Care Transitions Forum
September 21, 2010
Meeting Summary

Participants

Sandra Albright, Executive Office of Elder Affairs
Mary Ambrefe, Pharm. D.
Rich Balaban, MD, Cambridge Health Alliance
Madeleine Biondolillo, MD, Radius Healthcare
Alice Bonner, Department of Public Health
Carol Broverman, Partners HealthCare
Patti Calvert, Norwood Hospital
Tom Champine, American Medical Response
Keith Chudyk, Department of Public Health
Keren Diamond, VNA of Boston
Deborah Dolaway, Cranberry Hospice/Jordan Hospital
Janice Foust, UMass Boston
Jane Franke, Blue Cross and Blue Shield of Mass.
Lou Freedman, Group Insurance Commission (via phone)
Sharon Gale, Mass. Organization of Nurse Executives
Pat Gavin, Norwood Hospital
Tim Griesmer, Masspro
Paula Griswold, Mass. Coalition for the Prevention of Medical Errors
Jon Harding, MD, Tufts Health Plan
Susan Jamieson, St. Elizabeth's Hospital
Amy MacNulty, Community Care Linkages
Jessica Moschella, Health Care Quality and Cost Council
Pat Noga, Mass. Hospital Association
Terry O'Malley, MD, Partners HealthCare
Cheryl Pascucci, Park Avenue Medical Associates
Mary Ann Preskul-Ricca, Mass. Association of Health Plans
Craig Schneider, Mass. Health Data Consortium
Helen Siegel, Home Care Alliance
Mary Sullivan, Mass. College of Pharmacy and Health Sciences
Jeff Wetherhold, Institute for Healthcare Improvement
Joel Weissman, MGH Institute of Health Policy
Jean Zaleski, Holyoke VNA

Summary

Announcements

Alice Bonner, Department of Public Health
Paula Griswold, Mass. Coalition for the Prevention of Medical Errors
Craig Schneider, Mass. Health Data Consortium

Craig Schneider announced that the Consortium and the Massachusetts e-Health Institute will be holding the HealthMart Conference and Trade Show on October 5th in Worcester. This event is focused on EHR deployment, and is free to members of the Massachusetts Medical Society, the Massachusetts Hospital Association, the League of Community Health Centers, and the Medical Group Management Association. To receive complimentary admission, go to http://mahealthdata.org/Events?eventId=173080, select: Partner – MeHI, and enter the case sensitive code: HM10-maehi

MeHI is conducting a series of programs on the Regional Extension Center around the state. After HealthMart, there will be programs in Brockton on October 7th, Fall River on the 19th, and in Fitchburg on November 3rd.

The Consortium's fall workshop will be held as part of the World Healthcare and Innovation Technology Conference near Washington on November 9th. www.whitcongress.com

Paula Griswold announced that there will be a summit on February 2-3 for new cross-continuum teams for the STAAR project, at a site TBA (Worcester?). A save-the-date notice will be sent out by IHI.

Paula noted that the Patient and Family Advocacy Council requirements go into effect on October 1st. A group of hospitals are thinking about how the PFACs can help improve the care transitions and discharge processes. Alice Bonner added that one of the frequent comments regarding the Care Transitions Strategic Plan is that it needs to be more patient-centered, and the PFACs can be a great resource to accomplishing this.

In reference to patient-centeredness, Craig pointed out that the only two requirements that were added in the final meaningful use rule (all the other changes were reductions in mandatory requirements or levels of benchmarks/thresholds) were patient-centered: advanced directives and discharge/transition information provided to patients; both of these are optional requirements.

Terry O'Malley said that Partners is adding a PFAC representative to the STAAR team. In addition, a JCAHO consortium is working to improve handoffs by involving the patient in signing off on the transition plan.

Resident Transfer Form
Alice Bonner, Department of Public Health
Keith Chuydyk, Department of Public Health

(Please refer to form, attached)

There are discussions with Rhode Island about making this a New England-wide form.

The form will be re-piloted in other facilities before applying it statewide. DPH is seeking skilled nursing facilities to test the form.

One suggestion has been to use the instructions page as a checklist for clinicians.

The current transfer form in use is structured according to the clinician role (physician orders on p. 1, a nurse checklist on p. 2, p. 3 with information for physical therapy and social workers, etc.). Our goal was to make the form inter-disciplinary, but the clinicians in the pilot objected to this approach. The latest revision has the physician orders in the front. One question is whether to include an indicator as to which clinician should fill in the box. Another is whether the doctor should sign every page, and should there be an attestation statement. We need accountability.

Some have commented that medication reconciliation and medication lists should be on a separate page.

People have asked whether an electronic form is acceptable. Yes, as long as the data elements match. We are talking to the Consortium about holding a meeting this fall with hospitals and vendors to discuss how to implement such an idea.

We learned during the pilot that this form is not particularly appropriate for home health care. We are working with the Home Care Alliance and the VNA on a way for home health care to provide information to hospitals.

Dr. O'Malley said that if we can fix medication reconciliation, we are a long way to fixing care transitions. The biggest contributor of home health care would be to provide a current medication list, and to note the prescription drugs that the patient has in the home (whether they are used or not). Emergency departments need an accurate starting point.

Helen Siegel said that home health is interested in providing the medication list as well as the most recent clinical note and plan of care.

Tom Champine observed that EMS requests that people bring their prescription bottles, so that EMS can enter the information into a tablet PC and submit to the MATRIS registry. He suggested that the form indicate the means of transportation.

Dr. Harding suggested that home health nurses create a “go bag” for when the homebound patient leaves their home, with their medications and other vital information. The go bag should be treated as important as a passport – this would contribute to patient activation.

Q: Can you adapt the tools that have been created by INTERACT?
A: That's a good suggestion. The tools are available at www.interact2.net. There are 10 facilities in the pilot, but the number will be expanded to 50 by January.

Q: Should you use a single form for all conditions, or multiple condition-specific forms?
A (Dr. O'Malley): There are essentially four types of transitions: from a facility to the ED (temporary), a discharge from one facility to another (a permanent transfer of accountability), from the ED to the sending organization, and from a facility to an off-site testing location. The single vs. multiple form issue is being discussed.

Alice reported that Dr. Lucian Leape said that there is nothing he would take out of the form, but that it is really long. Dr. O'Malley said that it may be long, but it's so much easier than not having this vital information. The problem is that we are in a transitional time, between the current state and the day when we will have electronic health records and health information exchange and won't need such a form, but we're not there yet.

Medicare Home Health Regulations
Helen Siegel, Home Care Alliance

(Please see handout)

Helen Siegel explained the new Medicare home health regulations and the providers' concerns with the proposed rule (details are in the handout). She added that Cong. McGovern wants to amend the current Medicare home health conditions of participation to allow nurse practitioners to be able to sign home health orders and certifications. Helen also distributed a white paper entitled "Opt-In: Optimum Performance Standards for Patient Centered Transitions to and from Home Health Care."

Discussion:

Q: Does the new rule apply to Medicare Advantage plans?
A: No, just to Medicare fee-for-service.

Comment: We need to make sure that the federal form aligns with the Massachusetts form.

Q: What is the rationale for this rule?
A: They wanted to make sure that the physician is more involved in home health care; they want to fight fraud and abuse; and they want to reduce readmission rates.

Q: How does CMS know who the PCP is? Shouldn't the ordering physician sign the form?
A: "PCP" does mean the doctor in the community who is responsible for the patient's care – it's the physician whose NPI number is on the claim.

Comment: The Medicare homebound definition is an obstacle for effective care transitions. Home care assessments should happen in the home, even for non-"homebound" patients. Medicare Advantage and Senior Care Organizations can do this, but fee-for-service providers do not get paid for such assessments.

Project Update RoundTable

STAAR: About $500m is expected in PPACA community care transitions grants. We are waiting for the

RFP to be released, and the timeframe will be tight: the program begins January 1st. We believe that STAAR is well-positioned to receive these funds.

Public reporting: There is no public reporting of readmission rates imminent. Hospitals are working on voluntary data internally. A national measure may be created by the National Quality Forum. Could the members of the Care Transitions Forum develop a definition of "readmission"? We need agreement on a measure standard that is appropriate for comparisons between hospitals.

LifeBox: Videos were completed in August for PCPs and patients/families. We are now in the final five months of the project.

MOLST – Jena Adams sent the following information after the meeting: The Massachusetts MOLST (Medical Orders for Life-Sustaining Treatment) process and form have been in use for six months in demonstration sites in the Greater Worcester area. More than 500 EMTs and hundreds of other health professionals have received training and or information about MOLST. To date, more than 100 MOLST forms are known to have been established for suitable patients with their clinicians. Several health care institutions in the Boston area have also begun planning for MOLST implementation. Program and process data continue to be gathered, including input about final changes to the MOLST form. A final report containing lessons learned from the demonstration and recommendations for statewide expansion of MOLST will be submitted to HHS Secretary JudyAnn Bigby in December 2010. For more information about MOLST, see www.molst-ma.org or call 508-856-5890.

Pressure Ulcer Collaborative: 50 facilities are involved, and are looking at baseline data, and posting presentations to the website.

Community Care Linkages has received a grant to support the Aging Service Access Points (ASAPs). They want to identify opportunities to integrate the ASAPs with community health systems.

An excellent resource for care transitions issues is www.nextstepincare.org.

Next Meeting

Wednesday, November 17th, 9:00 – 11:00 at IHI's office, 20 University Road, Seventh Floor, Cambridge (near Harvard Square).
http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=20+University+Road,+7th+Floor+02138&ie=UTF8&hq=&hnear=20+University+Rd,+Cambridge,+Middlesex,+Massachusetts+02138&ll=42.371418,-71.119523&spn=0.008037,0.024719&z=16