

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Linda Magno: We have some time for questions. This time, I think, in the interest of fairness, I'm going to start with questions from the audio participants in the conference. So, if the operator could please open the lines?

Operator: We will now open the line for question and answers. To ask a question, please press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question and pick up your handset before speaking to ensure clarity. Please note, your line will remain open during the time you are speaking, so, anything you say or any background noise will be heard in the conference.

We have a question in queue from a participant whose name was not captured.

Please state your name and organization to identify your line to our presenters. Caller, your line is open. Caller, your line is open.

Female: (Inaudible)

Linda Magno: Excuse me. Can you start all over again and speak up a little closer into the phone please?

Female: We were wondering if possibly you could check the mic? We believe that the mic that's being used – that was used by Dr.

Berwick and the last speaker might be the cause as why we're not being able to hear.

Linda Magno: OK. We're very sorry. We'll check those mics again, right now.

Female: Thank you.

Linda Magno: We'll take a question from the floor.

Female: Thank you. Dr. Brock, thanks for a great presentation and congratulations on the success of the work. As we in communities trying to basically take step one, know who your patients are, what are your recommendations for those of us who do not currently have Medicare data sets for taking an efficient stab at that? Do you have any thoughts for us?

Jane Brock: Well, my hope is – there's no guarantee – but my hope is that there's active intention at CMS to make this kind of data much more easily available. We hear rumblings. So anyway, I know that's not a totally satisfying answer but ...

Female: If I could – could I ask a follow up?

Linda Magno: Well, why don't I say something first. We have every

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intention once the program is up and running to be providing feedback data to hospitals and other – and community organizations about transitions in their communities.

But in terms of the start up since hospitals will have to look at their readmissions based on their own, you know, based on internal data and their readmissions to their own hospital, unless they can come together with and share data with other organizations, other hospitals in the community and other providers in the community because we don't have the ability to make community-wide data available, patient-level data available to applicants until they're actually part of the program. You had a follow up?

Female: My follow up was going to be just based on the data and your experience in the real world given that the Medicare data won't be available, thinking really specifically about these meetings, you know, and who's coming with what and we're going to have nursing homes, we're going to have home health agencies all of whom can bring to the table their own populations. Given that messy reality, any specific recommendations on how to use that data well?

Jane Brock: So our hope is that this entity that is a community-based organization can become a legal structure where providers can share cost-provider data. I mean, I don't know, it's not strictly specified in the law but I think there's a fair amount of acknowledgement that within a group of providers there needs to be

a legal way to establish a data exchange forum, so that hospitals can know their arrangement.

Female: Thanks.

David Schulke: David Schulke, HRET. Great work on the project. I think one thing– one kudo to CMS that is deserved, in addition to the obvious, great work by hospitals and community providers and QIOs is that CMS and the design of the 14-state project allowed the interventions to be selected by the sites and that did not mean the QIOs, but the QIOs let the providers that they worked with figure out what they wanted to do and that's very powerful way to do things – it puts, you know, CMS was under some pressure to define the interventions. So, this was a very, I think, courageous and smart thing that they did and I think it shows results at the community level. People got to work on things they wanted to work on and the way they wanted to work on them. One of the things that the hospital community is concerned about and would like to see resulting from the national implementation of the 3026 pilot is sharing of interventions that seem to work.

So, of course there may be, I hope there will be a community of practice between the sites, but for everybody else, it's not in, I agree with you 500 million sounds like a lot but there's not that many sites compared to all the people that are trying to make a difference here and all that are subject to penalties potentially.

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So do you have a mechanism in place for getting, pushing out intervention strategies as soon they start to show promise or are you going to start by promoting the evidence-based interventions strategies, RED and the Coleman and the other interventions?

Linda Magno: It's our intention – as Juliana mentioned this morning to have a technical assistance contractor who will cull the data from our monitoring of the projects to see where we think we're seeing early successes to bring the community of participants in 3026 together initially, to share those results, to learn from one another what's working, what's seems not to be working, how things can be tweaked, how things have been adapted to particular circumstances and to build on that and in fact participation in these collaboratives will be a requirement for participants in 3026 because our goal is to spread the learnings from this.

And then we are working actively with our colleagues in the Office of Clinical Standards and Quality – I can do acronyms but I like to pronounce for people who don't live in our world of alphabet soup. Anyway, we're working very closely with our colleagues to figure out how to take the information then that we develop from this project and use the QIO program in the 10th Scope of Work to begin to spread those learnings more broadly across the community of hospitals and other providers so that we're not confining those learnings to ourselves.

And I think in combination with OCSQ and in combination probably

also with our innovation center that we will be doing a lot more in the way of spreading the learnings from this project as well from other things that we're doing.

Good question. Thank you for asking.

Male: Hi, I'm not going to tell you who I am because I have yet another annoying logistical complaint request. The last, great presentation Dr. Brock, the last few slides however are not in our notebook and they were the best stuff including the web link to the evidence publications. So if we could somehow make sure we get that.

Linda Magno: If they're not already on the website fully, we'll make sure that any additions get added to the website.

Jane Brock: I think they are on the website because I got them.

Linda Magno: OK, they are on the website. Any other questions, do we have any other questions from the audio participants?
Operator, if you could open the phones?

Operator: Your next question comes from the line of Joanne Handy, your line is open.

Joanne Handy: Hello. I'm with Aging Services of California. I was –

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I'm really fascinated by your outside-in approach which I've contrast to the more inside-out approach that we heard in the earlier presentations.

I wonder if you could comment on two aspects. We heard earlier that it's all in the execution and the execution among so many different players is indeed difficult. What were your observations about the actual execution of the evidence-based tools in your projects? And did you observe that there was one provider type that often took the lead in the community coalition?

Jane Brock: So, let me answer the second question first. There often was a single provider – or provider type that would step up within each community, but I would say across the board we think there's many different possible models for doing this and that's why we say, I think the strongest strategy is to get your community together, figure out who is in it both in terms of who need services and who supplies services and negotiate that locally. I think, that in the end, that was almost our biggest learning.

In terms of outside in, I think, you're probably referring to the fact that we did this through community coalition work, is that right? If that's not right, correct me.

Joanne Handy: Yes, yes.

Jane Brock: And so, in the beginning, we didn't necessarily intend to

do so, but within a couple of months, it was just obvious that that was going to be the best way to do it. And so, I think that's one of the reasons that this is being framed as community-based transitional care because we think that's what works. And we were so fortunate to go forward with visionaries at CMS who had a suspicion that it would go this way from the very beginning and it's just been very powerful.