

Care Transitions Forum
November 17, 2010
Meeting Summary

Participants

Mary Ambrefe, Consulting Clinical Pharmacist
Mirena Bagur, CONTeXO
Rich Balaban, MD, Cambridge Health Alliance
Randi Berkowitz, MD, Hebrew Senior Life
Madeleine Biondolillo, MD, Radius Healthcare
Alice Bonner, Department of Public Health (via phone)
Amy Boutwell, MD, Institute for Healthcare Improvement
Emily Brower, Harvard Vanguard Medical Associates
Debbie Costello, Caritas Home Care
Keren Diamond, VNA of Boston
Julie Farian, Emerson Hospital
Linda Fitzgerald, AARP (via phone)
Jane Franke, Blue Cross and Blue Shield of MA
Michelle Freshman, Newton-Wellesley Hospital]
Sharon Gale, MA Organization of Nurse Executives
Tracy Gay, Department of Public Health
Jocelyn Gordon, Lifeplans, Inc.
Paula Griswold, MA Coalition for the Prevention of Medical Errors
Jonathan Harding, MD, Tufts Health Plan
Laurie Herndon, MA Senior Care Foundation
Jodi Hinkle, Genesis Healthcare
David Johnson, MA Pharmacists Association
Nancy Kelly, Mass. General Hospital
John Krueger, MD, Institute for Healthcare Improvement
Eby Kuriakose, Partners HealthCare System
Jan Levinson, Commonwealth Care Alliance
Donna McCabe, CMIPS
Pat Noga, MA Hospital Association
Terry O'Malley, MD, Partners HealthCare System
Cheryl Pacella, Hebrew Senior Life
Judi Painter, Covisint
Ruth Palombo, MA Executive Office of Elder Affairs
Cheryl Pascucci, Park Avenue Medical Associates
Craig Schneider, Mass. Health Data Consortium
Rob Schreiber, MD, Hebrew Senior Life
Patricia Sokol, Institute for Healthcare Improvement
June Stark, Tufts Medical Center
Louise Steenkamp, Department of Public Health
Judith Stroble, Institute for Healthcare Improvement
Mary Sullivan, Mass. College of Pharmacy (via phone)

Summary

Announcements

Amy Boutwell announced that the Long-Term Quality Alliance will be holding an Innovative Communities Summit in Washington, DC on December 10th. If you are interested in attending, please contact Stephanie Naylor at snaylor@ltqa.org, (215) 573-4225.

Jena Adams submitted a MOLST update in writing: The project team is continuing to track MOLST experiences through December, collecting data from the demonstration sites, and the Steering Committee plans to submit a report to Secretary Bigby by the end of February with recommendations about the statewide roll-out of MOLST. The other notable development is that there isn't any funding allocated for sustaining or expanding MOLST beyond June 2011. Everyone strongly supports MOLST expansion and wants it to happen but there is no money at the state or Commonwealth Medicine to continue paying for it. The team is collaborating with DPH to seek funds from a number of foundations. A full MOLST report will be presented during the January Care Transitions Forum meeting.

Ruth Palombo said that Massachusetts has received a grant from the healthcare reform law (ACA) funding to pilot the Coleman Model at an ADRC in the North Shore. Three ASAPs, a home health agency, an independent living center, physician offices, and Beverly and North Shore Hospitals are participating. The grant is \$200,000 a year for two years. A fuller briefing will be presented during the January Care Transitions Forum meeting.

Ruth added that the End of Life Expert Panel report will be released by the end of the year.

Amy said that there will be a Centers for Medicare & Medicaid Services conference and webinar on December 3rd regarding the ACA Section 3026 funding for reducing readmissions. The Care Transitions Forum may want to form a task force to look at the opportunities for this and other grants. For example, the new Center for Medicare & Medicaid Innovation will be offering funding for states to coordinate care and reduce readmissions for the dually-eligible. In addition, a Promises grant will fund patient safety in the primary care curriculum – if you have ideas for this project, please send your ideas to Paula Griswold, PGriswold@macoalition.org.

Paula announced that the STAAR summit will be held on February 2-3 at the Sheraton Framingham, with registration expected to open shortly after New Year's. In the interim, there will be conference calls on November 29th at 11:00, December 17th at 2:00, January 14th at 1:00, and on January 18th at 1:00. For information about the calls, please contact Elizabeth Wiesner, ewiesner@IHI.org. Pat Noga added that STAAR is working with Bailit and Associates on the patient-centered medical homes initiative. Paula requested that Forum members e-mail her barriers to improving care processes across the continuum of care in advance of the February summit.

The interactive map with STAAR, INTERACT, and other project sites was shown on the screen. It was suggested that the map be updated to include ADRC locations (Aging and Disability Resource Centers,

which are partnerships of the area agency on aging, ASAPs, and ILCs, and are intended to provide information and referral services and options counseling).

Craig Schneider reminded the participants about the value of joining the Massachusetts Health Data Consortium. The Consortium's next conference, The Tools for Meaningful and Accountable Care, will be held on Friday, February 4th at the Burlington Marriott. The program will feature panel sessions on clinical decision support, the Regional Extension Center, comparative effectiveness research, and technology solutions, as well as a keynote address from the CEO of an actual accountable care organization. For information about membership and the February conference, please see www.mahealthdata.org.

Transfer Form

(please see handout)

Pat Noga reported that Alice Bonner presented to the Health Care Quality and Cost Council annual meeting on the status of the Transfer Form. Implementation is scheduled to begin in January, but it will take a substantial amount of time to roll out the Form. We held a meeting with vendors earlier this month to talk about how to include the Transfer Form in electronic health record systems.

The issues with the Form that are being discussed and addressed are whether the Form will be in paper or electronic version in each organization, the roles of various clinicians in completing it, the role of vendors, and its usefulness to patients and families. The challenge being faced is that it is very hard to develop a cross-continuum form that meets all clinician/organization needs.

During our discussion, it was pointed out that the priority should be that the Form meets the needs of the receiving facility. Other concerns expressed were about the ambitious timing of implementation, the importance of notifying the primary care physician, finding out from the patient where they are going after discharge, and the extent of information that is requested on the Form. It was suggested that the pilot facilities use the Form with a large proportion of patients so that we can receive real-world feedback and assessment.

Alice Bonner said that the Transfer Form is an interim step between a one-page form and the CARE tool that CMS is developing. We are following up with Drs. Bates and Halamka and with the Massachusetts e-Health Institute on the data that is in the continuity of care document (CCD). We are looking forward to the feedback that emerges from the pilots, to learn not only about the Transfer Form but about the process and communication as well.

Partners HealthCare and Joint Commission Transforming Health Initiative

(please see handout)

Overview:

Partners HealthCare System has been participating in a project with the Joint Commission's Center for Transforming Healthcare. The specific project is on hand-off communication, and ten hospitals are participating in the effort which began in September 2009. The hand-offs being analyzed are both within a hospital and between facilities. The causes of poor transitions/hand-offs are incomplete information, poorly organized information, and information that is not available when needed. Addressing these problems will result in better and more cost-effective care, but we need appropriate metrics to improve the system.

Discussion:

Q: What is the relationship of your initiative to the Transfer Form?

A: They are connected. The Massachusetts form is based on other states' universal transfer forms.

Q: What is the connection between hospitals in the JCAHO project?

A: The tools are shared on the Center for Transforming Healthcare website:

www.centerfortransforminghealthcare.org.

Comment: The state performance measurement panel will be issuing a report on November 18th on accountable care organization measures. We should review these measures and advise them.

Next Steps

Care Transitions Forum 2011 Meeting Schedule

Location: Massachusetts Health Data Consortium office, 460 Totten Pond Road, Suite 690, Waltham, MA 02451, Wednesday's 9:00 am – 11:00 am. Note the change in dates for all meetings except the one in March, and we regret any inconvenience.

1.5.2011

3.16.2011

5.4.2011

7.20.2011

9.21.2011

11.2.2011

The agenda for the January 5th meeting will include presentations on MOLST and the ADRC grant. A detailed agenda will be sent in mid-December.