[00:00:47]

ANNE-MARIE AUDET, MD, MSc: Well, good afternoon from New York City, and welcome to our webinar. We're delighted that you have taken the time to join us today. We have put together a really top-notch panel of people with a lot of expertise and experience, so I hope you will learn a lot from what they will have to say.

[00:01:10]

Just on behalf of Karen Davis, who is the President of the Commonwealth Fund, I welcome you to this webinar. The fund is a private foundation and our mission is to foster the improvement and the achievement of the high-performance health system. And our programs have many different priorities. One is healthcare system redesign. In this area, we're focusing a lot on the issues of care transition/care coordination. Currently, we're funding a five-year, three-state project, the STAAR initiative, the State Action to Avoid Re-Hospitalizations in Massachusetts, Michigan and Washington State, and you will hear from one of the participants in this project.

[00:01:51]

So obviously it's a bit cliché, but I want to still say it, that we're really still at a time of unprecedented changes in our healthcare system. There will be in the next days, weeks, months and years a lot of changes in how care is delivered, how care is rewarded and what's really new and quite exciting, opportunity to seize the moment right now is that a lot -- there is a lot of alignment in the -- definitely in the federal program, and also in the private sector, to finally start to put our knowledge, our incentive to create the will to change.

[00:02:29]

Now we all know change is not easy and some of our panelists today are people who are really in the thick of it and can speak to their experience and what they've been able to accomplish.

Care coordination and care transitions is a priority right now at the national level, at the regional level, in your own community. I'm sure that's why you are here today. And again, there is a lot of activity, a lot of programs. STAAR is one program. We have Project Boost. We have Project Red. We have the care transition program

that Dr. Coleman has been spearheading for many, many years, and at the federal level, more recently, of course, we have the partnerships for patients that's focusing on patient safety and readmissions. Therefore, improving care transitions.

[00:03:20]

And in the Affordable Care Act, the section 3026, which is the community-based team approach -- community-based transition care program, and I'm sure a lot of you are looking at this program and hopefully are thinking about applying with organizations in your own setting.

[00:03:41]

Clearly, I think what's really important is that right now we know that care transition is not a problem. It's a problem that we've known about for a long time. The issue right now, and why we decided to focus our panelists on community-based approaches, is that when you look at transitions, at readmissions, it's not a question of pointing the finger to hospitals, to nursing facilities, to primary care practices, to home care services, to patients and their families or to someone else. It's a problem of the system.

[00:04:20]

We all know that in the safety arena, in the past decade we have made a lot of changes by thinking that if -- before we thought and error was a personal problem. And to err is human shifts the paradigm to the system instead of the person. So if you think about care transition, now it's not the organization that's the focus, it's the system. So it's all of the community services that are surrounding the patient that are involved in care transition and care in their own setting that have to come together to solve the problem.

[00:04:55]

So I was also -- I want to say one more thing. I think when many of you may be familiar with a model of change, the Prochaska model of change where you need to have knowledge of the problem. I think in this country, we are A plus 10. We have the knowledge. We know there is a problem there and we keep saying there is a problem. So I give us an A+++ on the knowledge.

[00:05:17]

Then you have to start to contemplate, and that's where you have to start to build the motivation, the will

and the incentives to change. Then you have to prepare. You have to have the right tools, the right models, the resources, and I think here -- and you'll hear again from Dr. Coleman and other panelists that we have good tools at our disposition. We need more -- we need more knowledge to improve our knowledge all the time, but there are really good things we can do right now and that people are doing right now and having an impact.

[00:05:46]

So I would say that in terms of tools, models, preparation, we're probably A-/B+. And today what you'll hear is -- and in terms of the will and the incentives, I think, as I mentioned before, there is payment reform that's on the horizon that also will create some of the incentives to allow more flexibility to do the right thing.

[00:06:08]

So today what you'll hear about is action and maintenance. You'll hear from three outstanding speakers who have been able over some time to really make a difference in terms of improving care transitions. The first speaker is Dr. Eric Coleman. He is the Director of the Care Transition Program. He is a Professor of Medicine

at University of Colorado Health Science Center, but even more, I think, Dr. Coleman is really our national treasure in terms of commitment and really trying to change and leading the national efforts to improved care transition.

[00:06:46]

Our second speaker will be Dr. Gary MacKenzie. He is the Medical Director of Cardiology Services at McKay Dee Hospital Center in Ogden, Utah. This -- the McKay Dee is one of the top performers in readmissions and so you'll hear about these -- what Dr. MacKenzie and his colleagues have been able to do, and he will be joined by his colleague, Dr. Jerry John, who is a cardiologist at McKay Dee.

[00:07:17]

The other thing is as soon we'll be posting some new case studies on our web site, Why Not the Best, which is a performance improvement tool at the Commonwealth Fund that profiles the performance of hospitals on a number of indicators, including readmissions, and also provides tools in the form of case studies and other tools to improve performance. McKay Dee will be profiled as a top performer in readmissions.

[00:07:47]

And our last speaker will be Janice Fitzgerald, who is the Director of Quality and Medical Management at Bay State Medical Center in Springfield, Massachusetts. Bay State is involved in our STAAR initiative and also is showing some really amazing results.

[00:08:03]

So without further ado, I will now pass the baton and the transitions to Dr. Coleman.

ERIC COLEMAN, MD, MPH: Great. Well, a virtual hello everyone. Thank you. This is a terrific turnout. The speakers are going to keep our remarks relatively brief because we're looking forward to having some discussion towards the end. I'm going to provide a relatively high-level overview that I'm going to provide you with a URL at the end if you'd like further elaboration.

[00:08:34]

But the answer -- as Anne-Marie suggested, I have been working in this space now for many decades, and what I would like to do is try to summarize some of the key learning points and attempt to answer this question, "What

will it take to improve quality and safety at the time of transition?"

[00:08:49]

To answer that question, the punch line is that there is no single quick fix here. There is no one intervention that is going to take us where we need to go. It's likely going to be multifaceted and it's going to be a team sport that involves cross-setting partnerships between some entities that maybe don't have a real track record in this area, and it also involves the patient being a full-fledged member of the team, and not, as Anne-Marie just joked about, as an aluminum object, such as a baton, that we pass back and forth between each other.

[00:09:23]

So I am going to provide you with seven key steps. The first one, the centerpiece, if you will, is really how do we foster greater engagement of our patients and their family caregivers. This really comes down to how we meet them where they are in terms of literacy, cognition and activation. It's really unacceptable as just labeling these individuals as being noncompliant, unless we really believe we have met them at their level in these regards.

[00:09:49]

Further, we need to encourage these individuals to express their preferences -- preferences for the types of the services, the intensity of the services and the settings of services and then we need to honor those preferences.

[00:10:05]

Continuing along on this theme, I would argue that the family caregivers are often the unsung heroes of improving quality and safety in this area. They are essential members of the team and yet they're often invisible. We just simply cannot afford to ignore this group, because whether we sort of -- it's imminently clear to us or not, these individuals are behind the scene and they're often the first line of defense when it comes to things like patient safety. They do a lot of care coordination, even when individuals are fortunate to have case managers and care coordinators.

[00:10:41]

Performance measurement has been a fairly significant barrier to quality improvement in this area. When I say performance measurement, I'm encouraging us to think behind

measuring re-hospitalization and other utilization measures. When we really look at principles around lean thinking and other industries, what's central to this concept is that the customer, or in our case, our patients are critical to providing that level of input. It tells us as professionals if we're on track.

[00:11:13]

And so how do we identify those quality improvement measures? Some of these have been endorsed by national quality forums, and how do we put these into practice?

[00:11:23]

The next area is affectionately called the A word, accountability. What is it that it takes so that patients understand who is the accountable professional overseeing their care at all times, and particularly as they're crossing through this vulnerable time as they're moving from one setting to the next?

[00:11:43]

About a year and a half ago, six physician professional societies got together as the Transitions of Care Consensus Group and issued a policy statement about standards, not guidelines, not good ideas, but standards

for what professionalism in this area of transition entails. There were, I think, eight specific standards that were articulated. The one that I wanted to highlight today really has to do with the fact that the descending care team remains essentially on the hook until the receiving care team has had an opportunity to review the care plan and the goals for care, the transfer information -- clarify any questions and then acknowledge assumption of responsibility.

[00:12:29]

I continue to be impressed as I dig deeper into curriculum for healthcare professionals how few of us have really had significant exposure to what it takes to not only coordinate care within a given setting, such as a hospital or nursing facility, but what it means to do this across care settings with health professionals that we may not necessarily have a longstanding relationship with or care settings that we really don't understand the culture, often because we really haven't had a chance to practice, or in some cases, even set foot in those areas.

[00:13:03]

We need to clearly understand not just the roles that these individuals play, but also what are the capacity of these care settings for delivering care.

[00:13:16]

It's always very tempting to immediately gravitate towards technological solutions. I certainly have had the opportunity to interact with a number of very innovative thinkers in this area, but again I would argue that this is necessary but not sufficient. We clearly can improve how we exchange information, especially between disparate providers. We have been pleased to see the federal meaningful use guidelines coming into play to not only articulate what these might look like, but also as a company incentive.

[00:13:52]

Anne-Marie made some reference to the fact that there are so many new initiatives that are being launched concurrently, which is very exciting. But again, it also suggests an important opportunity to make sure that these new developments are complementary and not necessarily competing -- competing for resources or competing for health professionals' attention span. And I -- in the

spirit of the emperor's new clothes, I think that when we really start looking at quality and safety during care transitions, it does expose the fact that in many respects we don't have a true system of care delivery in this country. We certainly have some strengths and we have some elements of a system, but we do have a little more ways to go here.

[00:14:39]

But when we think about improving care transitions -- and I will make reference to section 3026 next, but we'd like to see how this can tie into and hopefully enhance and synergize efforts going on in patient-centered medical homes, bundled payment and other new financial incentives that try to help us align the incentives to foster this kind of cross-setting collaborating in keeping with this idea or a concept of a team sport.

[00:15:09]

On that point of a team sport, a number of us here in Colorado had an opportunity to collaborate with Senator Michael Bennet to introduce what eventually became section 3026 of the community-based care transitions program. Really the essence of this program is about aligning

financial incentives for how we can encourage perhaps non-traditional partnerships among acute care providers and community-based providers.

[00:15:36]

We believe that both have an incredible value to bring to the table, especially in the area of cross-setting collaboration around transitions. And section 3026 has currently been launched last month. This is an opportunity for hospital community-based partnerships to apply for a sum of money on the order of $500 million to be able to implement evidence-based care practices that are designed to reduce readmission and improve quality.

[00:16:05]

The URL at the bottom of the slide is a little hard to follow. If you go to Google and put "community-based care transitions program," the CMS web site comes up first. I promised you that I would offer you a URL that expands on my comments further. If you'd like to come visit our web site, it's something that you can easily download. There are all kinds of resources that you can take advantage of as well. So with that, I will conclude my remarks and look forward to our discussion.

[00:16:33]

ANNE-MARIE AUDET, MD, MSc: Thank you Eric. Our next speaker is Dr. MacKenzie.

[00:16:42]

GARRY MacKENZIE, MD: Hello, my name is Gary MacKenzie. I am speaking to you from McKay Dee Hospital in Ogden, Utah, a 362-bed institution. We provider tertiary-level care and cardiac services for northern Utah as part of the Intermountain Healthcare system.

[00:17:00]

I think I was invited to speak today because of the fact that McKay Dee has done well in terms of a reduced readmission rate in heart failure, which we all recognize as a major problem. I'll move that slides to you now, but -- in the eight minutes that I have been asked to speak to you about how we managed to do that in a tertiary or a smaller or medium-sized community hospital, there are actually five major points that I would like to emphasize.

[00:17:36]

The first point is that of commitment to actually trying to get the job done. We'll come back -- sorry for the slide interruptions here. While we're trying to get

the slides in order, I also want to acknowledge that Dr. Jerry John, who joined us seven months ago as Clinical Director of Heart failure Services is with me here today and may participate in any of the questions -- question and answer session.

[00:18:05]

Now in terms of the first article, that is commitment. We recognized about 10 years ago with the rest of the country that heart failure was a big issue. And it became clear that we were going to have to move towards a dedicated heart failure service, that it was essential to do this. We needed commitment at the corporate level in terms of trying to establish best practices and encourage any efforts in that regard. But at the institutional level, in terms of our senior administration to allow funding and staffing of, if you will, a heart failure clinic -- though we call it heart services clinic, so as not to scare our patients away when they show up.

[00:18:47]

You know, it required clearly leadership in the world of cardiology, and initially thought that what we needed was a definite heart failure champion, a specific physician

to do this. We tried to actually recruit that initially to start as a startup to our heart failure services and had some very good people interested, but it wasn't established yet. So I took that actually on myself as the department head to just get going with it. And it did delay things, but we started about five years ago.

[00:19:22]

There was initially some issues with local cardiologists. We have 14 -- 14-16 people here, mostly cardiac surgeons. Whether this was really needed in a medium-sized community hospital, there wasn't an immediate buy-in. But we overcame that, just said, "This is what we're going to do," but invited their participation and ultimately established a heart failure service clinic.

[00:19:52]

That commitment was recognized that what we wanted was best care practices, not revenue streams, not necessarily to game scorecards, but just try and do the right thing for the patient. Once that -- once we had that uniform commitment, it actually started to roll on pretty well, and if we go back to just the next point -- sorry, Laurie

trying to run these for me and anticipate what I want to say -- the first thing was to educate.

[00:20:24]

Let's go back Laurie to the next one. We needed education on several levels. First of all, we needed to educate the cardiologists about why this was actually necessary, pointing out to them that access within their clinics, even though they can treat heart failure, wasn't always the way it should be. Education to the primary care doctors that the majority of heart failure patients in this country are actually seen by them first. They have a major role to play in not only treatment, but primarily in prevention, and that by the time they get to heart failure specialists, a lot of opportunity has been lost.

[00:21:03]

Then we, of course, focused on the caregivers and the patient and their family, education that was extremely important. We know that if you educate a patient how to follow the care of their heart failure, you'll reduce their mortality rate by 25% with that education versus implanting a $50,000 defibrillator, which will reduce their mortality by 25% -- very cost effective education.

[00:21:31]

And within our Intermountain system, we have an acronym called MAWDS. You'll see that on the next slide. That basically emphasizes things like medicines, activities, diet and so forth. Sorry these slides aren't lining up the way that I would like, but I take no responsibility for that, since my fingers aren't on the computer.

[00:21:58]

However, if we go back to education, that's a key part of our heart failure service. Our inpatient service, we keep emphasizing it over and over again in terms of what we're trying to do with education and we've got community lectures to primary physicians, grand rounds, invited guests lecturers, lectures to other community organizations. Eventually, they start to see what we're trying to achieve, and we -- I think we've made progress from that regard.

[00:22:25]

If we go next then, once you get this going and you're trying to improve the process, there are things you have to measure. If we go, next, under measurement, the -- I think

we need to measure not only what CMS wants us to do in terms of whether we're giving them ACEs or ARBs or whether they've got adequate teaching or whether their ejection fraction has been measured, but patients response to this followup in terms of whether they're getting called by nurses after discharge and so on.

[00:23:10]

But measurements are kept in a very accurate fashion in our institution. We actually have quarterly review of the -- of the results and we track not only our performance but also the performance relative to other institutions within our Intermountain system. Fortunately, McKay Dee's performance is with -- since we started to implement this in great detail in 2007 -- has progressed measurably.

[00:23:38]

If we keep going here, we have individual scorecards for our physicians, and certainly within the department of cardiology, we recognize what -- how we're achieving in terms of discharge planning and the use of the proper medications and so on. Individually, we have scorecards, as I just stated, and I think -- I didn't make this slide, but one of my assistants did. It used me as an example and

for the first time in my life I got 100% three times in a row. I have never done that ever in my career, but I'm glad to be an example of that. I'm sure next year may be different. But at least I can show you that.

[00:24:22]

But everyone in the department gets a scorecard in terms of measurement. And the -- these measurements have actually impacted behavior. We have people responding to this very well. We have one advantage in our institution, that many of our providers are actually employed within the Intermountain system and we actually had an incentive for them whereby if they didn't meet certain measurements -- not just in heart failure -- they may have had some of their pay at risk.

[00:25:01]

That wasn't very popular. In fact we removed that risk -- risk/pay stipulation, particularly now since compliance is so good. But it was an effective stick in terms of actually getting them to comply.

[00:25:12]

We have actually got discharge instruction protocols now that are going to improve compliance and improve

measurement. In fact, you can't discharge someone with heart failure now without red -- red alerts going off saying that you need to determine why or at least document why you don't have them on an ACE inhibitor or whatever else -- any other criteria we want to use.

[00:25:39]

So that measurement is done quite effectively within the Intermountain system. They've actually spent $2 billion in the last few years on infrastructure support and this type of information technology support. I think they actually probably have one of the best systems in the country, and this certainly hasn't hurt McKay Dee to take advantage of that infrastructure support.

[00:26:04]

And then finally moving in on terms of the five key elements, I mentioned commitment and measurement. Sorry, we're jumping ahead a bit, and that is access to care for heart failure patients. This is a real problem, and in any physicians office, including specialities like cardiology, the heart failure patient needs careful surveillance and they have to have -- not give you an appointment in a month or two weeks, they need to be able to get in to see you or

at least be able to get advice from an informed individual, not just a receptionist, about their problem.

[00:26:49]

This is difficult to do, to provide that kind of access, but we have nurses on call at night who can field some of their questions. The cardiologists on call during the day can refer to the clinic. The clinic is very receptive about working people in. And Dr. John, who has joined us and is helping promote this even more, made it a mandate for -- or a promise to our hospital service that after discharging someone, that they can get access for their patients.

[00:27:22]

In fact, Dr. John, in particular, has a -- just appears one morning a week especially for any urgent hospitalist request for discharge followup. The emergency department similarly has that type of promotion of access to our service, and the family practitioners are delighted.

[00:27:42]

Interesting enough, even though the cardiologists felt, "Well, we treat heart failure," once they realized the burden of support that these patients require and the

benefits you get from that support, they're actually quite onboard now in terms of promoting the clinic utilization.

[00:28:01]

Now finally, heart failure is a deadly disease. Actually, the mortality with heart failure if we got to end of life, is -- the mortality risk with heart failure is probably higher than any -- most cancers. I think the public and medical profession itself may not be aware of this. When you get to stage IV heart failure in particular, you're way past the curve. This is why we promote prevention amongst our primary care docs, since they see people when prevention can occur.

[00:28:30]

But end of life is a reality and there is a time when heart failure takes a person's life, and helping them transition at that stage of life is important. And if you're looking at just the cost of care at the end of life and the readmission rates to hospital or the emergency room visits that are impacted by care of these people, this is where a heart failure service can really be a benefit.

[00:28:59]

We've shown a dramatic reduction or readmissions on our emergency visits because of access for these people, a compassionate approach -- go to the next slide -- a compassionate approach to these people and helping many of them actually die with -- at home with the support of hospice and family, not in hospital. And the impact on cost of care, I think, is really significant.

[00:29:25]

I will end it here because I'm sure eight minutes has probably gone already, and I'm sure there will be a lot of questions. But I wanted to let you know and encourage you that in a medium-sized community hospital in a medium-sized city in America this is achievable and we're proud of our results.

[00:29:45]

ANNE-MARIE AUDET, MD, MSc: Great. Thank you very much.

GARRY MacKENZIE, MD: I will be open for questions, as will Dr. John at the end of our presentation.

[00:29:57]

ANNE-MARIE AUDET, MD, MSc: Our last speaker is Janice Fitzgerald, Director of Quality Medical Management at Bay State.

[00:30:01]

JANICE FITZGERALD, RN: Thanks Anne-Marie. It's a lovely spring day up here in Springfield, Massachusetts, so greetings to all. Thanks for taking the time out of your busy day. I just wanted to share with the people on the call the work that we've done truly looking at smoothing safe transitions into the community.

[00:30:21]

One of the things that you need to have in place is some kind of a model where you can actually execute -- execute a model. So we have a performance improvement system. It's the good-old PDSA. We're looking at how do we execute things. You need a team ready, willing and able and eager. You need the game plan, which actually is for Bay State Medical Center as a STAAR hospital, it is the four pillars of transitions in care, and you need a way to apply those things to really deliver patient-centered care.

[00:30:53]

We are a 650-bed community, academic referral teaching hospital and we really have a strong commitment to quality improvement, as well as reduction of patient harm and patient-centered experience. So when I think -- when I talk about the game plan, I really am talking about the transitions of care -- oh, for some strange reason -- the transition of care model that Dr. Coleman and his team have really been promoting, not only in the transitions model, but also kind of is the practice or the interventions that we want to put in place as a STAAR hospital.

[00:31:32]

Today, I just really want to focus on ensuring post-hospital care followup. So just a little bit of background around where we've been. In 2002 to 2006, we actually started thinking about community relationships. That would be thinking about where -- where should we really focus on our receivers? Where are we sending our patients? How can we partner with them to make sure that there is a common understanding?

[00:32:02]

So we worked on that for a while. We did some review of patient care, but it was kind of sporadic and informal.

2007 to 2009, we became a little bit more formalized on the process. We really saw it as a partnership in education. So what would happen is the hospital educators would actually go to our receivers and provide education that would hopefully improve the care that our patients got when they left our hospital.

[00:32:26]

Along comes 2009, which is at the end of 2009 we started our STAAR work. What we really found was an open sharing of the transition of care process. And we were really able to identify the strategies based on that pillar and were able to put those strategies in place and rigorously apply them using performance improvement methods.

[00:32:51]

The other thing that has been excellent is a regional awareness. We are in Western Massachusetts. We are the referral hospital. We get patients from all up and down the Pioneer Valley of the Connecticut River from southern Vermont, New Hampshire, through northern Connecticut and Western New York. So we really need to be thinking about this in a regional model.

[00:33:12]

And the goal of that regional awareness is how can we work together to make sure there is a common understanding of what it is we need to do and how that can happen. Now when we think about getting ready for the transition into the recovery phase, there are some key things that we really want to focus on at Bay State Medical Center, and that is the standardized assessment. That is for high-risk patients, as well as risk for readmission.

[00:33:38]

That list of current medications is key, key, key. We all need to know what is the patient on, and we all know there are four different models or lists that get generated. But the bottom line is when the patient leaves our door, what are they on and is there a plan and is there a plan and is the patient and the caregiver aware of what it is they need to do?

[00:33:53]

We start right at the beginning at admission customizing that plan. I think Eric said it so well, talking about literacy and really engaging the caregiver to

make sure that they understand what it is they need to do to be successful.

[00:34:07]

We have multidisciplinary rounds for each patient. Part of that rounds is looking at the verification and the confirmation of that discharge still makes sense, and is that patient at risk, and then looking at what the patient needs and making sure that what the patient needs, we can match services out in the community.

[00:34:26]

The last thing is the communication transaction. There is many ways communication happens, and we all know that that's the chief cause of patient harm or of safety events, is inconsistent or lack of communication. So we have really worked hard on communication transactions.

[00:34:45]

Just some lists -- oh, wait a minute. My goodness.

GARRY MacKENZIE, MD: I'm glad it wasn't just me.

JANICE FITZGERALD, RN: No, no. For some strange reason, it skips ahead two.

GARRY MacKENZIE, MD: That's what I found as well too.

[00:35:02]

JANICE FITZGERALD, RN: Thanks Garry. I want to talk about the community transition. So what happens at our hospital is the community-based caregivers and liaisons, whether it's from a facility or a physician practice, they actually come in to not only meet the patient and the family and the caregiver, but they also meet the senders, the nurses and the team that are sending the patient out into the community for recovery. And the hospital-based care coordinators actually go out to the receivers. They see what a great reception looks like in the community, at the VNA or at the facility. That has really helped clearly to understand what each area's issues and problems are, as well as areas of focus.

[00:35:43]

We have really come a long way with standardizing the plan of care across the continuum. And what we have really worked on is basic information. We used the zone model, red -- green, yellow and red -- and we have it for many populations. We use that as the standard education plan for the patient and the caregiver, and we move that across from the hospital to the practice to the nursing home to

the VNA. So the patient is really getting echoed what it is exactly they need to focus on and what they need to do.

[00:36:11]

We have really worked on cohorting [sic] patients around specific diseases, so the team is comfortable and knows how to care for those patients, as well as what are the key rocks in the roads or the elemental things that everybody needs to know. We have adopted ASK ME-3 as what to teach and teach back as how to teach.

[00:36:30]

And the other thing to kind of just echo what Gary was speaking about is a clear and concise plan, including the plan for re-hospitalization, especially around terminal diseases or where the patient has really progressed to the end.

[00:36:44]

Just a couple of examples of our standardized education. This is the heart failure zones and the ASK ME-3 thing we use. The other strong component is that regional continuation team. This is interesting because when we started it was quarterly. Then it was Q2. Now it's monthly. We get representatives from all services and

community-based organizations and ASAPs and nursing homes and VNAs that come to this two-hour meeting. It really has been very, very powerful to not only help with networking, putting names with faces, but to share new knowledge, what services are available; for example, Greater Springfield Senior Services, what can they provide. How can those things be accessed? What works? What doesn't work, as well as updates?

[00:37:33]

This has been key as we really are planning to go forward with the 3026. You know, we need the community to be engaged and to kind of partner with us to make sure we're successful, so it has really worked very well for us. Additionally, we look at a case study. We'd like to use patients that hit many components and see what worked, what didn't work, what did we do well, what didn't we do so well, and getting the feedback on the use of interact as well as standardized care plans.

[00:38:02]

The additionally [sic] thing -- additionally, we've actually done a lot of work around patient-centered medical home and have really listened to our patient/family

advisory council around things that have worked well for patients.

[00:38:12]

I just swing through here to show you how successful we have been. It has been truly a team effort with the patient at the middle of it, who has really helped guide us with the creation of our plan through post-discharge callback and patient feedback.

[00:38:30]

Then the last thing, when we think about idea, will and execution, we clearly have been so successful because we have been charged to be successful by our leadership and been able really to be flexible and to get to the end and be creative and do what we need to do to reach our goals with really reducing hospital readmissions.

[00:38:59]

ANNE-MARIE AUDET, MD, MSc: Excellent. Well, thank you very much all of our three speakers. Now we have a number of questions that are starting to appear, so this is great. One thing is that -- one question has to do with the focus on heart failure and whether there is always a decision to be made as to whether you look at all-cause

readmissions or you focus on high-risk populations. If so, I think it's fair to say that patients with heart failure are really -- really are at high risk and have the largest percentage of readmissions.

[00:39:44]

But are there other patient populations that you're starting to work on in your hospital? That to all three speakers?

GARRY MacKENZIE, MD: Well, heart failure was the key one for us because clearly, as we all know in the audience, it's the single-largest cost for Medicare in terms of diagnosis and treatment; hundreds of millions of dollars, if not billions. And readmission rates across the country extremely high within 30 days, with high not only costs but morbidity. So it became obviously -- and should be -- a major focus.

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We have looked at people with unstable coronary syndrome readmission rates after STEMI, non-STEMI or unstable angina and looking at repeat procedures or admissions. There is obviously standard of care for pneumonia readmissions. Certainly, heart failure isn't the

only area of importance. But as a single entity with our aging population and our success in treating MIs that now allow them to live to the point where they may, unfortunately, develop heart failure even though they survive their MI, it's going to continue to be a major focus.

ERIC COLEMAN, MD, MPH: This is Eric. I'd like to chime in as well. I certainly appreciate Gary's comments. I might just sort of take us back yet to maybe a higher view of the broader view of the problem. And when we think about targeting and risk, clearly we're -- in this context, we're thinking about sort of risk for what, risk for readmission. But I would also argue that it's not just in terms of risk from the standpoint of picking out who is most likely to incur high-cost utilization, but essentially we're looking for modifiable risk.

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And then taking that down yet another level, modifiable risk for which we have good evidence that our interventions work. You know, we have done some studies here funded by NIH where we have looked at what factors predict not just recall of discharge instructions, but

whether or not people follow through or execute. It turns out that things like health literacy and cognition, and something that Judy Hibbard at the University of Oregon has helped us understand better, patient activation, are much stronger predictors than diagnosis per se.

[00:42:15]

So we do tease our cardiologists here in Colorado that some of these heart failure admissions are not because heart disease is so bad, per se, but there is an organ further to the north that we shouldn't lose sight of that may have much more to do with why these patients are getting readmitted. Spoken like a true geriatrician.

[00:42:33]

JANICE FITZGERALD, RN: This is Jan at Bay State. I actually agree with Eric. We look at all the readmissions. And you know what? The bottom line is for the patient it doesn't matter why they came back. It's just that they came back. So we really focus on why did they come back and what can we do better with that patient to prevent it from happening.

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It really does boil down to do they understand what they need to do be to successful and can they do what they need to be successful? You can have the best model, the best program, but if people don't understand that good-old ASK ME-3, what's the matter with me, what do I need to be successful and why do I need to do that, and whether it's the patient or the caregiver. It's the common thread that we for so long have really not understood or appreciated.

[00:43:21]

ANNE-MARIE AUDET, MD, MSc: Then there is a series of questions about the cross continuum team. So who are -- do you use social worker, community-based care coordinators, care managers? So what is the composition of your cross-continuum teams, and also what are their roles? Do they do home visits? So the different aspects of what they do. And the third question related to them is, "How do you pay for them?"

[00:43:52]

JANICE FITZGERALD, RN: We have a couple of different groups that fit in these categories. So, for example, some of our medical homes have practice-based care managers. They can be a combination of outreach workers, registered

nurses, social workers or medical assistants. So it really depends on the practice.

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The person is responsible for reaching out to the patient, making the contact, making sure that they verify that the patient has what they need while they're at home, run through the ASK ME-3 and the teach back to really validate that the patient has a good understanding of what the plan is, and if they don't have a followup appointment already, is making sure that that appointment happens. That's just part of the care through our medical home.

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We also use our VNA for patients who are at moderate to high risk and if they don't meet perfect criteria for VNA, the hospital will certainly send -- support the resource going in, so that would be a registered nurse going in to do the environment assessment, as well as the followup around ASK ME-3 teach back, medication list, home safety and making sure that a followup is in place.

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So right now, we're kind of straddling several worlds, but what we've done is identify what is the skill set that

the patient needs based on their risk for readmission and build to deliver those interventions. Again, it does -- it does -- it does vary.

[00:45:22]

In the cross-continuum team, all of the above attend. You know, it's a combination of we have Greater Springfield Senior Services, who are not registered nurses, who are -- they're the people who do Meals on Wheels and home visits and home health aids. They attend. Then the nurse practitioners from the health centers and the heart failure clinics attend.

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So it's anybody that has the opportunity to work with the patient across the continuum is welcome at that group. We get between 100 and 120 people there are at any given session. It's really been very powerful so people understand the commonality in where we need to go together.

[00:46:04]

ERIC COLEMAN, MD, MPH: I echo everything Jan said. In the context of the 3026 opportunity, there is a very specific definition of a community-based organization that's found on that same web site that I provided the URL

to, or again, you can Google "community-based care transition program." In this case, it's defined in statute, so it's perhaps a little more narrow and rigid than what Jan just described. So it really depends on sort of what your current direction is.

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ANNE-MARIE AUDET, MD, MSc: And how do you use the families or volunteers in your programs? Do you -- have you institutionalized the use of family members in your care transition teams or management programs?

[00:46:51]

JANICE FITZGERALD, RN: Eric or Gary, do you want to comment on that? I'm taking up all the time here.

GARRY MacKENZIE, MD: Well, I think family is -- family is a huge part of the success, particularly with some of our older patients. They're important not only in terms of helping support or enforce the education we give them and helping them monitor some of the advice we give them related to medicines and activities, of symptoms and reporting worsening symptoms, but they also are critical in terms of ensuring access to care, giving us advanced warning of increasing symptoms when some of the elderly may

not be aware of what's happening, trying to prevent them from decompensating to a point where hospitalization would be necessary.

[00:47:36]

If they buy into the care model and understand it as well, and in particular when it comes to dispensing medications, that's a major point of our patient management, is getting the medication instructions correct. I think we have -- one of our nurse coordinators has done a great job of coming up with an understandable medication list. You'll see that, I think, on one of the slides. Or maybe not, but it's certainly available if anyone wants it.

[00:48:09]

We found things that we didn't understand. You say, "Take your medication twice a day." Some of our patients didn't know that twice meant two times. So we sent -- and it would be - things like that that we've learned, and with -- family is, I think, a key part. It is more difficult -- and of course, we have patients like that who live alone, don't have family support. Some of them are somewhat indigent patients, sadly.

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That's the other thing. We don't look at whether they're insured or not. There is an advantage in a nonprofit system, I guess, to do that. We have a major mandate for charity care here. But those people that don't have that kind of family support are at a real disadvantage.

[00:49:02]

ERIC COLEMAN, MD, MPH: I think Gary hit the nail on the head. I would just add two things. One is that Lee Lindquist at Northwestern has done some really important work looking at the family caregivers literacy rates and understanding. Sometimes we have an individual in our hospital bed that we've already kind of quickly picked up on the fact that they have some limitations. So then we kind of turn our attention over to the family member and just kind of hit the switch and start going without, again, doing any sort of similar evaluation of that individual.

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And again, not to sort of harp too much on geriatrics, but it's not uncommon for an older couple, for the husband to have cognitive impairment and the wife to have cognitive impairment. So I think we just have to keep on our toes.

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With the -- some partnership with the Gordon and Betty Moore Foundation, we're looking into adding a very specific family caregiver component to our evidence-based care transitions intervention. That will get started this summer.

[00:50:01]

JANICE FITZGERALD, RN: We actually noticed the same thing. We would be teaching the wife or we would be teaching the daughter and that person either asked -- the more, of course, you're with your patient and their family, the more you can appreciate or identify that there are cognitive issues. So we actually have been aware of that and have been really on the ball to identify when they early as we can that, one, they are not the primary caregiver and two, there are cognitive issues. Of course, there are certain interventions that you can do to support patients if they fall into that bucket. We have been mindful of that.

[00:50:38]

I just wanted to make one comment on our use of the patient/family advisory council that I had a slide of.

They have really helped us with focus groups and been a barometer to make sure that we're keeping ourselves on track and not getting far afield. I mean, they are from the community. They are people who have been patients in our hospital who from a bird's eye view can speak and articulate what it is we need to be keeping our eye on. They have been very powerful.

[00:51:09]

If you haven't, or you don't have the opportunity to use one, they certainly are quite -- quite a useful tool.

ANNE-MARIE AUDET, MD, MSc: And can you -- any of you three talk a little bit about how you are funding this? And the question here is, of course, when you're in a demonstration pilot research funding, then you can fund those teams. But are some of you exploring ways to finally get to fund this on a more stabilized way?

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GARRY MacKENZIE, MD: This is Gary MacKenzie jumping in on that. Of course, when we started our heart services or heart failure clinic, that was a question. Frankly, by doing the right thing, we felt that particularly as a -- that we were in the black at 11 months.

[00:52:02]

In terms of some of the readmission issues, and more importantly, there is some -- good care does provide some downstream revenue in terms of proper surveillance and treatment and the measurements that should be factored in. The balance, the cost of providing nursing support of physician support for uninsured patients, for example, but having an uninsured patient admitted three times in six months for three to five days, the payback comes back very quickly.

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I think that you have to look at those downstream savings, not just the upfront costs. In fact, we're a strong believer that the right thing -- and Brent James, one of our people in healthcare research for Intermountain the last 25 years, has demonstrated that good care actually costs less.

[00:53:01]

JANICE FITZGERALD, RN: This is Jan. Actually, it's interesting because you have to be mindful. As I said before, we're straddling the old world and the new world, so for a hospital -- here is the bottom line. I need

$100,000 to fund this physician so I can decrease the revenue around these 87 non-admitted patients by $2.4 million. So you have to some futuristic thinking in your leadership where they're going to know that in the future, this is going to be a money loser plus the public reporting and the hospital's reputation, as well as what's best for patients.

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So you have to mindful and kind of really send that elevator message as clearly and succinctly as you can. We actually were able to convert some preexisting positions into these care coordinators who were organizing the care on the unit, doing the post-discharge call back, as well as being the community liaisons. So you have to think about it creatively because we know right now with the economic climate, it's very tough to get new FTE for the most part.

[00:54:15]

ANNE-MARIE AUDET, MD, MSc: Great. A series of questions on how you assess risk -- the risk of your patients. Do you do that on a population basis, or so many different approaches? You could risk assess patients for their risk of readmissions as soon as they arrive in the

hospital, over the course of their hospitalization or even better, when they're not in the hospital and they're in the community. Talk a little bit about how you segment your population and identify those at risk and how you then go about developing your programs around them.

[00:54:55]

[CROSS TALK]

ERIC COLEMAN, MD, MPH: I will just talk a little bit and have Gary pick up from there. But, you know, of course there are valuated tools for evaluating literacy. There are at least two or three for literacy. Cognition we have a lot of tools, and patient activation, Judy Hibbard's tool -- it's shared through the Insignia Health web site -- are all examples of things that we could begin to recognize as adding value in terms of, say, a vital sign.

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If we knew the patient's literacy and PAM score and cognition, we could probably do a much better job of customizing their information, preparation and so forth. But, you know, in terms of how do we do this maybe in a more population-based way, an intermediate step, of course, is as organizations are beginning to implement more

electronic health records, that that first face page that pops up when you select a patient ideally would tell you who is this person, and not only for those three areas I just mentioned, but what's their baseline physical/cognitive function, what's their problem with medications and so forth, but painting maybe a more robust picture than just looking at this person as someone who has a specific diagnosis or takes certain medications.

[00:56:14]

There are, probably too numerous to count, risk tools that have been developed and are published in the literature. They all largely rely on some of the same variables of the usual suspects. They're all pretty good, but not great, and not all healthcare organizations necessarily have sort of the robustness of data to support them.

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So I am certainly a big fan of the answer to the risk question is at the bedside. One of the things that we've been trying to do through the STAAR collaborative, is encourage teams to do just that, to go to the bedside and

ask the patient open-ended, "In your own words, what do you think contributed to this hospitalization?"

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Interestingly enough, the types of answers aren't things like, "Well, I wanted to rebel and not take my medicines to make you mad." But more often you find out that a lot of these individuals, their lives are a little bit like a house of cards, and it takes sort of one of those cards to fall to make the others. Maybe there is a family caregiver who just had a health problem and that sent a shock wave that eventually affected this person's health status.

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I really see there being an opportunity to think about this on a population level, but also to complement that with what we learned at the bedside.

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JERRY M. JOHN, MD: If I could just add one thing. This is Jerry John, Gary's colleague here in the heart failure clinic, and we obviously have a large amount of both diastolic and systolic heart failure patients. There have been a lot of tools for systolic heart failure

patients, I'll agree with respect to ... [?] [00:57:30] We have a heart failure model, which we use extensively here in clinic, but independent of that, a lot of our other diastolic heart failure patients have at least three to four to, if not more, comorbidities with respect to lung disease, chronic kidney disease, peripheral vascular disease, etc.

[00:58:04]

So I think really taking a team approach with respect to tag-teaming with nephrologists, pulmonary specialists, really also creates a tightly woven safety net, if you will, for patients. There are multiple points of contact with respect to physicians and other care providers that do that.

[00:58:23]

Another major thing that we really focus on -- I think every heart failure person focuses on - is volume in terms of congestion. The thing that we've started to implement here, started to collect data on, is the education piece regarding salt. And the amount of salt patients eat in America on average is anywhere from 4 to 8 grams. In Japan it's about 10 to 12 grams. And so we end up teaching

patients about salt and then we actually measure it with 24-hour urine to try to document the actual total amount in terms of grams of sodium a person excretes in a day as a more objective measure saying, "Well, we understand you've been trying to make some headway with respect to sodium restriction or content in your diet, but this actually acts as an objective measure for us to try to evaluate volume status."

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And independent of that, the other thing that we really focus on is light heart failure. A lot of these patients end up getting navigated through pulmonologists or through some other individuals with respect to pulmonary hypertension and quite frankly they have heart failure as a cause for their elevated right-sided pressures. And our goal is really to try to obviate right heart failure to prevent them from getting them with either systolic or diastolic heart failure. So there are several tools that we end up using, but to summarize, it's really a coordinated process between multiple coordinated givers, some objective data and then lots of care points of contact with the patient.

[00:59:56] [WRAP-UP; NOT TRANSCRIBED] [01:01:20] [END]