory problems.

**Safe Transitions: From Patient Centered Care to Patient Directed Care**
*Stefan Gravenstein, MD, Rhode Island Hospital*

Rhode Island Hospital implements the Eric Coleman model of Care Transitions, where coaches teach patients to be engaged in their treatment with four pillars; a personal health record, performing medicine reconciliation, performing follow-up visits within 7 days of discharge, and recognizing "red flag" symptoms". The art of this model is not telling a patient what they need to know, but seeing if they can figure it out for themselves. If not, the patient needs to reach out for help. **(Please See Handouts)**

<u>Discussion:</u>

Q: In MA AAAs/ASAPs are committed to the Coleman model and have trained over 200 coaches, but are still finding it hard to integrate the coaching into the PCP practice/workflow.
A: The key is partnership. Work with your early adopters and ask them to measure their successes and confirm how fantastic the model is, then brag about it. The PHR can improve efficiency of discharge and value of visit, but we don't know yet if it has an effect on regular care.

Q: How are you being reimbursed for coaching?
A: First the Rhode Island Quality Improvement Organization was paid by CMS to do Care Transitions. Now we have received grants from the Beacon Community and ADRC. We are expecting future funding from other grants like 3026.

Q: Is there an Electronic Exchange for the PHRs
A: Still using paper, but this is in development. This needs to be a living document that can be edited by the patient. The act of writing is valuable to the learning experience.

Q: What are the differential rates of activation?
A: The numbers are too small to predict.

**Project Updates (State Action on Avoidable Re-Hospitalizations)**
*Kate Bones, Institute for Healthcare Improvement*

The MA STAAR Initiative is making a lot of exciting new steps in the upcoming year. They now have a total of 50 hospital participants, 69% of MA hospitals. They have also added two new initiatives to their regular task list, including the Improvement Science in Action Workshop, which includes monthly coaching calls, and Learning Networks for clinicians and staff in OP, SNFs, and HC agencies facilitated by IHI and expert faculty. They also continue to perform their usual agenda items and led a 1.5-day state-wide Learning Session last month. **(Please See Handout).**

## <u>2012 CTF Calendar</u>

- January 11, 2012
- March 14, 2012
- May 9, 2012
- July 11, 2012
- September 12, 2012
- November 14, 2012