Care Transitions Forum
May 11, 2011
Meeting Summary

Participants

Mary Meade Ambrefe, Independent Consultant
Zoe Barber, Massachusetts Health Data Consortium
Amy Boutwell, MD, MA Care Transitions Forum
Emily Brower, Harvard Vanguard/Atrius
Kathryn Burns, Elder Service Plan NS
Sujana Chalasani, PatientMetrics
Debbie Costello, Steward Home Care
Mary Tess Crotty, Genesis Health Care
Deborah DeLuca, Philips Lifeline
Keren Diamond, VNA of Boston
Cheryl DiPaolo, Emerson Hospital
Linda F Fitzgerald, AARP
Elizabeth Fluet, Massachusetts Association of Health Plans
Janice Foust, UMass Boston
Jane Franke, Blue Cross and Blue Shield of MA (via phone)
Tracy Gay, QPSD (BORIM)
Linda George, Mass. Home Care
Jonathan Harding, MD, Tufts Health Plan
Laurie Herndon, Massachusetts Senior Care Foundation
Sue Jamien, Steward
Emily Kearns, Greater Lynn Senior Services, Inc.
Vic Kingsley, Medical Resources Home Health Corp
Karen Koprowski, Radius Management
Amy MacNulty, Community Care Linkages
Donna McCabe, Central Mass. IPA
Christine McCluskey, Commonwealth Medicine
Lesley Nolan, Medical Resources Home Health Corp
Judi Painter, Covisint
Ruth Palombo, MA Executive Office of Elder Affairs
Valerie Parker Callahan, Greater Lynn Senior Services, Inc.
Dolores Schermer, Radius Management Services
Craig Schneider, Mass. Health Data Consortium
Denise Scott, Central Mass. IPA
Helen Siegel, Home Care Alliance of MA

June Stark, Tufts Medical Center (via phone)
Mary Sullivan, Mass Med Line
Michele Visconti, Department of Public Health
Loretta Winde, Medical Resources Home Health Corp

Summary

Announcements

Craig Schneider announced several upcoming Consortium events:

- GE Healthcare will be presenting on IT Solutions to Connect Communities of Care in the MHDC office on May 25th, 9:00 – 11:00.
- Ray Campbell will be giving a presentation on Payment Reform and ACOs – An Overview of State and Federal Efforts on May 26th, 1:00 – 3:00 in the MHDC office.
- The Consortium's next conference is Data, Analytics, and Accountability on Monday, June 13th at Suffolk University. The sessions will address the importance of analytics to healthcare improvement, the Blue Cross Alternative Quality Contract, analytics from the Medicare database, the Massachusetts all-payer claims database, the data needs of an ACO, findings from the Prometheus pilots, analytics from pharmaceuticals, and the MHDC Payment Reform Collaborative.
- Dell will be presenting to the new mHealth (mobile health) Forum on The Evolution of the Virtual Clinical Desktop on June 15th, 9:00 – 11:00 in the MHDC office.

Registration and further details for all of these events may be found at www.mahealthdata.org. Members receive a $100 discount on admission to these programs.

The Care Transitions Forum meeting schedule for the rest of the year has been changed – please make note of the new dates. (All meetings are on Wednesdays, and will be held at 460 Totten Pond Road, Suite 690, Waltham 02451.)

July 20th
September 21st
November 2nd

Dr. Madeleine Biondolillo is the new Director of the Patient Safety and Quality Bureau at the Department of Public Health (Alice Bonner's former position). She has agreed to become co-chair of the Care Transitions Forum. Dr. Biondolillo was a member of the Forum in her prior position at Radius Management.

Paula Griswold announced that she and Dr. Amy Boutwell met with Secretary Bigby and Dr. Biondolillo to discuss the Section 3026 grants (see discussion below).

There [was] a 3026 call on May 12th and a STAAR call on May 18th and a conference call on home health and care transitions later that week (a separate notice was sent to Forum members).

The QIOs are developing a care transitions resource. We will hear a presentation on the QIOs' work in the next Scope of Work during our July meeting.

Care managers are encouraged to join cross-continuum teams as part of the Executive Office of Health and Human Services patient-centered medical home project. Please let us know if there are other PCMH projects of which we should be aware.

The Governor's Conference on Health IT was held on May 9-10 and was very successful. We need to communicate the importance of care transitions as the system moves toward payment reform and accountable care.

Section 3026 Community-Based Care Transitions Program
Amy Boutwell, MD

(please see handout)

Discussion:

Q: If there are rolling applications, how will we batch them together?
A: It will take a few months for most providers to be ready to submit, so we should try to get them submitted by September 1st, and then request that a single review panel look at the Massachusetts applications together.

Q: How much work is involved in submitting an application?
A (Amy MacNulty): It is a substantial amount of effort. All 14 high-readmission hospitals plan to apply, and they are working with their ASAPs and home health agencies. Other hospitals are interested as well.
A (Emily Brower): Organizations that wish to apply have to perform a root cause analysis in order to develop their intervention strategy, and to define and enroll the population.

Q: Can you carve out Medicare fee-for-service from Medicare Advantage and other programs?
A (Emily Brower): What Atrius plans to do is to apply our managed care strategy to our FFS population.

Q: Is there a role for health plans in this project?
A (Dr. Harding): The grant is not designed for plans, but we have useful tools to share with providers.

A (Jane Franke): The Blue Cross Alternative Quality Contract has developed a fair amount of care management and disease management program expertise.

Q: Is there a role for skilled nursing facilities in the 3026 program?
A (Amy MacNulty): SNFs have a very important role, we need their data on readmission rates, and their participation will strengthen the applications. Interested facilities should contact Dr. Boutwell.

Helen Siegel noted that home health agencies are receiving pushback on the requirements that physicians complete the new Medicare referral form to home health. This is a significant problem, and education throughout the system is required.

In response to Helen's comment, there was a discussion about what the Care Transitions Forum members may do to address the problem. Educational efforts and standardization of forms (including the Universal Transfer Form) are part of the solution.

Behavioral Health in the Medical Home
Vic Kingsley, Medical Resources Home Health Corp.

(please see handout)

Discussion:
Q: What is your caseload?
A: It varies, but about 25 on average.

Q: What results have you achieved?
A: We are sending patients to crisis intervention centers instead of to emergency departments, and the readmission rate is between 25 and 30 percent, which is a reduction from the previous rate.

Q: How do you define the behavioral health population?
A: By the psychiatric diagnosis.

Q: How long do patients stay on your caseload after the 14-day intervention period?
A: Some stay 1-2 weeks longer, but the level of intervention is gradually reduced, and patients are phased into community services.

Q: What is your payer mix?
A: Medicare is about 25 percent, Medicaid 30 percent, and managed care contracts about 45 percent.

Q: How does communication work with the primary care physician?
A: This communication is essential. The PCP handles the chronic illness, and our nurse connects the patient to psychiatric and other behavioral health care.

IMPACT Update

Craig Schneider, Mass. Health Data Consortium

The Universal Transfer Form (UTF) is being finalized by the Department of Public Health. The next step is to convert the UTF into electronic form. The project will also try to translate the clinical content of the UTF transmission into patient/family-friendly language.

The Request for Information for the translator tool was issued this week. http://www.maehi.org/RFP/impact/impact_rfi.html. By the end of the summer we hope to issue the Requests for Proposal for the electronic version of form and translator; vendors will be able to bid on one or both of the RFPs.

Currently the IMPACT project is recruiting providers in Worcester. An Advisory Board has been created and held its first meeting in early May.

Discussion of consumer role:
Paula asked if the Patient and Family Advisory Councils are active in the STAAR teams. The PFACs' activities are being supported by a Health Care For All report and by a Massachusetts Coalition for the Prevention of Medical Errors listserv. "Every defect is a gem" – the system needs to learn from mistakes.

It was noted that the 3026 process includes patient interviews to identify the root cause.

Ruth Palombo said that the 175 options counselors in the state can be a valuable resource, and that we should include a presentation on a future agenda.

Next Steps

Presentations by Beth Israel Deaconess Medical Center, Masspro, and the options counselors will be included in upcoming agendas.