

Care Transitions Forum
September 21, 2011
Meeting Summary

Participants

Lindy Alves, Harvard Vanguard Medical Associates
Mary Meade Ambrefe, Pharmacy Consultant
Jennifer Beale, Minuteman Senior Services
Roberta Bernstein, Mass. Department of Public Health
Benjamin Bielak, Dovetail Health
Carol Broverman, Partners HealthCare System
Emily Brower, Harvard Vanguard Medical Associates
Beth Capstick, UMass Boston
Mark Craig, BON HealthWatch
Donna Curran, Masspro
Mary Tess Crotty, Genesis Health Care
Keren Diamond, VNA of Boston
Deborah Doloway, Cranberry Hospice/Jordan Hospital
Peter Eggleston, SBR Health
Linda Fitzgerald, AARP (via phone)
Karen Foss, Masspro
Janice Foust, UMass Boston
Jane Franke, Blue Cross and Blue Shield of Mass. (via phone)
Margery Gann, Ethos
Tracy Gay, QPSD, BORIM
Linda George, Boston Senior Home Care
Diane Gilworth, Harvard Vanguard Medical Associates
Amy Goldstein, Medical-Legal Partnership, Boston
Paula Griswold, Mass. Coalition for the Prevention of Medical Errors
Jonathan Harding, MD, Tufts Health Plan
Mike Hebert, Fallon Clinic (via phone)
Laurie Herndon, Mass. Senior Care Foundation
Susan Jamieson, Steward Health Care
Emily Judd, HouseWorks
Emily Kearns, Greater Lynn Senior Services (via phone)
Andrew Koh, Dovetail Health
Patrick Littlefield, JPL Ventures
Matt Lockwood Mullaney, Seniorlink
Kelly Magee, Caregiver Homes of Massachusetts
Phil Magnusson, VNAs of New England
Janice Masi, Caregiver Homes Network
Christine McCluskey, Commonwealth Medicine (via phone)
Dale Mitchell, Ethos
Terry O'Malley, MD, Partners HealthCare System
Ruth Palombo, Ph.D, Executive Office of Elder Affairs (via phone)

Cheryl Pascucci, Park Avenue Medical (via phone)
Jane Pike Benton, MetroWest HomeCare & Hospice
Iyah Romm, DPH Bureau of Healthcare Safety and Quality
Craig Schneider, Mass. Health Data Consortium
Helen Siegel, Home Care Alliance of Mass.
Sue Temper, Springwell
Jessica Wolfe, Ph.D, Partners Continuing Care

Summary

Announcements

Paula Griswold, Massachusetts Coalition for the Prevention of Medical Errors
Craig Schneider, Massachusetts Health Data Consortium

We're delighted to announce that today's Care Transitions Forum meeting is sold out – more than 55 people tried to register. This is an indication of how important the topic of care transitions is and how valuable these meetings are to the participants.

HealthMart'11 will be held on Wednesday, October 5th at the Beechwood Hotel in Worcester. This program is free for members of the Mass. Hospital Association, Mass. League of CHCs, Mass. Medical Society, MGMA of Mass. and Rhode Island, and enrollees in the Regional Extension Center. We will also extend complimentary registration to any provider organization that is a member of the Care Transitions Forum. A flyer is attached, and registration and further information may be found at www.mahealthdata.org.

Please save the date for Payment Reform: Innovation for the Nation at the Babson College on Wednesday, December 14th. Registration will open in mid-October.

The STAAR Summit will be held on October 11-12 at the Sheraton Framingham. There will also be a STAAR improvement science event on November 1-2, ideally for four representatives from each cross-continuum team.

The Centers for Disease Control and Prevention is funding an infection prevention initiative.

Care Transitions Initiatives at Harvard Vanguard Medical Associates

Diane Gilworth, Harvard Vanguard Medical Associates

(Please see handout)

HVMA is conducting a videography study to understand the patient experience of care and how provider workflows need to be revised to become more patient-centered.

Discussion:

Comment: One of your findings is that patients remember nothing at discharge (e.g., “Why didn’t they put instructions in writing?”). What you have learned about patients’ lack of understanding/comprehension at discharge underscores why the first home health visit can take several hours.

Diane: Patients assume that providers are talking to one another, but there is no central way for providers to communicate. When a patient leaves a facility, they will leave with a stack of discharge information, much of which they do not remember and often the information in those stacks is contradictory. In most cases the care providers are not notified of important information, such as discharge medications and follow-up/post-treatment plans, and this often leads to unnecessary readmissions. Maybe accountable care organizations will put us on the same team.

In the following video, you will see frail elderly patients. While these patients may not be representative of all patients, if we can fix the problems for high-risk patients then we should be able to fix things for all patients. We need to fundamentally change care delivery structures.

(a video of clips of interviews with patients was shown)

Q: Was anything you found in the interviews a surprise?

A: In general, we know how patients feel, but we don’t listen well enough, nor pay enough attention, and the systems don’t reflect patient preferences.

Q: How are you sharing information? What are the tools for reinforcement?

A: We are using a LEAN process improvement approach, and two main proposals emerged: geriatric support for PCPs (this is expensive), or create a geriatric-focused program (but this would take the PCP out of the care process). We instead developed a new model that combines these two approaches, in which the PCP sees the patient in a geriatric unit.

Q: How are you funding this initiative?

A: We have to make an investment, because I believe that better care will result in fewer readmissions. To date, disease management has been reactionary, and we need to become proactive, and to also promote palliative and hospice care.

Comment: This is a spectacular piece of work, and it should be disseminated widely. You should also inform CMS, so they can eliminate some of the regulations that prevent this kind of care.

Q: Should we shift control during the patient’s stay (e.g., live teachback while in the hospital)?

A: This is a good idea.

Comment: The home setting is better for teachback than the hospital. As one of your interview subjects said, “I’m not the same person that I was in the hospital.”

Q: Aside from the geriatric population, what other use cases have you been considering?

A: For younger patients, we could give them cameras to document their experience. We should also video providers – that is the next stage in understanding.

Comment: The timing is good for promoting the change in care delivery. Dr. Berwick should be on board with this approach.

Lindy Alves: Patients blame themselves for post-discharge problems. Through the interviews, we learned a lot about patients' conditions indirectly (e.g., asking what you enjoy, and finding out that the patient who enjoys going out to eat can no longer do so because she cannot swallow).

Q: What are the next steps?

A: We will pilot this at our patient-centered medical home practice in Medford. We will also engage in multiple collaborations, with the hospital, ASAP, and VNA. These new relationships can achieve a collective impact – there isn't a single technical fix.

Q: How do you achieve accountability?

A: The first barrier is the lack of an IT platform that supports centralized communication – if you can't communicate, you can't hold each other accountable. Ironically, technology can interfere with interdisciplinary discussions – we used to walk around and talk to each other, and now it's just e-mail. We need common goals for patients and to understand them.

Comment: Things are getting better with STAAR, 3026, and ACOs, but the technology piece is hard. The Care Transitions Forum is useful in helping us improve our systems.

Q: How do you engage the caregivers?

A: They are fundamental and need to be involved. However, to support them we need flexible hours and better communication.

Q: Does participating in the Blue Cross Alternative Quality Contract support your project?

A: We are capitated for 50 percent of our patients (and 70 percent of our revenue). HVMA has a pretty unique history, and this payment approach enables us to focus on value/outcomes rather than upon volume, and to provide better and more cost-effective care. Fee-for-service does not work for patients and gives the wrong incentives to providers. Our leadership has decided to assume that all of our patients are capitated.

Q: How did you engage the doctors at the Medford practice and convince them to participate in a PCMH?

A: We took them out of the RVU (relative value unit) compensation model, and ensured that no one would face a salary reduction. It was actually an easy sell, because the physicians like having the appropriate incentives, a team-based approach, and more nurse involvement.

Comment: You may want to observe a hospice interdisciplinary team meeting. These teams include social workers and clergy as well as clinicians, and it is a great model.

Note: If you would like to find out how to obtain the videos for viewing, please contact [Lindy Alves@atriushealth.org](mailto:Lindy_Alves@atriushealth.org)

Section 3026 Grant Applications

Kathleen Foss, Masspro

(please see handouts)

Section 3026 (the Community-Based Care Transitions Program) is a provision of the Accountable Care Act that offers grants to hospitals and community-based organizations for improving care transitions for high-risk Medicare beneficiaries. The new quality improvement organization contract – effective August 1st – provides funding for Masspro to assist with this effort. Masspro would like to build on what is already happening, and the existing cross-continuum teams are a great advantage for Massachusetts. The assistance available includes help with root-cause analysis, understanding Medicare claims data, and analyzing disease-specific readmission rates and observation stay rates.

Discussion:

Q: Did CMS make recommendations or explain why the 3026 application submitted by a Massachusetts provider was denied?

A: Applicants can request a discussion with CMS and may reapply.

Emily Brower added that it seems like CMS is seeking multi-hospital applications, and not just a multi-hospital system like Partners or Steward but a cross-system proposal that would serve a substantial number of beneficiaries. It also appears that they want to see a clear connection between the root cause and the intervention, and that the approach is community-based.

Q: How current is the claims data that you offer?

A: The data is as of October 2010, and it will be refreshed periodically.

Q: Can you provide hospital-specific claims data? Will CMS share data on admissions to other hospitals?

A: If we receive clearance from CMS on that type of data sharing.

Comment: We appreciate Masspro's efforts and your support of the October 11-12 STAAR meeting.

MOLST Update

Christine McCluskey, Commonwealth Medicine

MOLST (Medical Orders for Life-Sustaining Treatment) is an end-of-life care improvement program that has been piloted in the Worcester area. We are preparing to expand this project statewide, and there will be training sessions during the next several months, and we hope to be across the state by the end of 2014. There will be a training session during the STAAR conference call on October 19th, and the effort will focus on STAAR Cohort 1 with a train-the-trainer approach.

Next Meeting Agenda

The next meeting of the Care Transitions Forum will be held on Wednesday, November 9th, 9:00 – 11:00 at the Consortium's office. The agenda will be sent out about a month before the meeting.