

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

Female:

My name is (inaudible) I work for Maryland Health Care (inaudible). First of all thank you, it was a great speech. There were a lot of points that I think everyone should have taken note. Two things that kind of emerged from the earlier portion, this concept of expanding the definition of transitions to other settings. I think that's very important to think about it and expand the idea of rehospitalizations or transitions to other settings so we could have a more coordinated care for the person.

And the other point that came out was that this fragmentational funding which was often these breaks in the transition process and from there my question is related to long term care.

In the previous sessions, you know, we saw that the patients' discharge from skilled nursing homes have higher readmission rates but if you look at where they are coming from in the beginning they are also coming from nursing homes. So I was wondering what kind of programs exist to improve the transitions in the nursing homes with the hospitals from the beginning because

what I observed in the nursing home sector is there is this revolving door, patients are coming and going to hospitals so often that it seems to me that the nursing homes are also another place that we could actually impact readmission in the hospital. Thank you.

Kathy Greenlee:

I absolutely – I absolutely agree with you with regard to the nursing home back to the hospital. I'm not a clinical person working in a clinical setting but I'm a lawyer so I can like spot the issues. And the ones that I know are about making sure that the records transfer, that one of the things that we've all talked about certainly from the hospital to the nursing home with regard to the meds, it's equally important that we have record transfer.

One of the things that I think we need to pay attention to is the growth of electronic medical records and the use of health technology. And I saw this starting when I was a secretary in Kansas because I was making the Medicaid payments for nursing homes and I was also at a survey and cert agency in Kansas.

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

That we have started by focusing on electronic health records on hospitals and medical systems and somewhere in this concentric circle of health providers we need to make sure that nursing homes are there because as we build national systems for electronic health records, we right now have some very, very progressive nursing homes and nursing home systems, larger systems that can capture electronic data on kiosks and computers, and so, we have already building sort of in this other venue, people who are capable of coming to the table first as early adopters and partners to say, "Listen, this needs while we're transferring a person all of the information, the plans of care and so forth need to be sent back and forth electronically."

I think between those because, you know, so much of what we do is are these artificial distinctions that I talk about between the hospital and the nursing home, that one of the great opportunities to start trying to figure this out are the hospitals that are running long term care units that are a part of the hospital system. So, as we work on electronic health records that those I think could be some

of the earliest people to say look this has to include the nursing home wing of a hospital for skilled long term care unit and then pick up the rest of the nursing homes as well. So that at least on an electronic basis we're doing a better job. And that's just one piece of the transition back and forth between.

Eileen Bennett:

Hi, I'm Eileen Bennett. I'm a local ombudsman here in Maryland as well as the chair of the National Association of Local Long Term Care Ombudsmen. And it is Friday and you know where I'll be this afternoon. But I do want to really overemphasize the point that you brought up about the transition of, "Oh my gosh, my Medicare time is over while I am in this skilled nursing facility." It is probably one of the biggest issues that ombudsmen are dealing with that's the hidden issue because miraculously on day 21 somebody is better.

There are very few people who actually receive 100 days of Medicare coverage in the skilled nursing facility and it's the least known fact in the world, of my world.

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

And that's what I'll relate it to, is my world. So there's also another scary part and we are seeing these observation days in emergency rooms and people not being admitted and I would like to just point that out since this is a group of people that can really be also monitoring that issue.

From the point I work in is strictly in nursing homes and assisted livings. I do not have a community-based portion in my own job description but there are ombudsmen in the community that are – I think there are 13 states that have long term care ombudsmen that actually follow people into the community. But we're seeing more and more people just being held in emergency rooms for observation so that somebody's magical numbers don't trigger something that doesn't look so bad. So I just ask you to pay attention to that.

Kathy Greenlee:

And I will tell you that we are aware of that, I mean, the Washington Post did a big article about this a few weeks ago and have reached out to CMS directly so that we can talk to them about it and share our concerns.

Kathy Greenlee:

Hello.

Amy Berman:

Hello, Secretary Greenlee, Amy Berman from the John A. Hartford Foundation.

Kathy Greenlee:

Hello again.

Amy Berman:

Hello again. First I would very much like to thank you and the AoA for the remarkable work that you've done through the Aging and Disability Resource Center network and the recent awards that were made to build the evidence into those networks even further, so congratulations.

Kathy Greenlee:

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

Thank you.

Amy Berman:

Second, I just wanted to go back to your comments about the electronic medical record. I think that that is a very important area that is currently being built out but perhaps within the conversations that are going on nationally we're somewhat siloed. So right now here, we're having a conversation about how to build in care transitions and within perhaps meaningful use, we don't hear that same conversation, so when the investment is fully done, will it be able to be supportive of the kind of care and the integration of medical and social supports and services in the way that we'd really like to see. I'd love to hear your thoughts on that.

Kathy Greenlee:

You know, quite honestly I've told you as much as I can at this point and I think what we need – there are times that we can step out and say we want to make this investment. There are times we need other people to

come to us as leaders as well to say, we see the same thing kind with regard to hospital records and nursing home records and help us figure out what the best role is that we can play. Because as you know there's a whole national initiative with office of the national coordinator and how do we then best bring to the table these particular issues.

So it may be something, Amy, that we certainly follow up so that I know how to articulate it because it's so massive and so acute care oriented that we may even need some guidance on sort of where to get in and specifically say, "Here's where you're not talking about transitions and here's what you're not thinking of long term care whether it's community care or nursing home care."

Amy Berman:

Just as one follow up, for the Office of the National Coordinator for Health IT, the Hartford Foundation in collaboration with the Gordon and Betty Moore Foundation in California, we brought in some of the

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

leading experts that will be on the panel later today around care transitions including Eric Coleman to be able to help these beacon communities understand how to do a better transition.

But I'm still a little concerned that the meaningful use is not yet being addressed.

Kathy Greenlee:

Right, and I think – when I listen to the conversations about health reform, there are so many things that sound similar to me like care coordination, care transitions and medical homes. They're all about the integration of a holistic approach, all of those, the meaningful use regs would have an impact on if they could fully be developed. There are some challenges in our part of the world with regard to data. And that's another reason why it's important for AoA to make an investment because we started from such different places. The ability to track data on a granular level at the Area Agency is far different than what a hospital is tracking.

So, as we merge into systems that work better

together, we have to have the ability to collect data and be able to transfer it from our side as well. And that requires investment and change from social services providers so that they understand. It's not just evidence that's important, it's the computer system and the data so that we can make the interface. And we're trying to help the network integrate those things.

Linda Magno:

I think we have time for one more question.

Heidi Garland:

Hello. My name is Heidi Garland. I'm a Director of Case Management of Memorial Medical Center in southwestern Pennsylvania, go Steelers. I'm very excited to hear this conversation. In fact, the first call I'll make when I get back to home is to the Area Agency on Aging because what I've seen over the years is a divergence between the community services and the acute care hospital based on finance. If there is an entity who is less financially viable than hospital acute care, it's not really

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

skilled because you reserve the right to say no when you cost out the patient, it would be community-based facilities like Are Agency on Aging.

To give you an example, we'll try to get a patient set up for a waiver program, it could be six to eight weeks before we can get the service available. It just doesn't meet the immediate needs. So, I'm very hopeful that we can reconnect and make viable programs.

Kathy Greenlee:

Thank you. Could I make a final pitch? And I know we're wanting to wrap up. I have another motive that I've not mentioned with regard to this, so I thought I should tell you that before. The integration that we're doing with regard to patients and their families must be paramount. But it's also important that we track the data and the investment so that we can show that for every dollar we spent supporting an individual's health, this is the amount that should go to the social supports and the amount that should go to acute care, and this is the amount for long term care.

As we all get more and more successful in integration, we will need to make sure that we resource the community services well enough so that we have the resources. And the other opportunity right now with all of these innovations is to show better health outcomes, but also wiser financial investment. And when we do that, I'm going to show up with my hand out saying, buy some more of us please, invest more in us please because we are value-added and we provide good outcomes financially and for someone's health. So there are all kinds of reasons to do this together.

Linda Magno:

Thank you, Kathy.

Kathy Greenlee:

Thank you.