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

Robert Pryor:

Thank you. It's a pleasure to be here. First, I'd like to start by talking a little bit about my, what I believe to be truth and what I believe to be assumptions as I move forward. First, truth. I don't do the project, all I do is remove the administrative barriers to allow the team to do the project. So, I am not the one that does it.

Second, when they asked me to talk about the economic impact of transitions to a hospital, I said, “Well, gee, this should be quite simple because a highly reliable, safe, quality organization should produce economic benefits and then I step down. Right?‖ They said, “No, you need to do a little bit more than that, so, I will.‖

It’s in all hospitals best interest to work with the community and we worked with the ADRC in our local community to connect with our patients and the communities in which they live. There's a time when physicians used to take their horses and the horse and buggy and visit the patients on the farms and where they lived, to understand about what is the context in which they're trying to get healthy as they go back into the communities. Well, those days are gone. We still do bloodletting, though. We only put it in small little tubes now rather than big pans. But, we don't connect with the community as we have in the past and as we should.

We need to better identify at discharge the needs of the patients as they go back into the community and transition from that acute care setting back to the home. And I worked in the intensive care unit for 20 years clinically and one of the things that I was noticing more and more is that as our patients left the high intensity of the intensive care unit, and then by necessity had less interventions in the hospital bed and then further decreased the interventions as they went home. This produced a lot of turmoil, a lot of angst with our patients and also the families that give care to the patients.

There's a need to link the goals of hospitalization with what the community does and how the community interacts with the health and well-being of our patients, as they go back into the community. The failure of good transitions is just way too expensive for us to continue.

So, I'd like to start with what I'm going to try to do. I'd like to talk about Scott & White Healthcare’s position in our community, the care transition impact on safety and quality and then try to give a very high level overview of the impact of the care transitions that we see.

First of all, Scott & White Healthcare is imbedded in our central Texas community. We're in the heart of Texas, deep in the heart of Texas. We are an integrated delivery system, a multi-specialty physician group practice of around 1200 providers. Primary and specialty care is given and one of the things that we have is we're fortunate in that we have a high percentage of primary care clinics in our network. About 35 percent of our providers are in primary care.

We have hospitals, long term acute care facilities, skilled nursing facilities, home health and hospice services. And we've been accountable for the health, quality of life and cost containment of high quality care in our community for over a century in central

Texas.

The care transitions allow the right care at the right place at the right time. These transitions occur within our system and across other systems that refer patients in to us and also allow the right sizing of our hospitals. Scott & White Healthcare's business is the health of our community. As Dr. Berwick so nicely summarized, we want to produce safe, effective patient-centered, timely, efficient and equitable care in our communities.

This has been shown a lot. This is the Dartmouth Atlas Study of the Medicare total cost non-capitated per beneficiary reimbursement in 2006. If you look at the red circle, that's central Texas, the heart of Texas, where we are, and you see a sea of green, an island of green and a sea of blue in Texas. This shows that in our service area, the cost is less than $7,500 per beneficiary.

This is the heart of Texas, and if you can see, it's very hard to see on the screen, the red dots are our 60 clinic sites, 12 hospitals, surgeon centers, dialysis centers throughout the central Texas region. And throughout that, again, we focus on primary care and the transitions of care from the hospital back to the home and then the community.

Care transitions, of course, impact safety and quality.

Safety – if we have good transitions and good handoffs, we can decrease medication errors. Now, I'm going to state the obvious now because what we're talking about is our most fragile patient at the most vulnerable period of their transition, as they go back in the community. We could also decrease other adverse events for the patient and/or system errors, as we help facilitate these transitions, that these exacerbations should be diminished.

Now, let me state that nobody likes hospital readmissions. The doctors don't like it, the nurses don't like it, the pharmacists, the other care members of the team, and the least of all, the patients and the families do not like it. One of our hypotheses early on was that for every time you readmit the patient into the hospital, the cost and complications can actually increase exponentially, not linearly. So, it snowballs and as these fragile patients get more ill with rehospitalizations, costs go up, quality goes down, quality of life goes down and the patients suffer. The accountability for patients' health includes – should include the known consumer needs post-discharge, so we can keep that transition going.

The economic impact on communities for the consumers.

Well, every time they keep coming back, there's another copay. That's an economic cost. There's additional treatment, that's a personal and an economic cost. So, the last thing I want to do is go in and have another central line put in me or another endotracheal intubation because I've got a hospital-acquired pneumonia and that wasn't taken care of adequately.

There's also caregiver time and resource utilizations from the families that give care. And the daily functioning is decreased, the quality of life of the patient is diminished. For our community, the employers suffer because as we go home to take care of our elderly

parents, we don't show up for work.

The long term care health facility impact is if we deliver a patient that's still in need of major services, back to the long term health care, of course, they come back because there's a limit to what we could do in the long term care facilities. The home health agencies are further impacted, and the AAAs with care coordination and transition programs are flooded if we don't do the job right at the time of transition.

The economic impact on the health system. Well, everyday, we need to earn our community's trust by taking care of our community. We need to develop consumer loyalty around our health care systems. But more than that, I would submit to you that this can protect the operating margin. It opens beds to more high acuity patients that need it where we're not doing rework, but we're doing the work for the first time and not doing rework after rework after rework.

And not only that, but we're in an area where we're actually adding hospital beds and hospitals in our community with a cost of about $1.2 billion per hospital bed, we need to make sure that we right size the construction of our hospitals because, as we put the burden of fixed cost into more and more hospital beds, that we frankly have to pay for over a 30-year bond proceed. You know, this is adding fixed cost to the health care cost, not just the variable cost that we talked about but also the fixed cost that we incur for a long period of time. And, of course, this also can avoid the penalties for excessive readmission.

We need to optimize the efficient use of our resources, take advantage of the economies of scale when we have them and produce safe, effective staffing ratios.

So, our approach is that intervention doesn't necessarily produce good outcomes. And we've had a three to four-year history of working with our community partner in the transition. We can show that we can implement this, but now we need to do further studies and add evidence to show that the interventions can be personalized to the patient as they leave the hospital.

Because in order to give patient-centered care, our transitions of care has to be personalized in order to give that patient-centered care because that’s essentially what patient-centered care is, a personal discharge plan for every patient that leaves our hospitals and goes back to the community.

So, we also need to know what consumer characteristics and behaviors predict readmission so that we can prevent these readmissions and what interventions at the patient level can address their identified personal needs.

With that, I'd like to thank you for allowing me to be here today and be a part of this. And you can call me, contact me at anytime. Feel free, there's my data. And contact me anytime for questions.

Thank you.