

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

Remarks by Kathy Greenlee

Linda Magno:

I'm sorry I see that we've come to the end of our time and don't have time for more questions at this point. I'll encourage you to look for members of the panel or members of the CMS staff who might be able to help you with some of your questions during the break. We have a limited amount of time for a break but I'd like to now turn and welcome our next speaker Kathy Greenlee to the stage.

And Kathy Greenlee is the – Kathy Greenlee is the Assistant Secretary for Aging with the Administration on Aging. Of course it's the programs that she administers that are playing such a vital role in many of the communities around the country in developing models for care transitions, in training people, in working with hospitals and health care providers and others to make the kind of work you've heard about so far this morning a reality. So with that, I'd like to ask all of you to join me in welcoming Kathy Greenlee.

Kathy Greenlee:

I'm the only speaker who is ever late to the podium because I was looking at the handouts from the last panel, so, and copying them. Good morning to you all. I think it's still morning. This is a great group of people that you have and quite literally I was looking through the PowerPoint. I don't have PowerPoint slides.

If any of you have ever heard me speak they would be so constraining for me that I would have to stick to something that I have written already, that I find them inhibiting. Thank you for introducing me, Linda, it's good to see you all. And I was sorry that I wasn't able to come up from Washington earlier this morning to hear Dr. Berwick speak. I've had the opportunity to do several things with Don, he and I met recently to talk specifically about the vision we have at the Administration on Aging with regard to the interface between AoA and CMS.

Don and I recently did a senior event. Much as we love you all I think probably he and I like going out to talk to seniors the best. So we did a senior event to promote open enrollment this year for the prescription drug plan

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and we've done a couple of webinars. So, we hang out in the green room getting makeup sometimes as well.

So where ever he and I can appear together and promote the same things I think we should – so you can look for us one or the other or together as we continue our partnership. This is quite a talented pool of individuals. Some of you who just spoke I'm familiar with your work and just am here to cheerlead for you all a bit. It's Friday. I'm always glad when it's Friday.

I've been working now as a professional for two decades. So Friday for me means yes indeed I survived another week and TGIF, so happy Friday to you, Happy Hanukkah to those of you celebrating Hanukkah.

Fridays, I think, are significant, for all of us who are working. Fridays are also significant for another reason. All across the country this afternoon the phone calls will start because it's Friday. A daughter will call an Area Agency on Aging and say, "My mother is being discharged from the hospital now, what do I do?"

A son will call the local ombudsman and say, "The nursing home says my father can't stay any longer

because his Medicare days are up. Now where does he go?" And for those of us in the field of aging it feels like all of these calls come at 4:30 on Friday or at 10 till 5:00 which is worse because at 10 till 5:00 you already have your coat on and you're turning off your computer.

And those of you who have done this and I can hear from your response know that this is true. And I don't have data, what I have is the truth of the reality of being someone who has received these calls by working in the field of aging. And Fridays can be difficult for people. They can be scary for people in hospitals and nursing homes and for their family members as they struggle with the enormous decisions that they need to make with little time and lack of information.

Who do they call on Friday or any other day? They call me. That's who they call. I want to talk about the relationship between Medicare and Medicaid and the Older Americans Act. As we end 2010, it's been a reflective year because we have celebrated the 45th anniversary of these three laws this year. All three were passed and signed by President Johnson. And what you

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do not know because you don't work at AoA is that we're 16 days older than both of them. That Medicare and Medicaid finally showed up, two weeks later and we were glad to see them as critical, critical partners in 1965.

And those three laws are important to understand as all three of them, the triumvirate of those together with Medicare being of course the acute care support for seniors and people with disabilities; Medicaid which for those in this work has become the primary source of support for people who need long term supports and services and the Older Americans Act. The Older Americans Act was never designed to be an entitlement program. The funding at this point reflects that distinction. That's both a good news and bad news story.

The Older Americans Act from the beginning was envisioned to provide community-based supports to individuals to help them be healthy and independent for as long as possible. I did a public hearing on the reauthorization of the Older Americans Act in Milwaukee and one of the people who testified had this proposition that perhaps the Older Americans Act or the original

home and community-based services – we have been around for that long. And all three of these were passed at the same time.

It wasn't until the early '70s, though, about seven or eight years after the Older Americans Act was passed that we developed this current national network that you're all familiar with, the national structure of the Area Agencies on Aging. And quite literally the piece I was pulling out of my materials for prior workshop was Cathie Berger's slide that describes the structure and the relationship because even though I don't have PowerPoints she did, of the relationship between Congress and the Administration on Aging, the states and the AAAs.

That basic slide from her presentation, that structure has been in place since 1973. And when I present that slide it looks a little bit different than Cathie's because it's really an inverted pyramid. This is a very atypical Federal structure to have by design a small Federal agency at the top with tens of thousands of providers in the community. That's how it was always designed to work and we have

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been doing this work for a very long time.

For the past two decades CMS has been an essential partner with working with us. And CMS relies on this core network of Area Agencies on Aging to deliver four different but very important services. CMS is working with us and the area agencies in the network to provide home and community-based services waivers and since 1981 as we started to implement ACBS waivers, CMS has been relying on the network.

CMS relies on area agencies to implement the Senior Health Insurance Partners program – the SHIP programs. Two thirds of all the SHIP programs are area agencies. CMS works with us and our network to support (inaudible) the person looking for assistance for people living in any institutional setting who want to return to the community.

And of course the more recent and fabulous partnership with CMS and AoA for Aging and Disability Resource Centers. This is a combined partnership. These four things represent a significant investment by both agencies in developing a national network to provide

home and community-based services.

So we're very happy to be here today to talk to you all about community-based care transitions because we've been around for a long time. I've only been around for about half of those 45 years in this work but I have seen all these transitions in care settings from the community to the nursing home, the nursing home to the hospital, the community to the hospital, the hospital to the nursing home or the community back to the hospital and the hospital to the nursing home, we all know these.

My proposition to you and the thing I want to impress upon you most today in terms of my philosophy is that none of these transitions is a medical event. And if you view transitions from the single lens of medicine and medical events you miss the large and essential picture. These are life events. They impact the person needing care, their family, their caregivers and their community.

Hospital discharge and hospital readmission cannot be solved or resolved by hospitals alone, and I know we have wonderful, wonderful hospital partners here and also listening in. Managing a successful transition

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involves all of us -- the medical people, the social service people, the long term support providers, their family, the caregivers and most essentially the person who needs care.

I am convinced that the aging services network, the network that we oversee at AoA and our community partners are essential to building successful transition care and that was evidenced by the panel before me and will be talked about this afternoon. There are three things that we do really well in our network. Information and referral, case management, and services.

And what's been hard for us over the years and I get asked about this a lot in Q&A, I was asked about this at my first national speech as assistant secretary. How do we tell people about case management and information referral? They have often been, in our world, undervalued but what we know about people and the supports in the community are what people need to know. It's what people know or need to know this afternoon at 4:30. Those are the things that we know, the kinds of questions that they're asking.

Where do I go? How do we provide these particular supports? Our goal at AoA is to support a person-centered approach to transitions by creating formal linkages between and among the major pathways that people travel while transitioning from one setting to another or from one public program to another.

I want to stop there briefly and give you a couple of other ideas on things that you won't necessarily talk about today as I don't think it's the main focus. But certainly because of the work that I've done both as an ombudsman and at the insurance department and as secretary in Kansas.

I believe that there are two more transition points that are not usually thought of, they weren't on the list I just read of all these different pieces. But that transition from Medicare to either Medicaid or private pay at the end of the skilled rehab Medicare days is a transition in care. That's not a necessarily transition in setting although it might be, you might be moved to a different place where you are in the same building or you may go home.

But that transition at the end of the Medicare skilled

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rehab days is a place where I think we need to do more work and I would like to put on the short list of future projects at CMS and our friends at CMS, because at that moment when the Medicare skilled rehab days come and people get this notice and they start calling or they don't. And maybe what worries me more is people who don't, who don't realize that when the Medicare days run out this is a transition point and we need to show up again with good information.

The other transition point that we all know about but don't talk about as much because it's not necessarily seen as a transition in care setting, is a transition to hospice, and when we go from the Medicare beneficiary benefit to a Medicare hospice benefit there's also a significant transition in care. And those of us who do this understand that different people show up to provide care. This is another significant transition and some place where I would also like for us at AoA and our partners in the network to work with you at the hospitals and CMS to talk about those two transitions as well.

The pathways that we work with on these other

transitions and settings include pre-admission screening programs because of the necessary – the need to look at hospital discharge planning upon admission and pre-admission. We look at screening for nursing home services and we – these different opportunities really present to us the critical junctures where decisions are made.

And I've always seen transitions as the opportunity for a tremendous risk for individuals. And I usually call them consumers not patients because of my background I've never worked in a hospital setting and so they're just consumers to me; the transitions in care and that those opportunities they are critical for success or failure, that's why we're having this conference today, that's why the Federal government is investing more money with you as partners; tremendous, tremendous time of crisis for individuals, often done with lack of information based on a sudden change in someone's health status.

And this transition period can be determinative of the future of care for that person in a way that's significant when someone is old, especially if they move at that

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point to a nursing home when they prefer to be in the community.

I'm not an anti-nursing home person. I believe that nursing home needs to be there and present as a choice and a viable option. And that we should never look at community service as the ultimate goal and never set ourselves up in a dynamic where a nursing home admission is failure because I think we always need that option, but most people want to stay in the community for as long as possible.

And if we are not doing the work well, we are not providing options and someone goes to the nursing home early where they have other options. Those kinds of stories are the failures to me, not the fact that someone eventually needs to go to a nursing home.

Aging and Disability Resource Centers can play a pivotal role in those transitions to ensure that people end up in the setting that best meets their individual needs and their preferences, which like I said is often at home. Our staff can be present at these critical points to provide individuals and their families with the information they

need to make informed decisions about their services and support options and quickly arrange for services.

I was working in Kansas with my friend and colleague who was the Secretary of Social and Rehabilitation Services. And he said something that we all know that sometimes someone else has to tell you for the light bulb to go on. He said, you know those nursing homes, what they have going for them is the credibility of stability – that people are – that they're going to be there, there's that building. And we all know this about nursing homes. And in my hometown there is a nursing home there and there will be one next week and there be will one in ten years. That the bricks and mortars is the nursing home work and these buildings have been around long enough that consumers rightly or wrongly attribute good care and stability to the fact that that building exists.

And one of the challenges for those of us trying to do something new and show up is that, you know, the Clearwater nursing home in my hometown will always look more stable than ACME home health that someone hasn't heard of. And so, to catch up what we need to be

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able to do is quickly respond to services, to be open 24/7 like a nursing home is, and also be around long enough and have enough goodwill in our community that we can be trusted because not only are people making decision in a crisis, they only want to make this decision once. And so, we are going to make a decision we want it to stick and don't call us in six months and tell us that this home health company is not there.

So we have to develop the credibility and the stability. The partnership with the hospitals can help us go a long way in this regard because of the goodwill in the community and the staying power.

The work that we do with ADRC is in providing education and information to consumers can help them break the cycle of hospital discharge and readmission. It can help them when they're chronically impaired get the services that they need so that they can live sufficiently and live well in the community.

We first again this partnership with CMS and I told you that working on the Aging and Disability Resource Centers is a newer endeavor, we first began funding

Aging and Disability Resource Centers in 2003. Since that time we've been able to demonstrate evidence-based models and I know that people from Central Texas. Scott & White were on the panel before me, they took that piece out of my speech because I was going to promote their good work as well and say thank you. We also know at AoA because we write it our documents that you all are wonderful examples of the community partnership. This is how we've been able to model the Aging and Disability Resource Centers and use of Eric Coleman's model in the community.

We also have been doing work, and I know Mary Naylor is speaking this afternoon. The Delaware County Office of Services for the Aging is working with the Crozer-Keystone Health System, Taylor Hospital, the Crozer-Chester Medical Center, Springfield Hospital, the Delaware County Memorial Hospital and the Quality and Improvement Organization of Pennsylvania on the transitional care model. These are great, great collaborative efforts going on in Pennsylvania.

I said earlier that when you're wondering what to do

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and where people should call at 4:30 in the afternoon, they should call me. And by that what I mean is not to give them my phone number but to realize that this network that we built is an Administration on Aging for service and network supplemented with great partnerships from you and with CMS. When someone calls an Aging and Disability Resource Center they are calling me. This is the work that we do in the community and this is where people need to go to get good help.

One of the opportunities that we had earlier in the year with the passage of the Affordable Care Act was to look for some innovative ways to use the dollars that we have at AoA. The formula grants, the discretionary grants, the partnerships that we have with CMS and so we announced in September \$68 million that we are investing to fund initiatives to help people stay in the community and get long term supports. One of those initiatives of the four was focused specifically on evidence-based care transition grants. With those grants we funded 16 states to provide coordinated and comprehensive service to encourage evidence-based

transition models to help older persons and persons with disabilities remain in their homes after a hospital, a rehab stay or a skilled nursing facility stay.

The objective I know of the conference today is to talk about what's coming next. What we've been able to do with our partnerships so far demonstrates that we're committed, that we're on the right path. Where we're going with CMS is much reflected in the upcoming announcements about the additional investment in the community-based care transition program made possible through Section 3026 of the Affordable Care Act.

We will look for every opportunity to talk about what we can do in the field to work between ADRCs and the hospitals and the other community providers to support good evidence in the work that we do for transitions in care.

I believe that once upon a time we divided the world into two camps, the medical model and the social model. Medical care and social services. That's somewhat even reflected back in 1965 when we adopted Medicare and the Older Americans Act as separate acts. Social

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services and medical care. I think this division between the medical model and the social model is a false distinction, and with false distinctions come silly conversations.

I've been involved in some of these conversations. They sound like this, is long term care health care? It's a silly conversation. They also, these false distinctions, create false assumptions such as only medical services need to be grounded in evidence, and as we know the future is evidenced based practice in everything that we do. And we've been committed for the past decade at AoA to support evidence-based practice, this is not an enigma when we're talking about social services. We have to have evidence-based science on the social services component of holistic approach.

These distinctions, the medical model and the social model, have created tremendously complex systems for consumers to navigate. And really, the reason I think these conversations are silly is that they don't matter. The only thing that matters to a consumer, to a patient is who are you and what do you need and we go from there.

I believe the topic of care transition provides the opportunity to reset the frame for all of us, not to a frame of medical versus social. We are very, very much interested in the three part aim that CMS and Dr. Berwick have talked about of better health, better cost and better care and lower cost. And that we are value added to this process by investing in community-based services such as ours, that we are a good investment. By working with us and the Aging and Disability Resource Centers and the experts that we have for the last 45 years been created in the system.

I believe we can provide integration, better health and most importantly support the whole person, that we have now finally this wonderful opportunity through the Affordable Care Act for tremendous intervention and innovation with regard to care transitions, that through this innovation we can finally have a holistic approach. I know this is the same approach that Dr. Berwick talks about; he talks about it – he talked about it this morning – his example of this 15-year-old patient. He says, you know, doctors and nurses need to talk to each other and

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then they need to talk to me. That it's all about being person-centered.

I look forward to more work with CMS and more work with Dr. Berwick and I wanted to close by telling you about this funny email exchange I had with Dr. Berwick last month. I had listened in when he was doing a presentation to CMS staff about the three part aim and where he's going. And after that I sent him an email, and the gist of the email was an attempt to get him to include some Jimmy Buffett quotes in his speeches. Now, you wouldn't think that's normally what we talk about but he used a quote and I thought a quote, a Jimmy Buffett quote was really a little bit better at that point.

So he and I had this email exchange about Jimmy Buffett quotes and he's onboard. So in honor of our new working relationship, I would like to point out it is 5:00 o'clock somewhere but not everyone can head to happy hour. Some of us have to stay behind and take off our coat and sit back down and help a distressed family member negotiate this complicated system of finding the right care.

Thank you all very much for your commitment to this issue. I know they had wanted me to save some time for Q & A, and so, I have done that and I also have wonderful staff here from the Administration on Aging that I would like to acknowledge. I'd like to acknowledge them now for two reasons, I forgot to acknowledge them earlier and we're about to do Q&A so I've got help. So do you all have questions or thoughts, other ways that we can be supportive to what you're doing in terms of care transitions?

I've given you the Jimmy Buffett quotes that I have written already in my speech. If he's providing more wisdom for us in this work, I'll let you know. Anything?