Care Transitions Forum
January 5, 2011
Meeting Summary

Participants

Mary Meade Ambrefe, Pharmacy Consultant
Rich Balaban, MD, Cambridge Health Alliance
Madeleine Biondolillo, MD, Radius Healthcare
Carol Broverman, Partners HealthCare System
Emily Brower, Harvard Vanguard
Tom Champine, American Medical Response
Debbie Costello, Caritas Home Care
Keren Diamond, VNA of Boston
Nancy DiMattio, Holyoke Health Center
Cheryl DiPaolo, Emerson Hospital
Deborah Doloway, Cranberry Hospice/Jordan Hospital
Linda Fitzgerald, AARP
Janice Foust, UMass Boston
Jane Franke, Blue Cross and Blue Shield of Massachusetts (via phone)
Lou Freedman, Group Insurance Commission (via phone)
James Fuccione, Home Care Alliance of Mass.
Tracy Gay, Board of Registration in Medicine
Linda George, Boston Senior Home Care
Jocelyn Gordon, LifePlans
Tim Griesmer, Masspro
Paula Griswold, Mass. Coalition for the Prevention of Medical Errors
Jonathan Harding, Tufts Health Plan
Alan Harvey, MD, Mass. Medical Society
Susan Jamieson, Caritas Christi
Emily Kearns, Greater Lynn Senior Services
Leslie Kirle, Greater Boston Aligning Forces for Quality
Paul Lanzikos, North Shore Elder Services
Jan Levinson, Commonwealth Care Alliance
Barbara Lund, Massachusetts eHealth Collaborative
Amy MacNulty, Community Care Linkages
Donna McCabe, Central Mass. IPA
Christine McCluskey, Commonwealth Medicine
Pat Noga, Mass. Hospital Association
Terry O’Malley, MD, Partners HealthCare System
Judi Painter, Covisint
Cheryl Pascucci, Park Avenue Medical
Janet Patterson, Quincy Medical Center/Adams Geriatrics
MaryAnn Preskul-Ricca, Mass. Association of Health Plans
Craig Schneider, Mass. Health Data Consortium
Rob Schreiber, MD, Hebrew Senior Life

June Stark, Tufts Medical Center
Mary Sullivan, Mass Medline – Mass. College of Pharmacy
Barbara Wales, Bristol Elder Services
Jeff Wetherhold, Institute for Healthcare Improvement
Kathleen White, UMass Medical Center (via phone)
Jean Zaleski, Holyoke VNA
Justine Zayhowski, Brandeis University (student shadowing Craig Schneider)

Summary

Announcements

The STAAR Summit will be held February 2-3 at the Framingham Sheraton. Registration is now open at http://www.ihi.org/events/SourceTracking.aspx?returnUrl=http%3a%2f%2fwww.ihi.org%2fevents%2fSelectAttendee.aspx%3fNew%3d1%26EventId%3d2065&EventId=2065&EnrollmentStatus=IN_PROGRESS . The registration fee is $100 per participant for the two-day meeting.

The Patient-Centered Medical Home Initiative now includes 46 practices, and there will be linkages between PCMHI and STAAR.

Massachusetts has submitted a proposal for the Office of the National Coordinator's HIE Challenge Grant, for up to $2 million for improving care transitions with technology. We will hear if the state gets the grant around February 1st.

The End of Life Expert Panel's recommendations were accepted by the Secretary, and are being formally released this month.

Section 3026 of the health reform law (PPACA) includes a grant for care transitions (Section 3026). Massachusetts stakeholders are holding conference calls to plan for a proposal to be submitted.

The Massachusetts Health Data Consortium is largely funded through memberships. Care Transitions Forum members are encouraged to become organizational or individual members of the Consortium.

The Consortium's next conference will be The Tools for Meaningful and Accountable Care on February 4th at the Burlington Marriott. The sessions will address clinical decision support, the Regional Extension Center, how to become an accountable care organization, comparative effectiveness research, and technology solutions for these challenges. Jim Conway will receive an Investing in Information Award, along with Dr. Marylou Buyse and Dr. Sam Thier. A flyer is attached to this summary.

Our co-chair Alice Bonner will be leaving Massachusetts to become a senior manager with the Centers for Medicare & Medicaid Services in Baltimore, overseeing nursing home quality. Craig Schneider gave a presentation to wish her well in her new job and city. Alice will be missed by the Care Transitions Forum members and by the entire Massachusetts healthcare community.

MOLST Project Update
Christine McCluskey, Community Outreach Director, Commonwealth Medicine

(Please see handout; further details and documents may be found at www.molst-ma.org.)

Discussion:
Q: EMS personnel find MOLST easier to work with than the DNR form. What are you doing about community identifiers, and what about incomplete forms?
A: Bracelets for patients are problematic. A laminated card might be a good approach. Regarding the forms, it is necessary that they be complete – if incomplete, the MOLST form is not valid. We need provider education, and maybe a DPH circular can clarify the requirements.

Q: Do you need community education before you implement MOLST?
A: Community education is important, but it does not have to precede implementation.
Comment: The EOL Expert Panel report recommends statewide education.

Q: Does Commonwealth Medicine want to be the "home" for MOLST for the upcoming phases?
A: We would like to be, if we can obtain funding.

Comment: The care transitions/end-of-life community should re-frame the "death panels" conversation as being about patient empowerment. Involuntary resuscitation is not a pleasant experience.

The ADRC Grant: Navigating Across Care Settings; At My Side
Valerie Parker Callahan, Director of Planning and Development, Greater Lynn Senior Services
Paul Lanzikos, Executive Director, North Shore Elder Services

(please see handouts)

Navigating Across Care Settings Discussion:
Q: Are there income eligibility requirements? Are only specific types of insurance accepted?
A: There are no income eligibility requirements, and the patient's insurance does not matter.

Q: How do you coordinate your program with the health plan's case manager?
A: This does need to be sorted out, but the coaching role is different than the case manager's (or the hospital discharge planner's) role. The goal is to empower the patient to advocate for him/herself – the coach is not replacing the case manager.

Q: Does this work through an electronic health record system?
A: No, the Eric Coleman Care Transitions Intervention is a paper tool.

Q: This is a big project. Will you be able to accomplish and learn from all of its components?
A: We will start with what exists today, and the coach will introduce the patient to an array of resources.

Q: You are addressing transitions from hospitals to the home. What is the role of home health care and hospice?
A: One of the coaches is from a home health agency, and there is an HHA representative on the steering committee. HHA nurses also have a role in helping with non-English speaking patients.

Q: Are the nurse visits billable? This could be key to the sustainability of the project.
A: There will be an Administration on Aging workshop on the sustainability topic. We will have to figure this out, and ACOs might be an opportunity for billing these services.

Q: Where does the number of 300 patients come from?
A: We wanted the figure to be large enough to be statistically significant, and it was the number estimated by the evaluator.

Paul Lanzikos: The At Your Side program involves 21 volunteers who are serving 25 clients (60 during the past three years). We need more grant funding to keep the program going. The physicians like having the advocate involved. We have found that the biggest challenge is not physician acceptance, but rather having a sufficient number of volunteers.

Next Meeting Agenda

The next meeting of the Care Transitions Forum will be held on March 16th, 9:00 – 11:00 at the Consortium's office. The topics will be summaries of the STAAR Summit and of the ADRC national meeting, and if the HIE Challenge Grant proposal is approved, we will have a presentation on the model. Another possible agenda topic is the Section 3026 grant proposal.