Issue Brief

Massachusetts Health Data Consortium

Massachusetts Care Transitions Seminar

Doubletree Hotel, Westborough, MA

Wednesday, April 29th 2009

Introduction and Background

The genesis for the Massachusetts Care Transitions Seminar began a couple of years ago when the Massachusetts Senior Care Federation helped establish the Transitions Task Force. Shortly thereafter, the Massachusetts Health Data Consortium decided to establish a Continuum of Care Forum. Alice Bonner and Craig Schneider met and decided that, rather than duplicating efforts, the groups should merge, and the Care Transitions Forum was formed. This Forum also serves as an important resource for the Health Care Quality and Cost Council.

The Care Transitions Forum has been enormously successful, and has grown so large that a Steering Committee is needed to manage the group's efforts. During many of the Care Transitions Forum meetings the participants learn about exciting projects going on in Massachusetts, and the Steering Committee decided that there should be a public meeting to share these developments with providers across the continuum of care in the Commonwealth. This led to the planning of the April 29th seminar.

Improving care transitions should be the elusive "triple-win" in healthcare: care that is of higher quality, with lower costs, and that is more person-centered. The agenda for the Seminar was designed to address how the Massachusetts healthcare community might achieve this. The program began with representatives of health plans, providers, state government, and the Health

Care Quality and Cost Council offering a Massachusetts vision for improving care transitions. The first panel shared its perspectives on what the Commonwealth's vision should be, one of the nation's leading experts on care transitions - Dr. Eric Coleman - delivered the keynote address, and the next panel discussed community-based projects that are being planned or are already underway in Massachusetts.

Carol Levine, from the Families and Health Care Project in New York, gave a talk on the importance of effective care transitions to patients and their families. The final panel of the day addressed potentially avoidable hospital readmissions. (A recent paper written by Dr. Coleman and others estimated that preventing avoidable hospitalizations could save Medicare alone more than $17 billion.) The panelists represented providers, state government, and a non-profit organization.

Ten organizations partnered to hold this program: The Care Transitions Forum, Home Care Alliance of Massachusetts, Hospice and Palliative Care Federation of Massachusetts, Massachusetts Association of Health Plans, Massachusetts Health Data Consortium, Massachusetts Hospital Association, Massachusetts League of Community Health Centers, Massachusetts Medical Society, Massachusetts Senior Care Association/Foundation, and the Visiting Nurse Association of New England.

The sponsors for the seminar were: Allscripts, Curaspan, Health Dialog, PointRight, and the VNA of Somerville.

A Massachusetts Vision for Improving Care Transitions

Moderator: Craig Schneider, PhD, Director of Healthcare Policy, Massachusetts Health Data Consortium

Marylou Buyse, MD, President, Massachusetts Association of Health Plans
A Massachusetts Vision for Improving Care Transitions: What are Health Plans Doing to Improve Members' Care Experiences?

Massachusetts is not doing the best job in care transitions. We are 41st out of 50, and being 50 is being last. If we merely met the standards of Vermont, which is number one in the country, that would be 6000 fewer hospital readmissions yearly and would save $73 million per year just with Medicare alone. We need to spend more attention on Care Transitions; what gets attention gets done.

One of the key issues is communication, or lack thereof. Better communication through electronic records is one of the best ways to address this failure. Health plans are uniquely situated to address care transitions. The health plans are the glue, filling in those gaps in care through care management programs. Finally, we need payment systems which align incentives; until doctors and hospitals are rewarded when decreasing readmissions we will not see real change.

Kenneth LaBresh, MD, former member, Health Care Quality and Cost Council
Improving Care Transitions: A Key Strategy to Improve Health Care

We are doing well with healthcare in single environments, but we are not doing as well with care across multiple settings. One of the main problems with transitions is that the patients, and not their doctors, are left with the impetus to solve their health problems. Effective care transitions involve a lot of work in the home besides just in the office or the hospital; patients need to be involved with their medical care because they are the one constant across multiple settings. Structures need to exist to support the patient in arenas outside of the hospital. Medical home activities are a key part of care transitions; we need to transition the way we support patients in their self-management.

Terrence O'Malley, MD, Medical Director, Non-Acute Care Services, Partners HealthCare System, Inc.
The View from Partners: Clinical Transitions and Readmissions

We are developing a new definition of clinical excellence: and care transitions is an essential part of it. This definition has four parts: 1. providing the next clinician with all essential clinical information required to care safely for the patient. 2. providing a clinical envelope with a supervising clinician at all times. 3. support for patients and families to manage medications, treatments and the

logistics of care. 4. a new way of measuring quality that identifies those patients who have received 100% of all essential elements of care. It takes a system to provide resources to practitioners to meet these goals.

Joel Weissman, PhD, Senior Health Policy Advisor, Massachusetts Executive Office of Health and Human Services

Massachusetts is the envy of the rest of the country because of our coverage of the uninsured. However, when these people find out about our high costs and high utilization, they begin to shake their heads. 50% of patients who are readmitted don't even have a doctor's appointment within three weeks of hospital discharge. Massachusetts is also 32nd in avoidable hospital conditions: the kinds of hospitalizations which might be avoided with timely ambulatory interventions. MedPAC has found that up to ¾ of all 30 day readmissions are in fact potentially preventable.

The challenge in state government is to take the personal anecdotes we all have of care transitions of our friends and family, and turn them into some sort of public policy. You have to involve the patients, public health agencies, and the health policy perspective (financing and delivery of services). One way to do this is the formation of partnerships; no single actor can change how healthcare is delivered on its own. Massachusetts is involved in the State Quality Improvement Initiative, and has identified reducing unnecessary hospital readmissions as one of the top goals in the state. The State Quality Improvement Institute thinks about three broad strategies to take: data collection combined with public reporting, combining provider engagement with consumer and family caregiver engagement, and finally payment reform and alignment of financial incentives. All three are necessary to reform the system.

Q and A:

Q: We as a nation are about to engage in comprehensive health care reform; to what extent is reimbursement policy a barrier to achieving effective care transitions?

MB: Studies that have reduced readmissions to hospitals allow these organizations to make more money by bringing in patients for procedures with higher margins. Hospitals who invest in better care transitions would do better financially than those who don't. Doctors also need to become more efficient in the way they see patients, and this may require a realignment of incentives so that the ambulatory community can change the way they practice.

TO: Will financial incentives make a difference and drive change? Absolutely. Bundling payments for 30 days has the potential to blow up the health care system for the good. It would force disparate parts of the system to

talk to each other and to work with each other because they would share the financial bottom line. I personally think this is a very good thing.

JW: We need more ways to pay and incentivize doctors to do the right thing.

KL: One idea to change things is to develop a payment incentive system from CMS.

Q: What is the concept around avoidable readmissions? Not many of these readmits are due to something being done wrong.

MB: Lack of communication is a systems issue. Failure of outpatient care and medication issues is also big.

JW: Better and higher quality ambulatory care is the key to preventing patients from having to be readmitted.

KL: The traditional blame falls on the patient, but it is really a failure of the health care system to support patient self-management.

TO: The challenge is to identify what admissions are preventable. We will learn what they are as we pay attention to preventing them. Right now, however, there is no good methodology for doing this. The health care system is currently too fragmented and does not provide the types of support that patients and families need to continue their care without the risk of readmission.

Q: What can we do tomorrow to achieve this vision?

MB: We pay enough already. Plans are limited by contracts, Medicare is unwilling to change. We must increase transparency, change people's mindsets and their practice patterns.

Summary by Craig Schneider, PhD, Director of Healthcare Policy, Massachusetts Health Data Consortium

To summarize the presentations in one line each, the Massachusetts vision for care transitions is:

- Better communication
- Moving beyond institutions to the patient in the home
- Achieving clinical excellence with reliable metrics
- To be strategic and collaborative

Keynote Address: A National Model for Improving Care Transitions

Eric A. Coleman, MD, MPH, AGSF, FACP
Professor of Medicine
Director, Care Transitions Program
University of Colorado Health Sciences Center

Listen to Your Patients: They Are Telling You How to Improve the Quality of their Transitional Care

Evidence on how we are delivering care shows that we are doing very poorly. We need to move from provider-centered care to patient-centered care. Even then, patients are confused as to their role, with healthcare providers giving many different answers to this question. Silos of care largely determine how we practice medicine, and they in turn are bolstered by the way we finance healthcare. We must become "silo-busters".

Patients spend much of their time in the "no care zone", between billable events as far as practitioners are concerned. During this time, patients and their families are coordinating their own care. How do we transfer skills to these people, to make them confident in their roles and provide them with the tools that they need? This is the genesis of the Care Transition Intervention.

This intervention is a low cost, low intensity self care approach. It includes one home visit and three phone calls over 30 days. It was developed with direct input from patients and families to come up with the "transition coach" who is the vehicle to empower the silent care coordinators and teach the four pillars. These pillars include: medication self management, a patient-centered record, appropriate and timely follow up with a primary care or specialist physician, and knowledge of warning signs or symptoms and how to respond. The provider who is working with the patient must move from being a 'doer' to a coaching role. Each coach can save nearly $300,000 per year in hospital readmission costs, and CTI has been adopted by over 150 leading healthcare organizations nationwide.

Q: HIPAA made care transitions more difficult by strangling communications. Do you have any comments about this?

A: I am concerned about misapplication of HIPAA; people hiding behind the laws and not giving out needed information. Just as there are penalties for giving out information when you should not, we may need to remind people that they can also be punished for not giving out information when it is in the best interests of the patient.

Q: What is the role of the home health care agency? Is it a relationship coach?

A: The key is good coordination, and clearly explaining the roles. Patients often have case managers but don't know how to use them.

Q: Can we really prevent "preventable readmissions"?

A: The data is not decisive. We are missing the key aspect of the patient and the family input and what is and is not working – these things do not jump out of the data sets. Current medical coding does not allow for the teasing out of individual vs. "cascade" events.

Community-based Care Transitions Projects

Moderator: Dr. Ronald Steingard, Associate Vice Chancellor and Chief Medical Officer, Commonwealth Medicine

Jeffrey Greenwald, MD
Associate Professor of Medicine, Boston University School of Medicine
Director, Hospital Medicine Unit, Boston Medical Center
A Tale of Two Projects: RED & BOOST

Project RED (Re-Engineered Discharge) is an AHRQ funded research project in which we randomized patients being discharged from a general medical inpatient service to an intervention or control arm. Those in the intervention group received attention from a nurse discharge advocate, received an after hospital care plan, and had a clinical pharmacist call them 2 to 4 days after discharge. We found that RED improved readiness for discharge, improved the primary care physician follow up rate, and decreased overall hospital use by 30%.

Project BOOST (Better Outcomes for Older adults through Safe Transitions) is a Hartford Foundation funded quality/process improvement project run by the Society of Hospital Medicine to improve discharge transitions. The principal BOOST intervention is a tripartite tool called the TARGET (Tool for Adjusting Risk: A Geriatric Evaluation for Transitions). There are three components including the 7P scale which analyzes key risk factors for repeat hospitalization with associated risk specific interventions; the Universal Patient Discharge Checklist, which ensures a general improvement for all discharges without risk stratification; and the GAP (General Assessment of Preparedness), which is a patient-centered checklist of patient concerns that need to be addressed. Finally, we have a very simple, low-literacy, patient-centered discharge plan called the Patient PASS (Patient Preparation to Address Situations after discharge Successfully). This form brings the key issues and information that patients need to leave the hospital with into one place for easy reference and self help.

Dominique Kim, MPH, Program Manager
Partners Healthcare System
MOLST Demonstration Project: Medical Orders for Life-Sustaining Treatment

MOLST – Medical Orders for Life-Sustaining Treatment - is a portable medical form to translate the patient's wishes for end of life care into immediate actionable medical orders transferable across settings; not just to document the patient's wishes, but to actionably honor them. It is not merely a form, but a process that culminates with the completion of a form. Communication between the patient and the provider is the core of the approach. The form is much more

than just a Do Not Resuscitate – it includes wishes around transfer to a hospital (yes, no, not to ICU, etc.), and can include other preferences such as dialysis, artificial nutrition and more.

We are currently finalizing and vetting the MOLST form in several communities, and continuing our education and outreach efforts. We firmly believe that collaboration is key to this project. MOLST will make it a lot easier to collaborate between consumers and providers by creating a common language to talk about end of life issues.

Cheryl Pacella DNP(c), HHCNS-BC, CPHQ,
Quality Improvement Manager, Hebrew Senior Life
The Role of Home Care in Care Transitions

The Masspro collaborative project looked at the role of home care in improving care transitions. It has several key initiatives:

- Identification of patients at high risk to be re-admitted, and "front-loading" their care in the first several weeks after discharge
- The "call me first campaign" which encourages patients and families to call the home care agency before calling 911
- Encouragement of patient self management
- Working with care transitions to decrease unneeded re-admissions

and has the goal of seamless transitions from inpatient settings to home care.

The business case for this project is to view issues from the "What's In It For Me" perspective from hospitals, patients and home care. Hospitals can save money, patients will have higher overall satisfaction and quality of life, and home care will be freed from the burden of much of the bureaucracy of stopping and resuming care of these patients. Pilot projects have shown a decrease in the re-hospitalization rates of patients in the program. While there have been some issues with the program, particularly in the area of using and maintaining coaches, solutions are being developed, and the process continues to grow and develop.

Karyn Rizzo, Director of Clinical Services
Dovetail Health
Pharmacist-Led Transition Services to Avoid Costly Readmissions

Dovetail health is a health service which joins physicians, family and caregivers to make sure that patients receive the care they need while preventing unnecessary re-hospitalizations. We have taken elements of the plans from Dr. Coleman, Mary Naylor, and Dr. Wagner, and combined them with the use of a PharmD to not only prevent re-admissions, but the initial admission as well.

By using predictive modeling, you can identify the patients which will need care transition coaches. Selecting only the patients who will benefit from this service leads to the return on investment. The use of the PharmD brings in experience and knowledge of drugs and their physiological interactions not found in other transitions programs. Our 30 day re-admission rates are a testament to our success: our average is nearly ½ of the Massachusetts average, and nearly ¼ of the home health agency rates.

Q & A

Q: With MOLST, how is that implemented with patients at home? How will they post the information to make it conspicuous, and what training will there be for emergency personnel?

DK: We have covered providers in home care, EMTs and first responders, and have plans to roll out education materials to educate and encourage implementation.

Keynote Address: *A Patient- and Family-Centered View of Care Transitions*

Carol Levine, Director, Families and Health Care Project
United Hospital Fund

Transitions in Care: What Patients and Families Need

The US healthcare system appears to the average consumer as a maze, but one which is navigable. However, in the last 20 years, this has become more complicated and harder to navigate. Patients in transitions need several things: to know who is in charge of the transition, to be part of the plan, to understand the plan and follow up instructions, and to know whom to call with their questions. Older and sicker patients, those with chronic conditions or cognitive impairments, or those with language or literacy problems cannot self-manage their transitions, but need someone to manage their care or advocate for them. These people are family caregivers, a term that should be broadly interpreted beyond blood or marriage. There are an estimated 34 million family caregivers in the US doing a predominantly unpaid job.

Coordination of care transition is very difficult because of the silos within silos in healthcare in which individual practitioners have rigidly defined roles. Often, there is not enough information or time for individuals to plan appropriately nor enough resources or options. Family caregivers often are unprepared for their roles: not seeing themselves as caregivers, lack of knowledge of how the system works or how to find and coordinate the services they need. Since professional

care managers are not routinely available or know the whole spectrum of patient needs, we need to change provider practice to include family caregivers and to provide the tools and information needed to allow family caregivers to manage transitions properly. The United Hospital Fund's Next Step in Care guides and checklists are available free and downloadable at www.nextstepincare.org.

Q & A

Q: What happens if the patient does not wish to participate in this process?
A: In that case it is important to engage in a conversation where you do not talk, but rather listen to hear the patient or caregiver's perspective.

Q: Have you thought about using multimedia presentations to distribute this information?
A: We have, but it is very expensive. We would prefer to develop scenarios, and talk about how you approach different situations.

Q: Have you done anything around provider training?
A: Yes. We have worked with content experts (all of whom were providers) on our content, and worked with the front line providers during our pilot testing. The providers really liked the materials, but still did not use them very often.

Preventing Unnecessary Hospital Readmissions

Moderator: Paula Griswold, Executive Director, Mass. Coalition for the Prevention of Medical Errors

Alice Bonner, PhD, RN.
Executive Director, Massachusetts Senior Care Foundation
Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents

It is fairly common for nursing home (or other skilled nursing facility) patients to be transferred to a hospital. These transfers often result in morbid complications as well as being very expensive, and previous research shows that many of the events triggering these events can be managed without transfer to a hospital. Reducing these potentially avoidable hospitalizations represents an opportunity to improve the quality of care and to reduce overall medical expenditures on this population. We began looking at reducing potentially avoidable hospitalizations of nursing home residents with a CMS special study awarded to the Georgia Medical Care Foundation. We developed an intervention toolkit with three major foci: improvement of clinical assessment skills by nurses, improving communication tools, and advance care planning. Conservative estimates on the Medicare savings achieved by using this toolkit would reach over $1 billion annually. Further studies in 30 nursing homes across Florida, New York and

Massachusetts will continue to refine the INTERACT (Interventions to Reduce Acute Care Transfers) toolkit and implementation strategies of the project.

Amy Boutwell, MD MPP
Primary Investigator, STAAR Initiative
Institute for Healthcare Improvement
STAAR Initiative: STate Action on Avoidable Rehospitalizations

The STAAR initiative (State Action on Avoidable Re-hospitalizations) is a Commonwealth Fund supported initiative to reduce avoidable re-hospitalizations taking the state as the unit of intervention. There are currently three states involved in the STAAR initiative: Massachusetts, Michigan and Washington. The initiative has three high leverage opportunities for action: improving transitions for all patients, proactively addressing the needs of high risk patients, and engaging patients and their caregivers in assuming a proactive role in their plans. Our goal is to reduce avoidable re-hospitalizations by 30% while increasing patient and caregiver satisfaction with the care received.

Karen Nelson, Senior Vice President of Clinical Affairs
Massachusetts Hospital Association
Hospital Perspectives on Readmissions

Hospitals in Massachusetts are in the middle of many different organizations and initiatives with the aim of reducing unnecessary hospital readmissions. In addition to these local efforts, the biggest drive for change may be coming from the biggest payer – CMS. Patients should be placed in the center of the model, with health information exchange an integral part, in order to make the changes successful. There are also public policy dimensions to consider when planning changes: issues around public reporting, payment penalties and rewards, community accountability and mental health services capacity and the lack of adequate numbers of primary care physicians. Only unplanned and related re-hospitalizations should be looked at for deciding what is preventable or not; considering all re-hospitalizations is too blunt an instrument. It is important to align incentives to move forward both cost and quality, that models are not inappropriately aligned and therefore drive community hospitals out of business, but rather to interconnect all resources and patients to make sure they get the care they need.

Kate Nordahl, Assistant Commissioner
MA Division of Health Care Finance and Policy
Potentially Preventable Readmissions

The Division of Health Care Finance and Policy has identified an important opportunity for improvement in preventable readmissions. The Division has

initiated a multi-stakeholder, statewide initiative to improve the quality of care through evaluating the 3M PPR (Potentially Preventable Readmission) tool. Different regions in the state have differing rates of re-admissions, as do teaching hospitals, Medicare/Medicaid and disproportionate share hospitals. Results of a survey of hospitals' feedback on the tool are expected to be released in the summer of 2009, and the issues of continued surveillance and reporting will be evaluated at that time.

Q & A

Q: 24 years ago, Massachusetts passed a discharge planning law giving patients 48 hours notice before they will be discharged – why is this not relevant to the current problem?

KR: It's still being done, but has lost its value and has become just another form to fill out.

Comment: The law needs to be updated: 48 hours is not enough time in today's system.

Q: What is the part that interviewing patients or families after the transition could play?

ABoutwell: Hospitals need to interview the patient's family to find out what the specific issues related to the re-admission. Post acute follow up phone calls are also needed.

Q: What is the role of the Medical Home?

ABonner: The Medical Home is very central to our care transitions work; it is part of the EOHHS and IHI models and agendas.

KB: There is initial but active work going on between the state and community health centers.

ABoutwell: The Medical Home efforts are not aiming to exclude Care Transitions, but are rather parallel and complementary.

Summary and Next Steps

Alice Bonner, PhD, RN.
Executive Director, Massachusetts Senior Care Foundation

Thank you to the members of the Massachusetts Health Data Consortium for all of their work in putting together the conference today. Also, please thank the members of the agencies and organizations which have provided funding to the many research projects you have heard about today: the Commonwealth Fund, CMS and MassHealth, and Commonwealth Medicine.

Everyone here in this room can be a leader on this issue; the best of the best are sitting here today. Patient by patient, community by community, hospital by hospital we can make change. We still have a hard path in front of us – it will not be easy. We know that we need to develop our infrastructure, our skills and knowledge, our communication and our sense of community. Finally, we need to realize that this is not a quick fix, that we will move along as quickly as we can while using some of the principles of teaching, coaching, empowering people and staying patient and family-centered.

We need to continue to collect data on this subject and to make our decisions based on what we have learned. We need to keep our projects connected and communicating, to continue to pursue the elusive goal of measurement and evaluation. There will be many more questions to come in the future; we must not lose the audacity of hope that we can create a sustainable state wide system of care transitions. I know we are well on our way.

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