

Transitions in Long-Term Care Settings

[ROOM NOISE/CONVERSATION]

ERIC COLEMAN, MD, MPH: Well, good afternoon. We're gonna go ahead and get started. I'm Eric Coleman. I'm from the University of Colorado Health Sciences. I'm the bouncer/moderator for this session, so I'm supposed to keep everybody participatory and paying attention.

I've been asked to make an announcement that all of you should be sitting at a somewhat different table that what you sat at in the morning. So, if you haven't done so, you can get up and move any time you like.

As far as choreography goes, I think you'll see some very similar choreography from the morning session, where, first, we're going to have a -- the findings from an important paper presented. Following that, we're gonna have panelists making some remarks related to that paper. And then you get a chance, as tables, to have your discussions and then we'll hear you report out and then we'll get to the really fun part, the interactive session.

I'm very happy to be part of what I call the "dream team" of care transition sitting before you here. I can

assure you there will postprandial napping, 'cause this group is so dynamic and so exciting. Their bios are all in your packets, so I don't think you need me to read them to you, but I am very privileged to introduce our leadoff speaker, Dr. Mary Naylor.

Dr. Naylor has not only been a pioneer in the area of improving the quality-of-care transition, she's also, through her endless passion, a source of inspiration to us all. So Mary's gonna present the findings from her paper entitled "Transitions in Long-Term Care."

MARY NAYLOR, PhD, RN: Thank you. [APPLAUSE]

Thank you and it is an honor and privilege to be here with you this afternoon. I really enjoyed this morning's conversation and I hope that we can meet the expectations that Eric has set to keep you awake and engaged through this afternoon.

It is a great honor to be here and I want to thank AcademyHealth and especially the Commonwealth Fund for this opportunity. They are both very much engaged, as I look at the program over the next couple of days. It's very exciting to me to see so much attention being paid to the issues around care coordinations and transitions in care

and this is a great opportunity to spend some time to focus on this.

Well, what I'd like to do this afternoon is to try to make the case to you, if I haven't done it well through the paper, that there is substantial opportunity to improve quality of care for elders in long-term care, receiving long-term care services and particularly if you focus on the opportunities related to coordination and that population, growing population of elders who are transitioning between the acute and long-term care sectors. And I'd like to suggest that there are two areas that we could focus on.

The first is that we know that elders in long-term care have acute care needs and one great opportunity is to begin to think about ways that we can increase both our investment in and response to avoiding preventable transitions to acute care. That means that, as individuals get -- develop acute care needs, we think about providing those in place.

And the second is that there will always be elders who will need hospital services who are also receiving long-term care and we have tremendous capacity to improve these transitions between the acute and long-term care sector.

I will focus a little bit on proposing a research agenda and some policy recommendations.

Now, our team has been involved in this area of transitions for many, many years and it -- most of our work has focused on the transitions of the population of chronically ill older adults living in the community who are not also frail, who are individuals, generally, living in homes, etc., but not receiving long-term care services. In the last two years, with the support of the Rand Hartford Interdisciplinary Center, we have begun to take a look at this population of elders receiving long-term care services in the community and assisted living facilities in their homes and independent living facilities as well as in nursing homes.

And as we do in our team try to get a sense of their stories, the issues that they're facing, the issues that their caregivers, family caregivers and the staff, both in long-term care and hospitals, are facing. So we've had a series of studies, some of which are just observational, really taking a look at the experience of these elders as they move back and forth between these sectors.

And one of the people that we met along the way was Mrs. Anderson. She's prototypical in some sense. She's

86-year-old woman who was relatively recent admission to a nursing home. She had lived with her daughter for about five years and the daughter actually wanted her to stay at home, like many daughters do, but her -- the daughter's spouse became disabled and found herself unable to meet both the needs of her spouse as well as her mother and so she was admitted to a local nursing home.

She's an individual with multiple chronic conditions. She has multiple functional deficits and mild cognitive impairment. She is, as you well know, one of the growing population of people 85 and older, the fastest-growing cohort in this country. And she's -- when we met her, fell into another category. She's one of about 15% of nursing home residents in this country who are living -- facing multiple readmissions.

Now, Gerry Anderson, his work at Hodgkin's, has suggested to us that as an individual's number of chronic conditions increase, so do rates of preventable or ambulatory care-sensitive hospitalizations. And Mrs. Anderson's profile, I think, fit that match in that the four hospitalizations she had in the six months prior to our [sic] working with us, she had three of them for acute exacerbations of heart failure and one for a fall, a

fracture as a result of a fall. And there is a pretty good sense that, if she had, in the nursing home available to her the kinds of services that she needed, either there was early identification that she was running into trouble with the heart failure or she had the services in place, we may have been able to prevent some of those hospitalizations.

Most people in this country recognize well that the acute care sector and the long-term care sector have rather distinct characteristics. The acute care sector provides services dominated by a medical model. Providers typically select the services and deliver them. They're typically high-tech in nature and there's usually limited family involvement. And that was the experience for Mrs. Anderson.

The distinct services in long-term care, as you well know, are that they're much more comprehensive in nature, health and housing and social. The providers, in this particular sector, are there to help and support individuals with long-term care needs, you know, to be able to function, achieve maximal function. The nature of the services are usually lower technology and family, in the best of all worlds, are equal partners. Are there as partners in decision-making. The payers, obviously, in

both these sectors are different with Medicare being the primary payor for acute and Medicaid for long-term care.

Increasingly, though, these sectors are characterized by blurred boundaries. It was Robin Stone's great paper recently that helped understand that we have -- it's very hard to know where one part of the -- one -- if you're receiving services from both, where one sector ends services and one begins. But that doesn't mean it's a continuum of services. There are no connections, generally, between these two sectors. And, in fact, there's often clashes between them because of the nature of the services and the goals that they have.

This has been recognized and multiple initiatives over the last couple years have been developed and tested in order to figure out how can we integrate acute and long-term care services. How can achieve both fully clinical and financial integration? And we have a number of models, the PACE program, social health maintenance organizations, number of state initiatives within Wisconsin and Minnesota and Texas, a number of provider initiatives testing intensive case management, which have attempted to figure out how do we bring these sectors together. And the bottom line is that they've been somewhat successful for subsets

of the population, those that can pay for it and those individuals that are usually dual-eligible.

But these efforts have been substantially hampered by, again, the issues that I just raised, two sectors, very different sets of goals, very different sets of expectations, fragmented financing. Sectors -- providers in these sectors who really know well how to deliver services within their respective sectors, but, if someone crosses the line, they do not know how to meet their needs. Nurses, for example, in hospitals really give excellent acute care services. They do not [sic] how to address the needs of Mrs. Anderson who needed help with feeding, who needed time to -- they don't have the time to deliver those services, etc. And there are real questions, overall, about the economic value of some of these efforts.

Yet they've taught us a great deal about what it is that we might do in order to improve transitions between and across these sectors and they specifically have highlighted the need for increased experimentation with care coordination, especially focused on the transitions between the sectors.

They've also taught us -- informed, I think, to some extent, what might be critical ingredients related to care

coordination. We need teams of people delivering these services. We need to have evidence guiding their work. We need the information systems that we talked so much about earlier today. We need care delivery that spans the silos. We need people who are focusing on the care of the person moving from one care setting to another, moving from acute to long-term care, not just handing them off. We need quality assurance, quality control. And, in order to accomplish all this, we need a great deal more flexibility in our benefits and funding.

So let's take a look, then, at the issue of transition, why it is that we should focus on it and why, I think, it represents so much promise in terms of improving quality for elders in long-term care. Bottom line, we know very, very little about the actual transitions experience between acute and long-term care. We have Chris Murtaugh here in the audience along with his colleague who, in the mid-'90s, really took a look at what was happening to elders over a two-year period, making transitions. And his work demonstrated that about 10% of these elders make frequent transitions, seven or more transitions, most of them to hospitals within that two-year period. But we don't have a very rich understanding of why these

transitions occur and what it is that we might be able to do to prevent them.

Much of what we know about transitions really relate to the general population of chronically ill older adults. So let me tell you what we do know and then what it is that we're -- I think we need to go.

We do know that many, many elders entering long-term care in the short term -- and, as a matter of fact, most of our work is really based on elders in nursing homes. Most of -- we know that there are high rates of hospitalization for older adults in nursing homes. In fact, many studies show, within the first six months, hospitalization rates are as high as 50% for that population.

We know that about 10 to 18% of those individuals have multiple hospitalizations within a very short period of time. There was one study that demonstrated that 40% of older adults who are hospitalized could have been cared for very effectively in the nursing home if the right sets of services were available. And then we also know that we have high rates of older adults, about 40% of whom, are entering hospitals during their last thirty days of life who would be very, very well-served by palliative care services.

We don't know much about the factors associated with preventable acute care transitions, preventing that move to the hospital. But available data suggests to us that we, as a group, do not provide the services. That there are a set of perverse financial initiatives. That there's a great deal of incentives for hospitals to fill their beds and there's incentives on nursing homes, for example, to send the people and to have them come back into their skilled nursing facility, 'cause they get increased reimbursement for that.

We also have a sense that we don't have access to the right sets of services. We don't have the right staffing in place in order to accomplish what we need to do to prevent acute care transitions.

The factors associated with breakdowns in care, when transitions from hospital to nursing home and back occur, are pretty well-established and they are common across all transitions. We don't have a very -- we do not have very good transfer of information. We have very poor communication between and among providers and between and among family members in terms of wishes. We do not have individuals who are focusing on prevention of transitions, etc.

And, finally, we know well that there are tremendous human and economic consequences. The hospital is not the place for a frail elder to be, to thrive. You can have elders who go through very rapid decline in very short periods of time in a hospital. We have very high rates of adverse events, especially medication errors, between the acute and long-term care sector, associated with breakdowns of care. We have serious unmet needs, poor satisfaction with care and high rates of preventable rehospitalizations, with estimates about a quarter to a third of rehospitalizations could be prevented if we did a better job in promoting good transitions between the acute and long-term care sector.

So the research agenda is pretty simple. We need to study this population in depth. We really need to examine, over time, what is happening to these individuals, why are these transitions occurring, what is -- what are the unique issues that older adults, coming from the long-term care setting or receiving service -- long-term care services in their home, what kinds of issues are they facing so that we can really target our interventions to direct them. Particularly, we know very little about those elders receiving long-term care in the community.

We need to figure out how to identify who's at highest risk for poor outcomes, what's their profile, so that, as we begin to target interventions, we can target it at those most likely to receive the greatest benefit. And we need to find out the factors associated with positive and negative outcomes.

In summary, in this section, transitions are increasing at a rapid rate. There are high -- we believe, high proportions of them are preventable. That, currently, transitions are associated with both poor quality and cost outcomes. And very few studies have explored the unique needs of older adults in the long-term care sector who need to traverse back and forth with transitional care.

So enter the promise of transitional care and let me start saying -- by saying that there is not uniform agreement on the definition of transitional care, so I have worked with a definition for many years, some of which is embraced by the American Geriatric Society. It really describes a broad range of services and environments. They are time-limited; it's not long-term care. And they're designed to assist and promote continuity of care and prevent poor outcomes associated with major changes in

health and/or associated with movement from one sector to another, one setting to another.

In terms of the state of the science related to transitions and this population, we have limited understanding of the benefits and the cost associated with interventions designed to prevent acute care transitions. We really don't know what it's gonna take and/or how much it's gonna cost us in order to establish within the long-term care sector the medical or palliative services, the training of the staff needed to do it that might prevent transitions, unnecessary transitions to the acute care environment. We do know a great deal from, again, interventions that have targeted the general population or chronically ill population traversing hospital to home.

Two innovations around avoiding preventable care transitions that I think bear promise and, actually, I was reading a poster, another one came to mind today. And one of them is that the use of the day hospital model built on the British system, in which services are available in the community, led by geriatric nurse practitioners but also supported by an interdisciplinary team aimed at -- once people are identified at risk for hospitalization, aimed at preventing hospitalization by providing a set of services,

intensive services to them in a community-based context.

Usually, the services range from six to eight weeks.

Another model just tested by Bruce Leff at Hopkins is the hospital-at-home model, in which older adults come to an emergency room, have ambulatory care-sensitive conditions and are sent home and they're sent home to a set of physician and nurse services guided by a very strict protocol. And Bruce was able to demonstrate no changes in terms of quality outcomes and decreased cost, decreased length of stay as a result of that.

In terms of improving transitions between acute and long-term care, a vast body of knowledge suggesting that nurse-directed, multidisciplinary teams, nurse-physician collaboration around this population can substantially improve outcomes and decrease costs associated with it.

Most importantly, all of this work, including the efforts to integrate acute and long-term care are helping us to define the core elements of effective transitions. One, we've gotta figure out who's gonna benefit the most. Screening of high-risk people and having -- targeting them for the interventions is critical. We have very much need to invest in transfer of information back and forth from hospitals to nursing homes to long-term care environments,

etc. We need point people, somebody who is guiding the services, who is helping to be -- navigate the seven or eight specialists, physicians, care and interacting with the long-term care providers and making sure that we come up with a rational plan of care that is well-communicated, well-implemented, etc. So those are just some of the core elements.

This kind of work, in terms of research, is not easy. I mean, you are studying methodological -- the methodological challenges are that you're studying multidimensional interventions. I mean, the nature of this population is that the simple answer is not going to be "Let's just improve the transfer of information." We know that because we've tested that. These are multidimensional interventions that need to take place in very different context.

We need to really focus on "What are the core elements? How is it that we're gonna adjust for severity? How -- what are the most influential and sensitive outcomes? And how is it that we're gonna take into consideration the impact of context of care?"

While we were engaged in a pilot study involving a couple of nursing homes, helping to help older adults have

better transitions from hospital to nursing homes, the leadership of the nursing home absolutely evaporated. There were massive organizational changes, etc. So really taking into account what's going on in each of these contexts as you're doing it is a really important methodological challenge.

There were also challenges to adopting proven interventions. Transitional care services do not exist currently. They don't -- we do not have a context for them. So, at the simplest end, we need to figure out where, in our healthcare system, might be the best context for transitional care services. From my vantage point, home care represents the best context. Home care is an environment that really has and does deliver services that include both acute and long-term care services and has the best context in order to be able to bridge the acute and long-term care environment.

We need to secure financial and other incentives that promote adoption of best practices, collaboration between hospitals, etc. And other challenges is that we still are trying to engage in this work of improving care coordination, improving transitions in care with a very

chronically ill, fragile population, in an environment that is still acute care-dominated.

Now, one of the major challenges associated with transitions and transitional care is to bring to the public's attention, to bring to the policy-makers' attention quality issues and the lack of quality measures has been a major barrier. There are very promising efforts in this regard and I'm delighted to announce (I hope that's okay) that Eric Coleman's measure, the Care Transitions Measure 3, has just been endorsed by the National Quality Forum as a measure to assess quality -- the quality of transitions from hospital to home and that is a major, major accomplish, so. [APPLAUSE]

But the challenges remain. We need to know what are the appropriate process and outcomes for this population. There is a tremendous amount of work that needs to be done in terms of defining the outcomes, especially the outcome measures, etc., and then defining accountable organizations. I mean, in this context, we have sending and receiving organizations. Who should be accountable for transitional care? The hospital, the home care agency, the long-term care setting, etc., that's an exceedingly important challenge.

So in terms of the research agenda, define the population best-served, compare the benefits and costs of alternative models. Does it make more sense to invest in those kinds of services and programs that prevent acute care transitions or should we focus on those that cut across settings? Identifying the most efficacious elements, designing and continuing to test quality measures and evaluate real-world experiences.

In summary, nurse-led, multidimensional, multidisciplinary interventions have demonstrated the greatest promise in improving transitions among this population. We are beginning to sense what the core elements are. Translation of our evidence is key and challenging. And future research needs to emphasize avoiding preventable acute care hospitalizations.

There are enormous policy implications. We need -- financial and other incentives to make sure that we have the adequate staff -- adequately prepared staff in both of these settings to either avoid preventable transitions or make sure that they occur as they should. We need a very strong attention to the development of integrated information systems. We need to encourage the delivery of services within long-term care to prevent -- promote the

use of evidence-based models and reward high quality. And, finally, we need to make sure that measures such as the CTM-3 are well-integrated into our information systems and national performance standards and I wouldn't be a researcher without saying we have a very robust research agenda here and we need to have investment in it.

Thank you so much. [APPLAUSE]

ERIC COLEMAN, MD, MPH: That's fabulous. Thank you, Mary.

We're gonna move from Mary's comments into our discussions and I think we'll just stick to our regular order that we originally set, okay? Do you prefer to be here or up here?

FEMALE SPEAKER: [OFF-MIKE]

ERIC COLEMAN, MD, MPH: Okay. Well, a true champion, Carol Levine, has provided a strong and effective voice for the rising numbers of under-recognized and undervalued family caregivers in this country and has helped us move from awareness into action and I'm really pleased to hear what Carol has to say. [APPLAUSE]

Sorry about ... [OFF-MIKE]

CAROL LEVINE: That's okay. Thank you. This is -- I always have to move this down.

Thank you and I'm very pleased to be here today and I'm having just come from a two- or three-day bioethics retreat at Lake Tahoe and I thought, "Well, now, I'm going into a different world." It's really not all that different and I saw many connections in our morning discussion and I think there are many here.

Eric introduced as Carol Levine. I feel now I should introduce myself as Daughter 1 and Wife 1 and that is my experience with long-term care. My mother was in hospice for one year and I was her primary family caregiver. My husband was injured in an automobile accident 16 1/2 years ago and is at home and I am his primary caregiver.

I wanted to say a couple of -- it's almost as if I can sort of put the family in the little pieces of what Mary was saying because I agree with everything she was saying, but it's often not made explicit, the role and importance of the family caregiver, so that's what I'm going to try to do in a few minutes.

One of the things is that, in this transfer of information, the family caregiver, who probably has been involved for some years before anybody on the medical side or the hospital side or the long-term care nursing home side gets to be involved. The family caregiver is the

historian of this patient's health. Now the -- as the historian, the family caregiver is not necessarily in -- has control of all the archival data, but the family caregiver kind of has a sense of the trajectory. Where this patient started out, where -- where they are now, how it's different and that is the expertise of the family that is not acknowledged, often. It's not solicited practically ever and it's not really valued for what it can provide in the sense of the information for the providers in all of these different settings.

And so I think that family caregivers are -- come in many different languages and educational levels and some are more articulate than others, but through listening to the family caregiver, one can often gain very important insights about that patient's medical history, social history, cultural history that are -- all those things are terrifically important in the -- in these transitions.

The family caregiver is confused, because many of us, until we got into the real world of it, didn't know the language, didn't know what different acronyms mean. Maybe, in some cases, didn't even know the difference between Medicare and Medicaid. And we don't -- we aren't often given the kind of information that will help us make the

appropriate decisions, so I hear now from family caregivers a lot of confusion about home care, what it is, what it provides.

They think that they're gonna get a full-time nurse to be -- or at least an aide. They think that Medicare's gonna pay for absolutely everything. They think that a short-term nursing home stay is a nursing home stay not a rehab stay. They don't know the difference in those terms and so there's a lot of confusion and no one really takes the time to explain it all. It's sort of that "Well, you're in the hospital. Mom is doing well with her hip fracture. We're gonna send her over to, you know, community nursing home." "What? No, no, no. She's not going to be in a nursing home." "No, no, no. She's going there for rehab." Have no idea what that means. "And then we'll get some home care for her." No idea what that means.

So there's got to be a lot of basic education that goes on and repeated, because, in a time of stress, you just simply cannot absorb all the kinds of information that is needed.

In terms of preventable hospitalizations, I think the -- I see the family caregiver as a kind of early-warning

system, as -- as the person who knows maybe not exactly what's clinically wrong, but something is different. And those alerts should be taken seriously, maybe eight times out of ten or I don't know what the statistics would be, but they may not amount to anything. But for those two times or three times that they do where some intervention could be made, it's really important to know that the family caregiver is noticing changes that the nurse who comes once a week is not going to be able to see and may not know to ask about.

And I've had personal experience with that and there's nothing more frustrating than to know there's something wrong with your mother or your husband and say, "I know this is different. I can't give you the exact diagnosis or I can't give you the symptom. Something is happening," and then, the next day, the something happens, whatever it was gonna be.

So I think it's important to listen to the family caregivers. That's what I was missing this morning in the discussion of the technology. It was a lot of "We're gonna give you all this stuff." I want some interaction. I want to be listened to. I want to have feedback about what is

going on and I think that's what most family caregivers want, too.

The family caregivers, as they move with the patient from different -- one system to another, are entering not, in your term, "silo" or my term "silos," they're entering different cultures. And there is a very distinct culture about going into a hospital that is different from the nursing home culture. And one hospital may have a different culture from the one that they went to the time before and the rehab setting is a very different culture altogether. And that's a shock to people, because they think they've learned how to manage one system, they've learned how to deal with nursing home A and how to kind of get what mom needs and deal with the nursing aides and do all of that and, all of a sudden, mom develops a fever and is off in the hospital and it's a very different situation.

So some attention much be paid to helping family caregivers and patients make that transition from one culture to another and then back again into the other culture. And those are things that people who work in different settings don't often take -- don't think about explicitly, because that's where you work, that's where you

live, but it's very different and home care is very different.

And I think hospital nurses, as good as they are, as skilled as they are, don't really know what home care really is about and so they will say, "Well, you'll get home care and someone will come and tell you what you're gonna -- what your mother needs and what -- so forth," but they don't really have the experience of actually being in that home and trying to set up the machinery that they have in the hospital room in the home setting. So there's a lot of transitional work that needs to be done in terms of helping one -- the staff of one setting explain to the staff of the other setting just what it is that's going to happen.

I think, finally, family caregivers see themselves as advocates and everyone might say, "Well, yes, I'm the nurse, I'm the patients' advocate," "I'm the doctor, I'm the patients' advocate," family caregiver, "I'm the advocate." Advocates are not necessarily people that one likes to have around. They make trouble. They raise questions that are not easy to answer. They make demands that are not easy to fulfill and sometimes they get very

annoying and very bothersome and, often, the easy way is to just shunt them out.

I think that family members need to be advocates, particularly for someone who is frail, who cannot speak for herself, who is perhaps mildly or majorly demented. You feel the need to be there for that person. And there are ways of dealing with even the most obstreperous of the family caregivers. I hope I've never been quite that bad, but I've been pretty annoying and will continue to be so when I have to be. And so there has got to be a way of incorporating that role into the other perspectives that are brought to bear on transitions.

I think that, finally, the research agenda that you will construct will have many aspects of it and will have financial aspects, it will have population, it will have the methodology and all of that. I urge you to consider bringing the family caregiver's role in explicitly, not just patient and family, which is like one unit. It's not one unit, it's different, it's very different to be a family member and very different to be the older person.

To include support and training and recognition of the difficulties in making these transitions from one culture to another, from one setting to another, because that

essentially is -- this person is gonna be with the patient no matter what, through all of this and it's important that this person understand what is going to happen, why it's going to happen, what needs to be done to follow up and what needs to be the -- how to activate that early-warning system, because that can be your most powerful tool in preventing unnecessary hospitalizations.

Thank you. [APPLAUSE]

ERIC COLEMAN, MD, MPH: Thank you, Carol, and I hope that, when we break out into our small groups, you'll think about the role of the family caregiver as you go through your questions.

Well, our second and final discussant is Richard Della Penna. Richard's been a valued friend, mentor and colleague for almost two decades with me and, in fact, Richard cared for my grandfather as he made his final transition to a very peaceful death. So Richard is also -- I can think of no other clinician that's had the impact on the healthcare delivery system as relates to taking care of older adults as Richard Della Penna. [APPLAUSE]

RICHARD DELLA PENNA, MD: Thank you, Eric, that's very flattering. And what Eric didn't tell you was he -- I took care of his grandfather when Eric was in medical school and

Eric graduated in 2004. So it was a relatively recent experience.

But, again, thank you for having me here today and what I'd like to do is talk to you about my experience as primarily a clinician, but someone who has worked in a very large system for close to three decades and talk to you specifically about collaboration with external researchers over that period of time. And explain to you some of the value that that has brought to me as an individual and also to Kaiser Permanente as a system. I think it's been enriching to those people as well who have collaborated with us.

But, first of all, I think true collaboration in research with a clinical partner or delivery partner really needs to be a true partnership. If people want access to us and our membership so that they have a huge population, that's not going to work. It really has to flow both ways and, in order for science and measurement to really advance, it needs to advance for both the researcher as well as for the system that is collaborating in the research.

So what I'm going to do is talk a little bit about Kaiser Permanente, a little bit about some of the

collaboration that we've participated in, specifically around preventing transitions and Mary summed it up so beautifully and also about work that we've done and are about to do and, again, making transitions when they occur from the acute to home better and easier for the people making those transitions.

In order for, I think, most organizations to be really interested in collaboration, the collaboration needs to address a significant issue. If it's kind of tangential issue for us, something that really is not one of our core interests or core values, we're not gonna be good partners in that. We might collaborate, but I can tell you, we're gonna lose interest and we're not going to be good collaborators over time. And I think collaboration with a little "c" means that we get the work done. Collaboration with a big "C" is that we get it done, we learn something - it may be a negative study, but we learned something, you learn something and we learn something and somehow that affects the way we deliver care, the way you consider and conceptualize future research.

I think if I look back at the research that we've collaborated in over the last number of years, there's sort of some buckets of benefit that come to mind when I think

of it. One is that we're able to use the new information to support new approaches to care or to retain existing approaches to care. I think another benefit that accrues to us is that I think the clinicians and the other people in our system working with researchers, being good collaborators really learn about the scientific method, about a rigorous approach to a problem and, although they're learning about that -- about the specific problem that we're studying, they carry that over to many other areas of their activity, which, in my experience, you know, they sorely need that type of rigorous approach in that work.

And another real benefit is having access to the best minds in a particular content area. So Eric said some very nice things about what I've been able to accomplish or my partners within Kaiser have been able to accomplish. Much of that has been due to the enrichment that has come from collaborating with people like Eric and Mary and I could read off a long list of people.

So, again, collaboration being bidirectional, being of benefit to the researchers as well as to us as we advance science and measure.

So what about Kaiser Permanente? We're huge. We have about 8.4 million members. We have about 950,000 members over 65, 80,000 over 80. So, huge. We have thirtysome-odd hospitals, home health agencies, hundreds of medical offices and yet we're a small microcosm of this entire country's healthcare system, but it's a big system.

I mention that not for a marketing ploy or as -- for marketing purpose, but to just tell you, as a large system that's integrated, that's prepaid, that's a group model, we can go on and on about the features of Kaiser Permanente. But, still, improving care is very challenging.

Care is fragmented in areas where you would think it would not be fragmented. We have all the stars aligned. Everything should be working, but things don't work, because we exist in an environment, benefits are benefits, sites of care are sites of care, so we face all the same challenges, maybe not as intensely as maybe in the fee-for-service environment, but we still face major challenges in providing care and specifically in providing and promoting good transitions and preventing them.

Why is this so? Well, again, because we're a system and why is it hard to improve? Because, as a big system, you know, big systems have inertia.

Another major problem is that -- and Carol alluded to this very nicely from the caregiver's perspective. But the people who control and allocate resources in a large system truly don't understand what we call the continuum of care. They really don't. They understand hospital. They understand -- and this goes for doctors, too. They understand the hospital. They understand offices and then there's this thing out here called the continuum of care, which is really a big black box. They really don't understand it.

They just assume everything out there is going well. And if you look at the way budgets are allocated and resources allocated, it's very clear that, I guess, they believe everything is well out there. And when you kind of wave the flag and say, "No, no, no, there's a problem here," it's sort of like, "Gee, I wish they would go away. Why are they such an annoyance?" But, at any rate, that's kind of the background and the challenge.

The current market forces that are going on in healthcare where, again, costs are escalating but people on the front lines are having to do more and more with less and less creates, again, another major barrier to bringing about improvement. You know, you might go to someone and

say, "We'd like to do a collaboration and we need some of our own resources to do that --" Mary knows exactly what I'm talking about. And people will say, "Yes, that would be really a good idea, but we have to run the business today and we're not really sure that this promised outcome or this possible outcome is going to happen and, if it happens, we're not really sure that the results are real and we're not -- if the results are real, we're not sure we really can scale that up so that it really affects a large number of people."

So huge barriers and the frustrating thing for me over the years has been that, while I'm trying to work on these things with other people, there are other things going on in the care system that are wasteful, ineffective, inefficient and nobody is willing to talk about that. One of the -- our regular consultants to our program, David Eddy was just interviewed by *Business Week*; I don't know if you saw that. But he was quoted as saying that doctor -- only 15% of things that doctors do have evidence behind them. And yet those other 85% of things that doctors do, not the healthcare system, but what doctors do are not really scrutinized, but, obviously, all of these things are.

Well, let me go on to tell you about some of the collaboration that we've had over the years, specifically in the area of transitions and how that has helped us gain new knowledge, actually build or sustain existing services and move us on and stimulate us to consider other areas for further collaboration.

The first one actually began in, oh, about 1986, '87. And that is when we developed, in San Diego, I was -- I did my clinical career in Kaiser in San Diego. We developed approach -- an approach to the care of people who were postacute as well as in long-term care in many facilities in San Diego County. And things that Mary said really brought back some memories, but we -- again, not a lot of science, but maybe just strong-face validity, we created teams of nurse practitioners and physicians to provide organized care to our members throughout San Diego County.

And the features of that program were regular visits, 24-hour telephonic coverage by the clinicians who were involved in the care of those members, we provided care in the nursing home that typically was not being provided in the nursing home at that time and met regularly -- you know, all the features of a well-organized service, regardless of where it is. And along came David Rubin at

that time from UCLA and Jack Schnele [?] who said that "We'd like to involve you in a study, want to examine your model, compare it to two other HMOs that have a similar model and also compare it to the care that the fee-for-service beneficiaries living in the same facilities -- we'd like to include them in this study as well."

Well, the bottom line which was very helpful to us and, again, advanced knowledge and science was that the model that we had, although it was similar, it was -- the structure was substantially different and what we did was substantially different. And some of the outcomes were that there were statistically significant fewer transfers to emergency rooms, fewer hospital admissions, fewer hospital days and so we were preventing admissions.

On the quality side, there were also some very positive trends so that we made more visits -- that wasn't a trend, that was statistically significant. We made more visits, more primary visits to nursing home populations. And there is also better response to fevers and falls and the things that happen in nursing homes every day.

Well, how did that end up impacting us? We already had that program in San Diego. Well, that provided us with the information and the power, really, to then replicate

that program throughout Kaiser Permanente, so it's not everywhere, but almost everywhere within Kaiser Permanente and it's gone well beyond our borders.

So I think a very good example of how collaboration with academic researchers led to new knowledge as well as advanced our own agenda for care within the organization.

The second thing that I'll mention was done with Eric, actually, in -- in Denver, where Kaiser Permanente was one of the sites for his nurse coach transitional care model and, if I recall, was probably one of the major contributors of numbers to your study. And, again, that was a positive study and -- although that model has not been rolled out, I'm very patient. I'm very patient, because I know it takes sometimes a very long time for these things to bear fruit.

I know that Kaiser hired your nurse coach, so she's now a full-time employee at Kaiser and they are thinking about different ways of incorporating the principles learned from Eric and possibly that model as something, again, that's part of regular care.

It's not originally part of my talk, but I -- Mary mentioned this transition from the nursing home to home as an example or Carol did. And I just had a conversation the

other day with someone from Colorado, where they're just doing medication reconciliation when people go from nursing home to home. The pharmacist calls, get the bottles of medicines on the table and they walk through it all. And preliminary data on this pilot indicate that there weren't fewer readmissions, but there -- and, again, they gotta roll this up, but it's very tantalizing, lower mortality. Which, in a sense, would not be surprising, given all the medications we give people and the regimens we give them. So, again, another possible transitional model that we develop.

And then, I think, one of the more exciting things that's happening in recent years, too, is that, for -- I would say for years, for a couple of years, Mary and I have been working together with some other folks with -- at Penn and at Kaiser to test the model -- test the model that she's developed. And it's been a long and winding road getting all of the funding in place and the resources in place, but we're there.

So there's a bit of a twist on that and, again, I think this shows very nice flexibility and, again, partnership because Kaiser -- Kaiser, me and others who looked at this said, "Gee, this is a really great model,

the results are good, they're published, but we're concerned about its scalability. And what we would like to test is whether an RN alone or an RN and an advanced practice nurse working in partnership with mostly the RN being the one who spends most time on the team and Mary's original advanced practice nurse, so those three models, let's see how they perform. Because, if an RN can achieve most of the results, although there's a shortage of RNs, there are more of them than there are of advanced practice nurses. So I think a nice example of collaboration even before the study starts.

The last thing that I will mention is that, really, for any collaboration, any research that we do, the impact has to really have a triple bottom line today. I mean, the business model is so powerful and the triple bottom line has to improve -- include value to our members, our beneficiaries. It has to have favorable clinical quality outcomes as we measure them typically and then the bottom line of the bottom line is it has to have a favorable financial impact. If it's big enough -- if it's a big enough issue in the minds of the people who make the resource decisions, if it's a really big quality issue, then, of course, they're going to address that. And if the

intervention or whatever is developed as cost-neutral, that's great, that's good. But if it actually lowers cost, then it obviously becomes much more attractive.

So, I hope I've given you a sense that collaboration between, again, researchers developing science, doing proper measurement really can lead to improvement in the care system and, again, although we're a microcosm, the work that you're all doing can inform public policy and, hopefully, much of the fragmentation and discordance that Mary outlined and Carol outlined from the caregivers' perspective will be improved. And, again, I think we've all been patient. I think we still have to be patient, but I'm becoming more and more impatient and I often wonder how many of these different interventions do we have to do to try to shore up this system that just is failing so poorly or is doing so poorly for especially vulnerable older people, but for many of us. And, obviously, that gets into broader issues of healthcare reform and all of that, which is really not on the agenda today, but thank you very much.

[APPLAUSE]

ERIC COLEMAN, MD, MPH: Good, well, thank you, Richard, and we are running on time. And -- just to make Cyanne and Christal happy.

And now is the exciting time when we break into our table discussion groups. You all know the drill, but just to refresh. In your packets, you have a list of questions for this session, which is "Transitions in Long-Term Care." The first four questions are fairly well-outlined. Question #5, of course, being a very important question which will lead us into the more interactive component of this. I'm not sure what happened in the morning as far as the reverse agism and having the youngest person at the table take notes, but you're free to pick whoever in your group of any age to serve as the recorder and, ideally, the reporter as well.

The members of the panel are gonna come join you. There will be a sixth panel question on transitions from the airport that Vince Mor in the back will lead for us. And so we will give you about a half-hour or so and we'll give you a five-minute warning when we're getting close.

[ROOM NOISE/CONVERSATION]

[RECORDING STOPS/RESUMES]

[ROOM NOISE/CONVERSATION]

ERIC COLEMAN, MD, MPH: All right, group number 1 in the far corner. Do you have a reporter? And here he

comes, all right. Do you want to come up to the microphone?

MALE SPEAKER: Well, we're trying to be adherent, not compliant, but adherent to the procedural rules that we've been given, so we just had a lively discussion of which of our many insightful points should be the primary one, but the one that we settled on and I'll -- if I can try to state it succinctly. Table 1. Has to do with is there a dark side to effort -- potential dark side to efforts to discourage and deter transitions from long-term care settings into the inpatient setting? At what point do you start having the potential for either undue risk or undue burden on caregivers and does there need to be some type of a caregivers' bill of rights to try to manage this process of shifting responsibility back to families and caregivers? Often, where there's a lot of technology involved and perhaps not adequate support.

ERIC COLEMAN, MD, MPH: Well, Mary just spun the random number generator and number 11 came up second. What do you know?

Long-term care is not predictable.

MALE SPEAKER: I thought I'd wait and see -- listen to all the others and say that everything has already been said, but --

ERIC COLEMAN, MD, MPH: Good strategy.

MALE SPEAKER: But we had four, but trying to pick which one. I pick the common language, so that we can all share what is being said. I mean, not only by the nurses and doc- -- physicians, but also by the family members, so that they can start to communicate with each other.

ERIC COLEMAN, MD, MPH: Excellent. Let's do table 5.

MALE SPEAKER: Vince Mor told me I'm the youngest and so I'm the recorder. Apparently, he didn't wear his glasses. We just bring one important question. Actually, we prepared four or five, in case the other groups in front before us already raised this question. We think this is the most important. If the demonstrated program was not found successful, how do we disseminate this program? Give you example, if this program as good as iPod from a Mac, why don't people adopt it very quickly?

ERIC COLEMAN, MD, MPH: Right. And table 9.

MALE SPEAKER: Hi. We mostly talked about how this issue doesn't seem new. How we've been talking about this for fifteen, twenty years and why is it that -- at the same

time that it seems like an old issue, it seems as though, aside from the great stuff that you presented, there really hasn't been very much progress. And we talked about the fragmentation of care, we talked about issues of culture and perhaps the segmentation of the continuum of care, where people might say, "This is my part of that continuum that I focus on and not this." And we'd appreciate comments at some point. Thank you.

ERIC COLEMAN, MD, MPH: How 'bout table 2?

[END OF AUDIOAFTERNOON1.MP3/BEGINNING OF
AUDIOAFTERNOON2.MP3]

FEMALE SPEAKER: Well, I guess I'm the youngest in my table. And I'm Ades Akamable [?] from the University of Iowa. And we came up with a couple of questions, but the one question that I think is -- we thought was most important is why we don't give nursing homes the permission to let people die in nursing homes. And in -- thinking about it as sort of an organization delivery system, why don't we let people who come in to nursing homes sort of give -- you know, when palliative care is the topic, you know, respond with the right mix of services and just let people die rather than transition in and out hospitals unnecessarily.

ERIC COLEMAN, MD, MPH: A little different than the morning panel, the afternoon panel recognizes all the expertise in the room and that, when we get to the point of interaction, we also want you to feel free to interact and direct questions to one another as well as the folks up here, so. Table 7.

FEMALE SPEAKER: I missed this morning's session, so I think to jump-start my experience here today, everybody decided that I would be the one to speak this afternoon. Our question actually -- or our discussion, which was very lively and we couldn't sort of narrow down pieces. We talked about sort of continuum of care as both a horizontal axis; that is, sort of the acute care hospitals, skilled nursing facilities, community-based services and home care and how they all sort of fit together or didn't fit together. But, also conceived of it as having a vertical axis that looks at education systems, policy systems, financing systems. And our question sort of focused on that vertical axis and where that intersects with the horizontal axis, specifically the existing and what we sort of termed as perverse reimbursement mechanisms that exist within the healthcare system, how these, in fact, have been a barrier to effective and cost-efficient delivery of

continuum of services and what we can learn from some of the demonstrations out there in terms of how they've navigated not only that horizontal axis, but aspects along that vertical axis as well.

ERIC COLEMAN, MD, MPH: Excellent. Table 3.

FEMALE SPEAKER: So, this morning, our table noticed that there were a lot of great solutions and that there seem to be things that are proven to be working and why aren't they out there, as people have mentioned. And what we would like to see is more research on payment methodologies and ways to actually pay people who are already providing long-term care, both in the primary care setting, physicians and nurses, and, in the long-term care setting also, especially community-based care, which is a big interest of some of ours at the table, to actually implement some of these -- reward people to -- for providing some of these proven models that people discussed this morning.

ERIC COLEMAN, MD, MPH: And table 8.

MALE SPEAKER: Our table decided to elect the most handsome to -- a couple of comments. Our table did decide that change was inevitable and how -- our questions were: How do you incentivize? And we decided that you'd have to

do it financially through clinical outcomes and through family perceptions and expectations. And what we're interested in hearing is how -- what a plan would look like that would give those incentives for change.

ERIC COLEMAN, MD, MPH: Excellent, thank you. Table 4.

LAURA SMITH: So we considered taking out our IDs to decide who was youngest, but I said that I would go ahead and do this again. So, Laura Smith from Brown University.

One of the things that -- we talked about a variety of things, so I'm just gonna pick one of them. And there was some discussion about what we could learn about these issues looking at care planning and community-based palliative care, where you have to balance out the potential need for truly needing hospitalizations, where that is appropriate and then also respecting family wishes for their -- and, also the individual's wishes for their care.

ERIC COLEMAN, MD, MPH: Thank you. Table 12.

MARTIN KITCHENER: Hi, good afternoon. I'm Martin Kitchener from University of California, San Francisco. Our conversation concentrated on the issue of transitions and we started off with a discussion of transitions from

the current to the next round of the World Cup. And this discussion actually evolves from empirical research and it was determined that Argentina had progressed at the expense of Mexico at lunchtime. So that was the important business of our discussion.

After concluding that business, we went on, as I said, to talk about transitions and we noted that, in Mary's paper, she had concentrated on one particular type of transition, from nursing homes to acute care settings. We were interested in broadening that out and wondering if there was anything that that line of research could tell us about other types of transitions to community settings or other types of healthcare facilities.

ERIC COLEMAN, MD, MPH: Okay, thank you. Table 6.

PAT MURRAY: I'm not the youngest person at our table. I'm Pat Murray from Case Western Reserve University.

We did -- we have a statement, I think, based on the information from Kaiser and from information from Arizona. We would like to make a statement that, to improve transition, there needs to be an integrator of care who's at financial risk for the care. There need to be tools to hold the integrator accountable for quality in addition to cost and the tools should include different domains and all

stakeholders involved. A final point is that there needs to be found ways to translate research into training programs for people who work in this area.

A final question we have is: We'd like to hear more about the day hospital approach to preventing care -- hospitalization.

ERIC COLEMAN, MD, MPH: Great. Thank you. And table 10. [ROOM NOISE/CONVERSATION]

MALE SPEAKER: It's working, right? We began with the same observation that table #9 did, that this is not a new problem. This is something that we've talked about for years and -- but we see in transitions, in fact, that perhaps it's more complex now. That providers, in the payment systems, in the organizations, new regulations and that maybe it's perhaps worse now than it was, say, even ten, fifteen or twenty years ago. And so we thought would be interesting, as a research question, was to look at the relative contributions to this complexity and how we would solve this in relation to transitions, so relative contributions of organization and the perverse incentives in financing and regulation and what kind of systems we could implement to sort of, I don't know, address these and, perhaps, in different contexts to see which is

contributing the most to the problem that we're facing in this area.

ERIC COLEMAN, MD, MPH: Thank you. I'd like to give the panel a chance, if they want, to jump in on any or all of these points and then we'll -- of course, we'd like to open it up for broader discussion and feel free to pick on friends at the other table, if you like, too. Any general comments from the panel before we open it up or --?

MARY NAYLOR, PhD, RN: I'd really like to hear more from your general statement about what kind of a -- I mean, in terms of solution, 'cause I think that we're all in agreement that is not a new problem, but what kind of integrated effort are you talking about? How might that get done? Who might be these players? This table, Carol's looking at me right ... [LAUGHING] yeah.

ERIC COLEMAN, MD, MPH: The numbers are facing the opposite way, so --

MARY NAYLOR, PhD, RN: Exactly, we don't know which table it is, so I'm sorry. 6.

PAT MURRAY: I'm probably not the best person to speak, but I think, I mean, the impression we had from hearing from Kaiser and from hearing from Arizona, where we have the director of Medicaid services there at the table,

that, if you have somebody at economic risk, you will get better -- you'll get improvement in transitions, but it'll only be on the cost side, unless you have a way to control or to manage quality, because they'll have no incentive to do anything but manage cost. I think that's the thought that came out of our discussion.

RICHARD DELLA PENNA, MD: See, I think the dark side would be if you're just managing the costs and, if you're able to manage the cost, but, at the same time, you know, meet the quality indicators, show that -- demonstrate better quality, then that's the sweet spot. And I think, in one of the programs, a couple of the programs that we've described, those were the things that were demonstrated. So, again, the triple bottom line is value to the -- the member or beneficiary, okay? Clinical quality impact and then the third thing is the economic outcomes.

So I think it is possible, but, again, safeguards have to be built into the system to make sure that it isn't primarily the dark side that comes through.

CAROL LEVINE: I just want to add one points and I -- believe me, I am no expert on the financing and all of that stuff. But it does seem to me that, sometimes, there's an issue in that the effort that's put in by one of the silos

benefits another silo and so what's the point, from that silo's perspective? If it's an integrated system, then there's a benefit through the system and to the patient and the family, but how do you convince a hospital to do a better job of preparing people to go home or go to the -- go into home care, if it's not gonna help them? So I think there's some -- that's an end result of the fragmentation is that it's fragmented in incentives as well.

I just want to comment about the -- you know, we've been doing this for twenty years? I've been doing it for ten years and we started at the United Hospital Fund really looking for a point at which we could make a difference in terms of family caregivers' experiences. As we talk to families and as we talk to providers, it was clearly the hospital-to-home experience. It -- that was -- you know, everybody agreed that was terrible and, in many cases, I would say scandalous.

And we've done some work on that and we've, more recently, done a study on transition from formal home care services to basically family-only services. So we've been doing it -- but, somehow, I do feel there's something new. I do feel there's some energy that's come together now that wasn't there may- -- I don't know, twenty years ago, but

now and I think it has to do with the fact that the quality -- it's the patient safety movement and the quality movement have come together around this issue. And it does seem to me that there's an opportunity now that might not have been there years ago.

MALE SPEAKER: Eric?

MALE SPEAKER: I just might not that the -- an illustration of that approach is the PACE organization, which is small, but does all that stuff and aligns it all correctly. And it will be interesting to see what this special-need population for the dually-eligible, it's extending extensively, how that'll come out'll be interesting to see. You know, Evercare, be interesting to see what that ha- -- so there are a number of efforts trying to embody that kind of activity.

ERIC COLEMAN, MD, MPH: Richard, did you want to --

RICHARD DELLA PENNA, MD: Yeah, I was just gonna comment. Another word that we heard today in actually one of the poster sessions was, again, on this entity that we're calling palliative care. And, again, we need a vocabulary here that I think we all understand.

But, again, we've just completed three studies. The one isn't finished yet, but all randomized controlled

trials. And one of them was home-based, a palliative care program; one is hospital-based and we have the results there. And, again, in all three of them, we were able to demonstrate or the people who did them were able to demonstrate improved adherence to quality indicators; higher patient -- because it was the patients who survived who were surveyed, higher satisfaction with communication and things that are terribly important to people; and, again, significantly lower cost associated with those interventions. And, again, that's not a surprise, given all the work that Wenberg [?] has been doing and all the care that is provided during the last year or last sixty days before death.

So, again, another example where integration, aligned incentives can produce, again, a positive triple bottom line and, again, there can be a dark side to that also.

ERIC COLEMAN, MD, MPH: That makes sense.

MALE SPEAKER: Just real quickly. I think it's really important, in the change that occurred with Medicare Part D and the development of this -- the special-need plans and thinking of it as PACE without walls kind of opportunity where you have now an entity that could be that integrator. The problem is the research has not informed those

organizations about these models and we've gotta get the research out there and the information out there, because it takes two to three years before it finally sinks in. But these new organizations are at financial risk for people in the hospital not moving appropriately either to home or to the nursing home facility as well as the fact that they have a responsibility for involving the family in a much greater way than the future. But the problem is they don't know what the models are that they should be implementing.

BILL BRANDON: Hello. Bill Brandon from the University of North Carolina, Charlotte. And I too would like to pick up on the issue of financing and funding. Mary's paper sort of said flexibility -- what we need is more flexibility in funding. And I had read your paper, which is very good and very interesting, on a too-long airplane ride last night, which might explain my incoherence today.

But -- and I really liked it, but I kept looking for capitation or -- because one of my mentors, the late Ernie Sayward, who is one of the founding physicians of Kaiser Permanente, enunciated, only halfway tongue in cheek, Sayward's Law, which is "Form -- function follows form, but

form follows financing." So that if you get an integrated finance -- if there is a capitation system, one pot of money, then, presumably, over time, there should be, depending on the rationality of the allocation and one hopes that the sweet spot will come out, that it will also be both financially effective and quality of care will be achieved.

But I appreciate, in a big institution like Kaiser, the hospitals of -- are evident there and the primary care docs are gonna be doing their talking, so there may not be much space for these new and perhaps slightly nebulous groups that are moving between 'em. But it strikes me that there actually is an analog that we should pay some attention to in terms of large organizations which have this problem of still being silos and that is -- following a political scientist named Harvey Sapolsky at MIT. Kept saying we really, in healthcare, ought to pay attention, believe it or not, to the Pentagon.

But one of the problems had always been, before the unification of the armed services that the Army and the Navy and the Marines were always fighting and, indeed, they still fight today about allocations. But we're a lot more integrated in terms of making decisions about defense

policy because we do have, instead of a separate department of the Army, of the Navy and of the Air Force, we actually have an integrated system that has a rational allocation system and, big and efficient as it is, it's a lot better than it was during the Second World War.

And I think that -- I appreciate the modesty with which you presented the Kaiser Permanente model, but somehow that is so much further along towards making allocations that respond to the real needs both of people and of the system -- the subsystems within it, that I guess I'd urge you to be a little less modest, because you were saying you have all the problems we do and then you went on to describe this great research, where you're obviously doing stuff that doesn't happen in my home community, where the -- the managed -- integrated managed care system went belly up. Thank you.

RICHARD DELLA PENNA, MD: Thanks. By the way, another thing that Ernie Sayward said was, "Managed care is better than unmanaged care."

MARY NAYLOR, PhD, RN: I appreciate your comment also about the funding and I wanted to maybe take this opportunity to talk a little bit about the partnerships that we need to think about to try to bring this science to

the consumer. We recently, in addition to the partnership that we have with Kaiser with the support of the Commonwealth Fund, Langala [?] Foundation, formed a partnership with Aetna, an insurer, to try to bring this model of care to its beneficiaries and they have, of course, in a capitated, every interest and incentive to participate.

And we -- tried to do it in such a way so that we would position ourselves to be able to have it rolled out and available to other insurers and other purchasers and other healthcare systems. So to develop the tools that some of you were talking about, web-based training modules that individuals across the country would easily be able to have access to, an information system that could easily be made available that has -- houses all of the intervention protocols and all the critical elements of these evidence-based interventions.

I think this is a -- it's a great journey, it's a great adventure and we are in a very early stage. Aetna decided, early on, to also make it a part of its CMS Medicare health support initiative, so now it's rolling out in Chicago.

Part of our deliverables is to try to really help people who want to try to bring this kind of approach to care or other evidence-based models, Eric's, everybody else -- every other researcher who has something that I think could bring meaning and value to elders, these -- this might become a path and a journey to help make that happen.

The day hospital, I think somebody was interested in that. To tell you the truth, what I know about it is the version of it that existed at the School of Nursing at Penn. We operated it -- we had -- own and operate -- the School of Nursing owns and operates a PACE program and we also owned and operated a day hospital based on the British hospital. What -- we designed it exactly. We visited the -- and designed it exactly as that model existed. Multidisciplinary team, nurse-led, targeting elders identified by discharge planners or, in the case of physicians, other providers who were at risk for hospitalization.

It ended up being a nine-week service. It was multidisciplinary. It -- we framed it or financed it as part of the CORF outpatient rehab. Reimbursement was cut. We had great outcomes, reimbursement was cut, program ended.

So I think that there are great, great models. We have to figure out ways to -- even in the best of worlds, to continue to sustain them, because they obviously make a great deal of sense and I think they can happen rationally and reasonably if we can convince people to pay for 'em.

ERIC COLEMAN, MD, MPH: Susan.

SUSAN HEDRICK: This is Susan Hedrick. I'm from the VA here in Seattle and the University of Washington and welcome to Seattle. I'm glad we got nice weather for y'all. It's the first nice day in six months, so it's --

Just wanted to follow up on Mary's point. One thing that's been depressing us here in Seattle is the -- Ed Wagner's chronic care model. A capitated staff model, HMO, what we thought would be a perfect place to be able to do something like that with patient activation and informatics and all that.

And they essentially dismantled the whole thing. They lost market share. Patients were voting with their feet to go to a cheaper health plan and they had to take it all apart and move the nurses that were doing the case management and group visits and all that over to essentially get people in the door faster. The patients apparently, they think, just wanted to be able to come in

faster. When they called for an appointment, that was the only thing that mattered to them.

So I think we have sort of an educational process to convince the folks who do vote with their feet that this kind of better care that we're talking about is worth paying for, more for if it's that kinda situation or at least staying with the PACE or the plan or whatever it is that allows them to have this higher quality care, 'cause apparently, even under a good system, it's -- it can go under, as you were just saying, so.

ERIC COLEMAN, MD, MPH: I think that's a really strong point. I read a paper on the plane on the way out that hasn't come out yet that was sort of comparing and contrasting Ed's model with the traditional vendor-based disease management versus provider-based disease management. And really the point of the article was that the model has really helped shape care, but, in and of itself, it's very hard to maintain.

MARY NAYLOR, PhD, RN: I also wanted to tell you a little bit about what we are doing in terms of our science with future relationships, because I think this might be a way to speed up -- I don't know if it will be, but to speed up some of the issues around if things work, how it is that

we're gonna get our end users to rapidly adopt them. So, recently submitted proposal to NIA that mapped out a research agenda but did it in partnership with end users, a health system and insurer and basically made the case that, if these findings -- they had to make the case that, if these findings were relevant and positive, that they would use them to inform changes in their clinical practice guidelines and standards of care, etc. So we have these letters at least -- I don't know, anyway.

I think that the partnerships between researchers and the units or systems that they're trying to answer, as someone said today, the big problems. As long as you got a big problem, a collaboration upfront where you will talk about people working with you on the design of the studies in a way that really can help them address and answer the questions, I think is also a critical element in making things happen. Very similar to what Richard has said.

ERIC COLEMAN, MD, MPH: You know, this is really, I think, in a lot of ways, new frontier. Mary and I were talking a little bit at lunch about the fact that, when you engage in these partnerships -- we've now disseminated our coach model to ten delivery systems, including a MHS site. There is this fidelity to the model question, there's how

much should the developer be involved in these other stages and then, you know, "How many places can Mary be at once?" type thing or her team. So it's actually -- you know, I think we're all trained, it's not just a journal article, you know, get this into practice. But that area is still relatively unexplored.

There's a few -- Tricia Greenwald [?] has actually written a very exciting paper that came out in *Milbank* a couple years ago that I think summarizes it better than anyone else has to date, but we -- I think both of our programs are learning as we go. We don't have a lot of guidance in this area in terms of these partnerships and making good choices, as Richard was talking about.

MALE SPEAKER: You mentioned the importance of having a nurse-led transitional multidisciplinary team. Karen Davis and I would like to see a test of an economist-led multidisciplinary team. And I think what -- partly, some of the discussion of transitional care sounds a little bit like putting the armor on the Humvees, trying to patch up a design of a vehicle that wasn't appropriate for what we're trying to do over there. And I wonder if a lot more attention needs to be given to the incentives in the system rather than -- so that that care -- some of that

transitional care takes care -- takes place appropriately as opposed to trying to put on an additional intervention with a different way of paying for it.

So I don't know if you have a reaction to that, but I would like to s- --

MARY NAYLOR, PhD, RN: I do. I actually think it's -- I guess -- I guess you might say, in the best of all worlds, it's what we should be doing and -- as the providers of services. But I think what our experience has been over the last fifteen or twenty years is that there hasn't been much of an evidence base to guide care of high-risk, chronically ill older adults population. And so, without question, this work has substantially advanced the base of science and guided best practices, some of which might seem like common sense.

It is absolutely critical that you have someone who is knowledgeable and skilled and sophisticated and able to navigate very, very difficult terrain to pull together a set of programs and services that work for an individual patient, for their family caregivers, etc. But to build the evidence necessary to make that happen and then be able to have many providers use it, it has really been a science. It's been the evolution of science.

Having said that, I also think it's critical that people going into this need an economist on the team and Mark Pauley's been ours for the last eighteen or twenty years and has always helped position us in saying, you know, what are the costs and what are the benefits and how are we gonna make the business case. The only reason that Aetna was interested in working with us is because we could make a business case for this approach to care. So I think that, while I certainly wouldn't want an economist serving me in terms of my healthcare needs, I'd be -- and I love Mark and it's critically important that you have the right team of players guiding this.

What we didn't have at the beginning were the end users and so now we're really now thinking about, as our science goes forward, having them as major partners on the team, because it's really gonna help our work a great deal.

FEMALE SPEAKER: Even as you have an economist on the team, I think the other thing is that we often don't look at other fields to find out what they know about integration of activities and services. And I know one of our grantees, Jody Gatel [?], has been working on a theory of modularity that has been used in the aerospace industry and some other industries. And when she looks at how they

have learned about what levels talk to each other and how they communicate, there are -- there are a lot of lessons that we could derive for the healthcare system that we just haven't looked in other systems.

So to include other social sciences, other kinds of things to really understand where the problems are and how other industries may have solved them. Even as we make business cases, we also may be able to think about different interventions that we haven't considered or that we may stumble upon.

MALE SPEAKER: I just want to follow up on the comment and I think it boils down to triaging and rationing resources that are available. So you mentioned about triaging, but you didn't go into specifics about what's your model to triage.

MARY NAYLOR, PhD, RN: Just to make sure I understand, are you talking about who is it that should receive these services, triaging in terms of high risk?

MALE SPEAKER: Yes, not like in the disease management model, but you need to screen and then to focus.

MARY NAYLOR, PhD, RN: Right. Well, at least in the work that we've done, which, again, focuses on what we describe as high-risk individuals. What we've done over

the last several clinical trials is attempt to define who are the recipients of these services that seem to benefit the most from the services, who seem to do just fine without those services and, in the randomized clinical trials, we're able to do that.

So we've been able to identify a set of risk factors - again, this is for the general population of chronically ill older adults living in the community, not who have frailty as an added complexity. And so we have a number of risk factors from our work, but this has also been reinforced by many, many other people's work.

Clearly, the presence of numbers of active comorbid or coexisting conditions (and we define those as those conditions for which there's active therapies) is a major risk factor. We have only worked, up until recently, with cognitively intact older adults, but clearly the presence of cognitive impairment -- mild cognitive impairment, any range of cognitive impairment adds complexity substantially to the issues and needs.

So there are those kinds of individual factors, there are system factors that we've outlined, etc. So that -- it's been our science that's helped to evolve and define that profile. People who define themselves -- who say that

their health rating is poor, regardless of any of those, are also at high risk for poor outcomes and this has been reinforced in many, many other studies.

ERIC COLEMAN, MD, MPH: And we are at time. I'd like you to join me in thanking our panel. [APPLAUSE] Very well done. Also like to thank the Commonwealth Fund and AcademyHealth for sponsoring us and it looks like we're ready to go.

PETER KEMPER, PhD: So my responsibility is to wrap up for the day and I'm going to take the prerogative of the chair and ask Anthony Rogers if he would make a couple of remarks. One perspective that has been missing from today's session is the state policy perspective and Anthony's director of the Arizona healthcare cost containment system.

And one of the things that AcademyHealth does -- there's a lot that AcademyHealth does that is not visible at this session that makes it very successful. But one of the things that they do is try to identify policy-makers with an interest in the area to come to this colloquium, 'cause we want to bring policy-makers, providers and researchers together. So Anthony was at my table and made

some remarks that I thought might be useful for the whole group, so you want to --

ANTHONY ROGERS: Well, I want to thank you for this opportunity and I really appreciate the dialogue at each of the tables and the people I've met. And it's a shame that more policy people in the state, Medicaid directors, even at the federal level can't hear these kinda dialogues, because there's a general sense that there's nothing we can do about it and what is is and that's the way it's gonna be. When the governor hired me in Arizona, she said, "I want it to change."

Now, there's two things you have to think about in terms of your research and model building. Does a system have to transform or transition? Transitional change is a little easier, more incremental. Transformation change requires major changes in how we think and do our work.

For example, IT or the technology is going to require transformational change. It's gonna take longer, it's gonna be a lot more involved and we -- and these kinds of efforts will definitely inform the policy-makers. The other part I would just say is that the problem we have today is not only do we have siloed systems, we have

multiple models and each state does it -- their Medicaid, long-term care program differently.

In Arizona, we're very fortunate. The reason I came to Arizona, it's got an organized system of managed care and managed care has a bad reputation, but Arizona's gotten beyond that and it's a great system to build on and to evaluate.

But, if you want to change policy, you have to realize two things about policy. You either have to have a crisis or you have to wait five years. You have to let the legislative process take five years, whether that -- you get rid of the legislators of today and you bring in a new one. If you think about what happened with national health insurance and why we didn't get it, it was because it was too big a policy and there was no crisis. If we have a pandemic, we will have national health insurance, because the haves and the have-nots will be identified during a pandemic.

The other part is that, if you are gonna do policy change, which I think is necessary to transform the system, your research and your models must be relevant to the policy-makers. They have to have the financial part, they have to have the quality part and they have to be doable

within the context of our current models and allow either incremental or transformational process, depending on what's necessary.

But I would continue to encourage you and there is one other thing I will say. I am concerned about management leadership in healthcare. We all know the system's broken and we are the system that broke it. There is no opportunity to learn that's consistent. If I had a doctor who did not do continuing education in medical practice, I would not go to that doctor, but I know very few managers who are required to do continuing education about how they're impacting the system of care and yet they have the greatest impact.

Somehow, we have to translate this into an educational process that forces people like myself to understand that is part of our stewardship, that we have to make these models work and that's gonna be a core competency that we don't have.

So I would like to thank you and just now that I look at your research as helping me to set the bar higher, to create the new performance metrics, so please continue and, if anything that we can do in Arizona to support you, please let us know. Thank you. [APPLAUSE]

PETER KEMPER, PhD: Thank you very much.

I just want to summarize several common themes that I saw across today's presentations. Russ Bodoff and the discussion following that identified the great potential for technology to improve care delivery. And I think the transitional care discussion with Mary Naylor and the discussion that followed that identified promising interventions, both for preventing unnecessary transitions and for providing good transitional care when they are necessary.

At the same time, they identified barriers to care and many of those barriers and those barriers are policy barriers. Reimbursement and funding of technology in the technology area and regulatory and legal issues, the liability issue, HUD regulations, cross-state licensure of treatment using technology are examples in the -- on the technology side. And, on the transition side, the financial incentives and reimbursement for transitional care and the absence of accountability for transitional care in a world of silos.

They also both -- both sessions identified the need for additional evidence. In the technology side, the evidence is a lot less well-developed, need for some very

basic cost-effectiveness in a world where the research has to be as fast as the technology to be useful and I think that's a challenge for us as researchers, especially in the world of publication lags.

And I think, on the transitional care side, where the evidence base is stronger, in part due to the excellent work that Mary's been -- and her team has been doing, there the issues are more of a -- it's almost a longer list of issues of figuring how to do it better, how to target it effectively and so on.

Both sessions also identified collaboration and I want to emphasize those as archetypal models of the kind of thing that the colloquium intends and hopes to do as part of these discussions. On the technology side, Carol Raphael talked about a number of collaborations between the delivery side and the research side of the VNS of New York. The -- Richard Della Penna talked about the Kaiser Permanente collaborations with researchers. And Mary Naylor talked about what is, I think, exciting collaboration with insurers and foundations.

So, I'm particularly interested in those, because, as Mary Jane Koren said at the discussion of the workgroups, part of the vision of the colloquium is to stimulate this

kind of collaboration between the users of research and researchers. So I think of this as use-inspired research. Another way of putting it is to move from evidence-based care to care-based evidence. That takes a minute, but, if you think about it, it's -- along with this theme of use-inspired research.

That is one thing -- the next three steps -- three next steps for the colloquium. The first one is to think about workgroups. Mary Jane talked about the workgroups that are -- exist so far. We hope out of this meeting will come some additional workgroups in the areas of use of technology and transitional care. These workgroups can take any direction that the group of people want to take. Can be a listserv, it can be actually trying to develop a research proposal for some kind of collaboration.

In the limited experience, so far, it seems to me that the key to success of one of these workgroups is to have a leader who's not afraid to lead the group and take it in the direction that the leader would like to take it. Obviously, leader has to get somebody to follow, but I think that's the single key ingredient. AcademyHealth can provide some administrative support to help the group keep going. So that's number one.

Number two is -- I know you've learned a lot today, so it's time for your quiz. So if you would take out your packet, your quiz is in your packet. It's on this pink form. This is the pink form and, for extra credit, the gray form, okay? Actually, these are the evaluation -- they're -- the pink form is the evaluation form. We actually do read these and use these in our planning committee. In fact, the table discussions were the result of comments that we received the first year when we didn't have that kind of discussion and I think -- well, I'll wait for your feedback, but I think they've generally been very well-received. So if you wouldn't mind filling those out and leaving them -- there's a box outside, at the end.

The gray form says "evaluation form," but it's actually a way for you to sign up for the workgroups or other activities and make comments on that. So that's the second next step.

The third next step is the reception that follows immediately next door. They may not quite be ready by the time we get there, but they should be set up shortly. This is something that is not actually technically part of the colloquium, but it's something that, when we formed the Long-Term Care Interest Group, one of the things we wanted

to do is have some activities to encourage the next generation of long-term care researchers. That came out of an observation that many of us have bald heads or gray hair or dyed hair, one or the other.

And so you each have a responsibility at the session. Need you to divide yourself in two groups, people younger than half my age and people older than half my age. There -- you can guess what group you might put yourself in, according to that criteria, and spend at least half the time at the colloquium talking to somebody in the other group, because one of the challenges for people who are just starting out is meeting people who are more senior in the field, since we tend to talk to each other. So that's the purpose of this.

And the last thing I want to do is thank people -- the people at AcademyHealth who made this possible. As I said, there's a lot that goes on that you don't really see the work, but that makes this all go very smoothly. So Christal Stone is back at the back of the room. [APPLAUSE] Cyanne Demchak. Is Cyanne here? She's probably out -- she's out front. Amar Narula [?] is -- where are you, Amar? Over here, who is an intern at AcademyHealth. Kristine Metter is not here, but she's the person who

coordinates the workgroups -- the support for the workgroups. And then, finally, Debbie Rogal who can't be here, but she is the project director at AcademyHealth who really makes all this go.

Next, I want thank Russ Bodoff and Mary Naylor for really very valuable papers and presentations, stimulating papers and for all the discussants. I think, for me at least, it was a very stimulating set of sessions, so I want to thank them. [APPLAUSE]

Finally, I would like to -- at the beginning, I think David gave Penny Feldman and myself credit for the vision of this thing at the outset. I don't mind taking credit for things that I don't deserve it for, but, in fact, it's Mary Jane Koren at Commonwealth who is the person who first said, "You know, we really need to have a five-year vision and an initiative." And some people mouth off a lot and, you know, sometimes, it gets to be a little bit much. Mary Jane is not somebody you would describe as somebody who mouths off, she's rather soft-spoken and made this suggestion in that way. But she's also different from people who mouth off in that she put her money where her mouth is and made it possible to do this, so I really am grateful to her and Commonwealth. [APPLAUSE]

Is there anything else that I need to say? Yes.

FEMALE SPEAKER: The reception is the room where all
the posters were, so there's drinks and snacks.

PETER KEMPER, PhD: So, enjoy.

And fill out your evaluation forms.

[ROOM NOISE/CONVERSATION]

[END]