Date: 13 June 2011

To: Key Stakeholders in the California Collaborative for Quality in Long Term Care [CCQILTC]

From: Alfredo Czerwinski, MD
Chief Medical Officer, Lawson & Associates

Subject: Notes from our meeting of 10 June 2011

Background

As you recall, we first convened under the auspices of the California Association of Long Term Care Medicine (CALTCM) with the support of the California Health Care Foundation (CHCF), immediately following the INTERACT training session at the Claremont Hotel on Friday afternoon, February 25, 2011. We agreed at that time to continue the discussion about creating a strategy to improve quality by focusing on care transitions as they relate to long-term care.

A second meeting of this group was held at the HSAG offices in Glendale on Friday, 22 April 2011. That morning's discussion was focused on clarifying the aim of this coalition, and determining its desired product.

This document summarizes the dialog that took place in the third meeting of this group, which was held at the CHCF office in Sacramento on Friday, 10 June 2011. The following individuals were in attendance:

By telephone:
Jodi Cohn, DrPH - SCAN Health Plan
Glenn Panzer, MD - CALTCM and Villa Pomerado

In person:
Deborah Bakerjian, PhD - geriHEALTsolutions
Avi Bhorik - CALTCM
Patricia Blaisdell, California Hospital Association
Alfredo Czerwinski, MD - Lawson & Associates
Pam Dickfoss - California Department of Public Health
Darla Farrell, RN, BS, MBA - Health Services Advisory Group
Mary Fermazin, MD - Health Services Advisory Group
Janet Frank, DrPh - California Geriatric Education Center (UCLA)
Lura Hawkins - California Association of Physician Groups
Lori Marsden - Country Villa Health Services
Dan Osterweil, MD - CALTCM and UCLA
Carol Turner - California Department of Public Health
Jennifer Wieckowski, MSG - Health Services Advisory Group

{Complete contact information for the participants in all three meetings is available from CALTCM: telephone (310) 312-0518}

Discussion Details

The first item of business covered a very important correction to the Agenda. The item listed as "III.A. Update on CGEC PIE Project" may have resulted in some confusion.

The CGEC PIE project is not part of the CALTCM-INTERACT initiative. Dr. Frank had simply requested a few minutes at the end of the stakeholder's meeting to mention the project, because many of those in attendance at this meeting might be able to refer specific facilities to that project. The PIE topic was in fact not part of the meeting agenda at all; rather it was a separate informal discussion which took place at the end of the main meeting.

So, the group was reminded that our previous two meetings emphasized INTERACT -- an acronym for "Interventions to Reduce Acute Care Transfers". INTERACT is a quality improvement program designed to improve early identification, assessment, documentation, and communication about changes in the status of residents in SNFs. The goal of the program is to reduce the frequency of potentially avoidable transfers to the acute hospital, and thereby reduce the occurrence of the many complications of hospitalization. In addition to saving the cost of potentially unnecessary health care expenditures by all parties, hospitals specifically will be looking to avoid financial penalties related to avoidable 30-day readmissions, and nursing homes rates will be looking to avoid the loss of referrals from hospitals concerned about high readmission rates.

At this time, INTERACT could be considered a proven methodology, based upon the results from projects in Georgia, Florida, and Massachusetts.

Once our motivation was re-established, Dr. Osterweil shared some important history from 2009 and 2010. CALTCM shifted its focus in 2009 to performance improvement education (PIE), as well as implementation. Subsequently, the California Department of Public Health (CDPH) expressed some interest in the possibility of integrating PIE with the "Plan of Correction" that is required for LTC facilities following findings of a nursing home violation of one or more specific licensure or certification requirements. Last year, CDPH conveyed the possibility that some funding might be found to support that work.

Meanwhile, leaders at CALTCM suggested forming a new coalition to press forward with INTERACT in California, by perfecting and conducting the necessary training, assisting with implementation, and measuring outcomes over time to assure that sustainable changes have been achieved. *(That coalition is this very group, meeting for the third time today.)*

Dr. Frank reminded the group that we should capitalize on the clinical expertise represented by CALTCM as well as the educational strengths of CGEC (which received approval in July 2010 for a renewed 5-year funding cycle).

Dr. Bakerjian reiterated that our discussions so far are quite consistent with *Advancing Excellence in America's Nursing Homes Campaign,* a national collaborative.

Dr. Fermazin clarified the role of HSAG (California's QIO). HSAG has a long history of involvement with collaborative QI projects, and their contract with CMS has been renewed for a new 3-year Statement of Work (SOW) which will commence in August of this year. As part of the SOW, HSAG will assist up to five communities to apply for federal grants aimed at reducing avoidable readmissions. In addition, HSAG will work with three Learning Action Networks (LANs) around the state, to

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implement best practices with regard to care transitions. She described a LAN as "an IHI Collaborative on steroids."

Pat Blaisdell shared a perspective from the California Hospital Association (CHA). In summary, CHA members have a growing concern about the new economics of readmissions, driven by reimbursement changes that will go into effect very soon. Only 10% of SNFs in California are hospital based, and 60% of Medicare patients are discharged to their home. It is likely that our hospital-based SNFs have little knowledge of INTERACT at this time.

While on the subject of acute care hospitals, we discussed Project BOOST (Better Outcomes for Older adults through Safe Transitioning) which is led by the Society of Hospital Medicine. Among its several goals, the project aims to reduce 30 day readmission rates for general medicine patients (with particular focus on older adults). While BOOST is a national project, CHCF will subsidize the training for 20 sites in California.

The group also talked about Project RED, which in our context stands for "Re-Engineered Discharge". The Agency for Healthcare Research and Quality (AHRQ) has funded Joint Commission Resources (JCR) to assist hospitals with implementation and dissemination of Project RED. About 250 hospitals are already involved.

As was mentioned in previous meetings, this collaborative should pay close attention to lessons learned from these projects and others.

Next, two attending representatives from the State of California expressed their appreciation at being invited to participate in these discussions. They reiterated the importance of the State as a stakeholder with regard to improving quality as well as reducing cost. A major effort in their office at this time is rewriting portions of California Code of Regulations Title 22. Since the change in administration at the beginning of the year, there are some new players and in fact many players "at the table" with regard to the topics of interest to this group. Though perhaps best known as the regulatory enforcement arm, CDPH is actively seeking more involvement in quality improvement projects.

The discussion moved next to the notion of this collaborative becoming the "Go-to" organization for INTERACT (now) and possibly other related initiatives (later). There was agreement about several key attributes of the effort:

- maintain focus on QI in LTC transitions
- recognize the state-wide scope of a problem that is prevalent and costly
- embrace existing regional and local networks
- avoid fragmentation
- use proven methodologies
- pay attention to other projects that are already underway
- acknowledge that this is complicated work
- attend to documenting outcomes and sustainability

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Significant results

The group drafted a **mission statement**

- Our initial aim is to improve quality
  by strengthening clinical performance related to care transitions.

and a high-level **strategic plan**

- Our initial strategy is the dissemination and implementation of INTERACT.

and two **measureable goals**

  - Get INTERACT implemented at 5% of California nursing homes (~50 out of 1100) within 18 months
  - Reduce avoidable readmission rates at those institutions by at least 10% within 3 years

At this point it seems clear that the coalition needs a name in order to move forward. Although the facilitator lobbied for the more pronounceable Avoidable Readmission Taskforce (ART), most participants supported this name:

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Next steps:

- ⇨ Lura Hawkins of CAPG asked for an article before the end of the month that she will be able to publish in the *CAPG Health* or *CAPG Update*
- ⇨ Pat Blaisdell extended a similar invitation to announce the collaborative through appropriate channels at CHA
- ⇨ Drs. Dan Osterweil, Janet Frank, Mary Fermazin, and Ms. Jennifer Wieckowski volunteered to collaborate on an article, and to seek resources for support of continued discussions

I would like to once again thank the California Health Care Foundation and Senior Program Officer Kate O'Malley RN, MS. Their interest and grant support has made this work possible.

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