Policy Briefing on Improving Care and Reducing Costs for Medicare Beneficiaries in Nursing Homes
Kaiser Family Foundation
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DIANE ROWLAND: Good morning and welcome to the Kaiser Family Foundation Barbara Jordan Conference Center. I'm Diane Rowland, the Executive Vice President of the Foundation.

We're very pleased to have you join us for this briefing this morning on one of the issues that challenges us all, how to improve care and reduce costs for Medicare beneficiaries and today we're going to take a particular look at the care for those in nursing homes and what some of the implications are for both their cost and the quality of their care in terms of their use of services and their transitions back and forth between the nursing home and other health care facilities.

This is a day in which we will be releasing two studies that look at these issues. We'll be having a panel discussion around the challenges and issues in addressing some of these concerns but we're

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particularly fortunate today to begin with Dr. Don Berwick who is the administrator of CMS and is joining us here this morning.

As many of you know, at the Kaiser Family Foundation, we focus on being a source of independent data and analysis on Medicare, Medicaid, and other health care programs. So we have, for a long time, looked at the Medicare and Medicaid programs and those that Don Berwick is now charged with administering in terms of the impact of the coverage policies and of the payment policies on access to care and ultimately health outcomes for the Medicare beneficiaries.

So we're particularly interested in being able today to have Dr. Berwick lead our overview and provide us with some of his plans and some of his insights into the challenges of coordinating and improving care for the Medicare beneficiaries who are so critical to our health care system and often incur some of the highest costs and most challenging issues.

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To kick off the discussion, Dr. Berwick is going to give us his comments. He is responsible, we should remember, for nearly 100 million beneficiaries between the Medicare and Medicaid and CHIP programs, older, disabled, low-income, vulnerable families, those with the most serious chronic illnesses in our population. He's also responsible for 41-percent of the total national personal health care spending in 2010. So it is a big challenge that he faces.

Dr. Berwick is, by training, a pediatrician with a passion for finding ways to improve the quality of patient care through delivery system reforms. He is previously the founder, past President and CEO of the Institute for Healthcare Improvement. The name there tells you what his lifelong challenge has been.

He's a Clinical Professor, Pediatrics and Healthcare Policy at the Harvard Medical School and Professor in the Department of Health Policy and Management at the Harvard School of Public Health.

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Before joining the administration, we have known Don for a long time. He's a prolific writer on topics related to improving the quality of care. There's much more on his background in your folders but without further adieu, I'd like to introduce Dr. Berwick and allow him to offer his opening comments to start this session. Thank you [Applause].

DONALD BERWICK: Thank you so much Diane and thank you for the chance to join you this morning and make some remarks to front-end this really important work you're doing. I want to thank Diane personally for her leadership through the years and for her mentoring me.

I know no expert in health policy in the country who's contributed more to my understanding about Medicare and Medicaid than Diane and her work and her team and Drew Altman's a great friend of mine. I constantly turn to the Kaiser Family Foundation for guidance and background.

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As illustrated by the two reports that'll be released today, I've read those reports, produced under Gretchen's leadership, they're extremely important, very well done, and typically useful. I'm very grateful to the foundation for all you're doing to advance health care in the country and health care in the country and particularly to help me right now in this new role.

I'm in the presence of a room full of people who probably know more about this topic than I do and I'm not going to try to get into the details. I want to give you some reflections on where I think CMS is headed right now and to place your really important work and conversation today in that context.

I took the job in CMS with an enormous amount of gratitude for the opportunity and particularly for the opportunity to link the work of my past that Diane referred to, the improvement of health care in our country, to the enormous possibilities that exist

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within the public sector and CMS to help catalyze, as a trustworthy partner, the improvement of care in America.

I want to try to lead CMS to be a trustworthy partner and a major force for the continual improvement of health and health care for all Americans. The possibilities are fantastic. I've been absolutely thrilled to get into this new role and every day I'm learning from my new colleagues at CMS about the enormous opportunity this country has now to set us on a pathway toward the kind of care we all want and deserve and can have.

CMS itself is a very interesting place. It's enormous. We are, of course, a very large insurance company. That's job one is to manage the processes of contracting and payment and oversight that come with supportive care for the 100 million people that Diane referred to.

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As you probably know, we now have a second major job at the moment and that is the implementation of the Affordable Care Act. This immensely important piece of legislation, landmark in our nation's history, a challenging task, and the organization that I now lead, CMS, has about 70 or 80-percent of the responsibility for that implementation. It's been executed brilliantly. We've hit every major deadline and I'm deeply indebted to the staff there for their ability to deal with that challenge as effectively and as buoyantly as they have.

In a way, what I'm bringing there as the administrator is sort of job three, it intersects with the other two very strongly, the insurance function and the Affordable Care Act implementation. That job is to try to help our agency become a more effective partner and force for the improvement of care in the country.

The Affordable Care Act, the new legislation, is a kind of trampoline. It's a very promising piece

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of legislation already with enormous benefits to people already this year just in the first six months of implementation. What lies ahead is even better, 32 million people who will have coverage that they wouldn't have had otherwise, an expansion of Medicaid as you know, to 16 million, helping beneficiaries with chronic illness be assured they'll get the care they want and need, helping people with pre-existing conditions to be able to get access to care. I won't go through the recitation of all of the benefits of that law.

It is an answer to many, many Americans who have been frightened by their inability to get health care insurance or by gaps in coverage that will now be closed. It's also a question for the country though and it bares directly on your topic today. The question the Affordable Care Act is asking America is will we change care? Will we make it what it should become in this country all together as partners in

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pursuit of the kinds of care we want for ourselves and our loved ones and our communities?

The Institute of Medicine, in the turn of the century in 1999 with the report *To Err is Human* and the 2001 report, *Crossing the Quality Chasm*, set in place that question as forcefully as the Academy of National Sciences ever has.

It, as you know, said that in our country the care we have and the care we could have are widely different. Between the care we have and the care we could have lies not just a gap but a chasm and that quality chasm report in 2011 laid out the nature of that gap, gaps in safety, effectiveness, patient-centered care, timeliness, efficiency, and equity but the report did not find fault with the care deliverers in this country.

It had the sophistication to take a system's view of the kinds of gaps we face and to recognize that the problem does not lie in the good intentions or

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capabilities or good will or efforts of the health care workforce, the doctors and nurses and other therapists, the managers, the pharmacists, the dentists, the health care leaders of our country are credited in that report with trying as hard as they can. The problem is that they work in care systems that are not well designed to support the effectiveness of the care they wish they could give.

The *Crossing the Quality Chasm* report is a resonant call for changing care so that it becomes more capable. The basic concept is the same as I used when I was at the Institute for Health Care Improvement. That is that every system is perfectly designed to achieve exactly the results it gets. If you want new results, you need a new system.

I own a 15-year old automobile with 110,000 miles on it and if I take it out on the Bonneville Salt Flats and floor the accelerator, it will reach a top speed. That top speed is a property of that

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automobile. It's probably 93 miles an hour given the age of that car, my kids know, I don't. But the point is, is that cars, as a system, has a top speed. Every system has a top speed. So does health care.

The performance we get out of our health care system today, its safety, its effectiveness, its patient-centeredness, its timeliness, efficiency, and equity are all properties of the way that health care system is designed, an exhortation pleading with people to try harder, pushing system to do better won't get us the fundamentally different results that all of us want. The root is through change, through designing care systems that have the properties that the workforce and the patients and communities that they serve want them to have.

From the CMS level, I'm trying to articulate with my colleagues there the direction that we need to move. The direction is embedded in the charter of this meeting and in a lot of the work of the Kaiser Family

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Foundation and the work you're engaged in that we're calling the triple aim.

That's a phrase that refers to the goals that CMS will be pursuing on my watch and it refers to three goals at once, better care: better health care so that people who need our services benefit from those services to the full extent that science and propriety call for, safe, effective, patient-centered, timely, efficient, and equitable care whether those patients be in an acute care hospital, in a physician's office, in a rehab facility, or in long-term care, safe, effective, patient-centered, timely, efficient, and equitable care.

The second aim is to reduce the need for that care in the first place by keeping people as healthy as they possibly can be through prevention, population-based prevention working upstream on the causes of illness. That's the second part of the triple aim, better care, better health.

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The third part is lower costs, to be able to achieve reduced costs without harming a hair on a single person's head indeed often by improving the care that they're getting. Their experience can often be improved while costs fall. That three-part aim, better care, better health, lower cost is the direction setting compass that I would like to be working with my colleagues in CMS to try to achieve with you and others around the country.

There are many components to the kinds of new care that can achieve that. I'd say if there's one hallmark censuring idea to achieve better care, better health, and lower costs without harming a single person in this country, it is through integrated care.

It's by forming the kinds of teamwork and partnership and smooth handoffs, the transitions, the awareness of the journey of the patient through their lives and through their illness instead of treating them in fragments. I see no stronger testimony to that

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idea of integration than the reports that you put in my hands for this meeting as we document the kinds of flaws and interruptions, the defects that enter in long-term care and the nursing home care especially in transitions between hospital, nursing home care, and between home and nursing homes.

We have a vision of what integrated care looks like. We all know what disintegrated care looks like. I wager you don't only know it. I bet you experienced it through yourselves or loved ones or friends of yourselves. Disintegrated care is care in which you have to tell your name and address and problems over and over again to every new person you meet.

It's care in which no one seems to talk to each other. It's care in which your record is forgotten or unavailable or where one doctor prescribes a medicine that conflicts with a medicine that another doctor prescribed. It's where you wait endlessly on hold or you can't get answers to your questions. The

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care's in fragments and you and your loved ones end up holding the bag.

What we're seeking is care that doesn't have those properties that instead has the properties of smoothness and secure handoffs and transitions and stewardship and in the particular case of nursing home care, anticipation, so we're not waiting for trouble. We understand the person we're trying to help as fully as we possibly can along with them and their loved ones so that we can plan ahead for the kind of care that they want and need without waiting for them to get into trouble.

We see examples of this especially in the long-term care arena where some of the great breakthroughs have occurred. We have, of course, the On Lok system, which is one of the great American achievements to have in our hands --- an example of a place that understands integration at that level and can prove its worth through evidence of its own effect.

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I had a chance, in August, to visit a regional office. I'm trying to visit every CMS regional office if I can, before the end of the year, and they brought me to Mercy Life, which is a PACE program in Philadelphia, provides care to 300 or so people. I wish you all could have seen that. Its roots are in On Lok.

It's been adapted to that local community, exists within a housing authority. PACE participants are able to reside safely in their homes, safe in the community, and with complete support from that well-designed program. That's a car that can go a lot faster than my jalopy and at lower costs.

PACE has reduced the hospitalization rates in that program as it does in many of its areas through providing thoroughly integrated, better care and better experiences, fully maximizing the resources that patients and families and communities can bring to the service of these extremely vulnerable people.

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I met Dr. David Mingle at that center. Dr. Mingle was proudly walking me through a number of patients, a man who I'll call George for example, admitted to the hospital I believe five times in the year prior to his enrollment in the PACE program, had not had a single hospital admission during the next more than a year. I met George and he's a far happier man in that program than he possibly could've been outside it. Integration works.

We're going to find out a lot more about that in Medicare and Medicaid in the years ahead beginning right away. As you know, we're setting up the new center for dual eligibles, the center that is mandated in the new law with this wonderful leader, Melanie Bello who'll be looking at a particularly vulnerable population, 9.2 million people who are covered by both Medicare and Medicaid.

We have an important new opportunity with the stand-up of the Center for Medicare and Medicaid

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Innovation, the innovation center now headed by Rick Gilfillan is having its strategic plan designed right now. It will focus heavily on forms on ways to encourage and support the emergence of forms of integrated care adapted to local communities because it always has to be adapted to local context throughout America.

We have the Accountable Care Organizations now about to stand up. Rules are being prepared now and will be out for comment in December and we'll be able to see how we can craft, in this country, again adapt it to local community by local community what integrated systems capable of supporting integrated care and rewarded for doing so. I've never seen a time of more possibility in our country. Despite the many questions and anxieties people have about health care, the direction is right.

We're now grappling, as we should as a nation, with what kind of care system we really want for

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ourselves, our loved ones, our children, our parents, and our neighborhoods, and communities, we're going to get this answer right. And we have now not just with a new Affordable Care Act but even without that, with the Ethos that's in the country, a chance to find our way to better and better care systems.

In the reports that the Kaiser Family Foundation prepared for this meeting, you can see the possibilities. I think it was 38-percent of nursing home residents being admitted to hospital each year and I believe it was about 14 or 15-percent more than once.

The possibilities for anticipating, for intercepting, for preventing and helping people not get into the kinds of deterioration that lead them inevitably into the hospital, that you can imagine a care system far better able to anticipate and help people to stay out of the hospitals is what they want to do.

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There is no way in the world that this country can achieve what we can achieve for the improvement of care without everyone participating. That's the last message I want to give you. Although we have a big role in CMS and there's lots we can do to set the stage and make it more possible for you and your colleagues throughout the nation to find the kind of care for the people you're taking care of that you want for them and they want for themselves, this is going to have to be done together.

We will either build the health care system we want together or it isn't going to get built at all. So my last plea is for partnership, the kinds of ideas and invention that you bring to this important set of tasks that you're tackling in this meeting today and that you are with your careers and organizations are crucial to our future.

I look forward, in my role at CMS, to building stronger and stronger partnerships with you in the

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private sector so that we're working together to achieve for America what I know we now can achieve and will with imagination and trust in each other undoubtedly get to. Thank you very much Diane [Applause].

DIANE ROWLAND: I think Dr. Berwick is willing to take one or two questions if anyone wants to raise their hand and we'll get a mic to you and please identify yourself when you ask your question. Thank you.

VICKI GOTTLICH: Hi, I'm Vicki Gottlich, Center for Medicare Advocacy. I was interested in your comments about PACE and On Lok because as a beneficiary advocate, we hold those to very high standards as well. I was also interested that you didn't mention Special Needs Plans for institutional individuals. As an advocate for beneficiaries, we have a lot of concerns about that and I was wondering whether you could

address some of the oversight and ways you're going to work with those programs to make them more like PACE.

DONALD BERWICK: It's always risky to praise some and leave others out. I've a full awareness of the wide range of needs out there. One of the important principles I'd like to bring into our work and innovation and support to improvement efforts around the country is pluralism that there are going to be many, many constituent groups, many, many kinds of patients and communities and deliverers of care that we're going to have to make sure get their own kind of opportunity to improve. So I'm well aware of the set that you're talking about.

The general point is we're going to have to mobilize not one answer or two answers but many, many answers around the country for each community and each stratified group of patients and beneficiaries and families that we have to be smart enough to allow that kind of diversity to thrive.

SUSAN SUDMAN: Dr. Berwick, my name is Susan Sudman, I'm a management consultant to large health care systems. I feel like it's deja vu all over again at times. In 1971, I worked for what was then HEW and you might remember sometime in the range of 1971 to 1973 the HMO Act was passed and the HMO division was formed. What's different from the concept that was there? It was always continuity of care, coordination of care, quality, lowering costs. I mean I think certainly there's some, pardon my French, bastardization of the HMO concept now but how is the ACO different?

DONALD BERWICK: Learning is crucial. We have many experiences year on from the past and we'll be learning from them. This is a remarkable time in American health care. We have information technologies and abilities to measure and track that we never had before. We have now major national investment in

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electronic medical records coming out of the Office of the National Coordinator.

We have new understandings of cost and the pressures from the interrelationship between health care and the economy. We have much better ways based on health services research to track and assess the progress of patients and the diligence and quality of the care they see. This is not 1971. This is now.

I think the possibilities for crafting integrated care in a way that really matters and is adaptable in local communities have never been better. I have no doubt that we are going to reinvent our way now into the kind of care we can build with the assets we've assembled. It's 40 years on from then and a modern version of what integrated care is going to look like will function very well if we keep our wits about us.

DIANE ROWLAND: On that optimistic note and looking toward the future, I want to thank Dr. Berwick

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for being here with us and to call Tricia Neuman up to begin the next panel so we could present the results of the research that he's referred to.

DONALD BERWICK: Thanks Diane.

DIANE ROWLAND: Thank you and let's give him a round of applause [Applause].

TRICIA NEUMAN: Okay, it's hard to herd cats, I can see that. Thank you all. That was such a great introduction to today's discussion. I am Tricia Neuman. I'm a Vice President here at the Kaiser Family Foundation. I direct our Medicare policy work and I think we should have titled today's session Better Care, Better Health, Lower Cost and what was it, without hurting a hair on the head of any single patient anywhere in this country because that really is what this is all about.

More than 2 million people on Medicare live in a long-term care facility at some point in the year. They are among the oldest, the most frail within the

Medicare population. Many have cognitive impairments and functional impairments. They tend to be in relatively poor health. Many, as you know, are the oldest, old, age is 85 and older.

They have many chronic conditions. Because of their many chronic conditions and all of these other factors that tends to contribute to the complexity of their care needs and their medical vulnerability in the system. They are also, 62-percent of them, on Medicaid. So many people who are in long-term care facilities are dual eligibles but not all.

More often than not, policy discussions about the long-term care population focus more on Medicaid than Medicare because Medicaid is the nation's primary public payer for long-term care services. Medicare, as you know, picks up a relatively small share of traditional long-term care costs.

Yet Medicare does pay for costs associated with hospitalizations, emergency room visits, post-

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hospital SNF stays, ambulance trips, and other services used by people who happen to live in long-term care facilities.

After you hear the first presentation by Gretchen, I think you will agree that Medicare actually has much at stake in the medical care that is now being provided to people who live in long-term care facilities. So we thought a careful review of these medical experiences would be just what the doctor ordered this morning.

We will begin with highlights from two studies that the Foundation is releasing today and as you've heard, they are in your packets. Dr. Gretchen Jacobson, a principal policy analyst at the Kaiser Family Foundation, will present key findings from a quantitative study that we did to answer the following questions.

Do residents in long-term care facilities have relatively high Medicare spending? That actually

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wasn't know before the study. What services do they use? Do they have relatively high hospitalization rates and, if so, to what extent are these hospital admissions, do they appear to be potentially preventable? What are the implications for Medicare spending?

The second study is more qualitative. It aims to get beneath the numbers that you will hear about first to help explain why nursing home residents are relatively frequent users of hospital services, and have high rates of trips to the ER and use a lot of post-acute care.

Michael Perry, a partner at Lake Research Partners, interviewed doctors, nurses, and others who care for patients in nursing homes and their family members of residents to try to get beneath the numbers and help us understand what are the factors that drive relatively high rates of service use.

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We will then turn to our panel of incredible experts and I'm going to introduce them quickly, although we'll get to them a bit later, just to keep the ball rolling. So let me start, we're going to begin with Toby Edelman. Toby's a senior policy attorney with the Center for Medicare Advocacy.

Toby has represented older people in long-term care facilities for many, many years. She is widely considered an expert both on policy issues and litigation related to nursing home issues and consumer protections and we're very happy to have you here.

We will then turn to Dr. Cheryl Phillips, the Chief Medical Officer of On Lok that we've already heard a great deal about this morning. On Lok is a wonderful example of integrated care for this population. Cheryl is the immediate Past President of the American Geriatrics Society and was previously President of the American Medical Directors'

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Association, an association of physicians that work with long-term care patients.

We will then turn to Larry Minnix. Larry is President and CEO of the American Associations of Home and Services for the Aging where he has been for nearly 10 years. He is passionate about long-term care issues. I have to say he is one of the funniest speakers about these issues. So we'll look forward to hearing from him. So we are going to start with Gretchen. Thank you.

GRETCHEN JACOBSON: Good morning. This morning I'm going to present our findings from our research examining Medicare spending and the use of medical services for people on Medicare who live in nursing homes and other long-term care facilities. I would first like to thank my co-authors, Tricia Neuman and Anthony Damico.

As Tricia explained, although people on Medicare who live in nursing homes and other long-term

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care facilities are frailer and sicker, we do not typically think of them as having high Medicare spending because Medicaid, not Medicare, typically pays for the cost of the facility. However, Medicare does cover the cost of their medical care.

Now there's been a fair amount of attention on high Medicaid costs incurred by people in long-term care facilities but we wanted to know if these people also incurred high Medicare costs resulting from their medical care.

So we looked at Medicare expenditures of people living in nursing homes and other long-term care facilities using the Medicare survey and claims data from the Medicare Current Beneficiaries Survey. We recognize that people may incur high expenses prior to entering long-term care facilities because something may have happened to their health, such as a stroke or a fall when they were still living in their homes if that resulted in them being admitted to the facility.

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So we focused our analysis on only those events and expenditures that occurred after they were admitted to the facility.

As you can see from the slide, we found for people on Medicare in long-term care facilities, Medicare spent, on average over year, more than $14,000 per person. In comparison, for people in Medicare living in the community, Medicare spent on average over year $6,700 per person. We next wanted to see why this population in long-term care facilities was so expensive and what Medicare covered services were using.

We found that people in Medicare who were living in long-term care facilities had high rates of emergency room visits, hospital visits, and skilled nursing facility stays. For example as you can see in the slide, half of the beneficiaries living in long-term care facilities had emergency room visits. In

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comparison, only 28-percent of people living in the community had an emergency room visit.

Thirty-eight-percent of beneficiaries living in long-term care facilities were admitted to the hospital at least once while only half as many, 19-percent, living in the community were admitted. High rates of hospital admissions are a concern because hospital admissions in the elderly are associated with hospital-acquired infections and cognitive decline.

More than a quarter of the people living in long-term care facilities had a skilled nursing facility stay, which likely occurred after the hospitalization. In comparison, only three-percent of beneficiaries living in the community had a skilled nursing facility stay. The people in long-term care facilities also not surprisingly, used a fair amount of hospice and surprisingly, also used a fair amount of home health.

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Now just focusing on the finding for hospital admissions, we looked at the conditions from which people were admitted to the hospital and found that 24-percent of these hospitalizations were potentially preventable. Other researchers have estimated that between 30 and 67-percent of hospitalizations of people in long-term care facilities are potentially preventable.

So we can now see that people on Medicare living in long-term care facilities used many high-cost medical services, at least some of which were potentially preventable.

We then dug into the most costly services, the emergency room visits, hospital visits, and skilled nursing facility stays and found that people living in long-term care facilities had multiple hospital visits, multiple emergency room visits, and multiple skilled nursing facility stays.

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For example, among the people who went to the emergency room, half of them were sent back to the emergency room at least one time during the year. Among the people who were admitted to the hospital, 41-percent of them were readmitted at least one time during the course of the year and stayed a total of 13 days in the hospital during the year. In comparison, the beneficiaries living in the community stayed a total of nine days, on average, in the hospital during the year.

Finally, among the people who had a skilled nursing facility stay, more than one-third had multiple stays in the skilled nursing facility and stayed a total of 40 days on average in a skilled nursing facility as compared to an average of 23 days among people who lived in the community.

As you can see, people on Medicare in long-term care facilities not only frequently had emergency room visits, hospital visits, and skilled nursing

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facility stays but they often used these services multiple times during the year and stayed a relatively long time.

This high use of medical care adds up to high Medicare spending. The first bar on the left shows the average Medicare spending, people living in long-term care facilities, which was on average more than $14,000 per person per year.

Overall, the largest expenditures are for hospitalizations, which account for almost 40-percent of all expenditures followed by stays in skilled nursing facilities, which account for another 20-percent. The remainder of the spending is medical provider visits, outpatient care, home health, hospice, and other services.

Recognizing that many people have high spending in the last months of life, we bifurcated the long-term care population into those who died before the end of the calendar year, the decedents, and those

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who did not die who we called the survivors. As you can see, average Medicare spending for those who lived a full year in a long-term care facility average about $12,000 per person and average spending for those who died during the year averaged more than $20,000 per person.

We expected people who died to have high spending, which they did, but the people who survived still had high spending. As you may recall, average spending for people living in the community was only $6,700 per person. For both people who lived a full year in a long-term care facility and those who died during the year, hospitalizations accounted for the largest share of expenditures followed by stays in skilled nursing facilities.

However, for the people who died during the year, hospitalizations accounted for an even larger share of expenditures than for those who did not die. For both those who died during the year and the people

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who lived a full year in the long-term care facility, hospitalizations and skilled nursing facility stays that followed the hospitalizations together accounted for more than half the Medicare spending.

Given these findings, we then estimated how much Medicare could potentially save if we were able to reduce some of the avoidable hospitalizations among the long-term care population. So we know from other research that between 30 and 60-percent of hospitalizations could potentially be prevented.

We estimated that if hospitalizations and long-term care population could be reduced by 25-percent, Medicare could save at least $2.1 billion in 2010 alone. We did not estimate the cost of the interventions but we still think this is a conservative estimate because it does not include spending for skilled nursing facility stays that may follow the hospitalizations that were prevented nor does it include expenditures for emergency room visits or

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ambulance costs. The estimate does not include any savings to Medicaid that may result from pure hospitalizations.

In summary, when we step back to look at the research produced, we conclude that delivery system reforms that improve the delivery of care and reduce avoidable hospitalizations may not only improve the quality of care provided to the long-term care population but may also reduce Medicare spending.

TRICIA NEUMAN: Great. Thank you very much. Mike?

MICHAEL PERRY: In the spirit of full disclosure, I need to tell you I'm not an expert in this topic. I'm a public opinion researcher and if I'm an expert in anything, which is doubtful, it is telling people stories, listening to people, and I tried to do that on this study.

Let me thank my co-authors because I would've been hopeless in writing this report without them, my

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colleague Julia Cummings who's in the audience, Gretchen and Tricia who are up here and Juliette Cubanski who is in the front row there, thank you very much. Let me tell you what we did. I think you'll find this study as interesting as I did doing it.

We interviewed 43 individuals involved in long-term care this past April. We told them their names would not be used in the report and because we did that, we had very frank, honest conversations about what happens on the ground in long-term care facilities when it comes to decisions around whether to hospitalize an individual or not.

We went to four different cities. We talked about nine to 15 people in each city. We talked to medical directors, attending physicians, nurse practitioners, social workers. We talked to family members as well. The family members had to be very closely involved in the care of the individual in the long-term care resident and they also, the individual

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had to have an ER visit in the last year because we wanted to talk to them about that visit.

We tried to get a mix of facilities. So we talked to people in nursing homes and people in assisted living facilities and some of the nursing homes had skilled units. Some of them did not. We talked to for-profit, non-profit, highly rated facilities, lower rated facilities.

Although this is qualitative research and only 43 people, I think it was striking how much similarity we heard from site to site to site and across these different facilities. Of course it doesn't come down to one big factor driving hospitalization. It takes a number of different circumstances and issues. I'll highlight some of them right now.

This quote is from a social worker in Miami. We heard this kind of quote, this kind of comment in every site that we went to. She said, "I called them frequent fliers. They come and they go."

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As that quote suggests, hospitalizations in long-term care residents are very routine, almost daily kinds of events. We heard some frustration among the providers in this study that more can be done bedside, in the facility to keep the individual out of the hospital. So we did hear that frustration of wanting to do more bedside care.

At the same time we did encounter a number of providers who really were more comfortable with these hospitalizations, who felt that they were giving the resident better care, that it was more convenient. The tests could come back quicker if they hospitalize the individual. So we heard both points of view and I highlight them both in the study.

We also heard the impact that these hospitalizations can have on frail individuals in long-term care settings that often there's disorientation and confusion upon return. This is particularly true with individuals with dementia.

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We encountered many family members who had family members suffering from dementia on different medications with new infections they got in the hospitals; so spiraling downward in their health. There was acknowledgment that these hospitalizations can really have a negative impact on these individuals.

So this theme of limitations, limitations on individuals to do more in facilities to care for these individuals, two quotes here. The first one I think is telling. A family member in Phoenix said "it was very difficult to get any of the testing done. Anything that needed to be done took forever and so it's actually much quicker to go to a hospital."

Some of the other limitations we heard had to do with licensing that because of licensing, some facilities were unable to do basic kinds of care, IVs, draw blood, those kinds of things. We also heard that if testing is done in the facility, it requires an outside vendor coming in doing the testing, sending the

testing out and so a delay, often of days, to get test results back.

We also heard there are too few nurses caring for too many residents. That was the theme in every single site we went to. Family members talked about that a lot. There just are not enough nurses and skilled medical staff to go around. If there is a crisis in room 25 and room 60, if there's another medical crisis, they can't deal with that.

That person ends up going to the ER. We also heard that there's not enough trained and experienced nurses to provide care. There's a lot of turnover. There's a lot of staff not familiar with residents and their families and their needs and the medications they're on.

We also heard that there is no protocol or policy within facilities to deal with medical crises. There may be a binder somewhere locked away in a drawer but there's not ongoing training and updating of

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protocol within facilities. I could spend all day on this slide alone. It was fascinating, some of the people we had in the study.

This slide is about physician preferences, their philosophy and how that can really shape when there's a hospitalization and when there's not. I need to read this first quote of the medical director in Philadelphia. Here's what he said. He said "they go to the hospital. I'm going to be at the hospital anyhow. I'm going to be there from 8AM to 2:30PM.

For me to see two more or three more patients at the hospital versus running around at the nursing home is going to be logistically easier, more effective, better coordinated, and financially profitable. I would have to be a moron to leave the patients that are moderately ill that I have to see daily at the nursing home right?"

Again I think the fact that I promised him confidentiality was the reason he was so forthcoming.

I think he regretted that comment immediately but then the quote below also was heard in these studies.

I quoted from a medical director who tries everything he can possibly do to keep the patient in their homes, in their beds, in their rooms, and prolong and put off hospitalization and that doing what's best for the patient is really driving his decision making around hospitalizations or not. So we heard these tensions and these different points of view and these different philosophies across a study. Those have huge impacts on whether a resident's going to go to the hospital or not.

In both of those quotes, you see a mention of financial incentives. That came up in our focus groups a lot. There is a perception that doctors make more money and can charge more frequently when they hospitalize a long-term care resident that they can bill more frequently, bill at higher amounts, and that came up from physicians themselves and from nurses and

others in the study. It's unclear what role that plays in driving hospitalization but certainly it's in the mix and something that needs to be looked at.

Relationship between staff and patient relationship is key when it comes to hospitalization we learned. The first quote here from a physician in Miami, "we're all trained to say I don't know this patient, send them to the ER and call me from there," but the lower quote from the social worker in Phoenix tells a different story. She said "I know every one of my people inside and out. I can tell you the family members probably even phone numbers. I think that helps. I don't have that many hospitalizations." So knowing the resident really does matter.

We heard that often the first couple of months when a resident is new to a facility, that's when the hospitalizations happen. That's when they don't know that individual. They're unclear how that individual reacts to different medications and issues. They don't

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know that family and that's where more panic kind of decision making often happens and they get sent to the hospital.

Relationship between staff and family members, we had talked to 15 family members in the study. We thought the most compelling comments, the most passionate pleas for fewer hospitalizations would really come from the family members. That didn't happen actually. We found most of the family members in our study really to be on the sidelines of decisions around hospitalizations. We found a reluctance to second guess the decisions that were made. A whole bunch of complex feelings go into this.

One interesting issue was that the hospitalizations in every case, the family members were not called in advance of sending the individual to the ER. They were told after the fact.

They were told when they were on the way to the ER literally were not in the decision making around

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hospitalizing or not. But we also saw from the family members' points of view, a lot of complex feelings particularly when there is a loved one placed in a nursing home, around neglect in terms of not wanting to stop them from getting the care that they might need. So the family members we found fairly passive, not really in the decision making around this.

The next slide speaks to liability. It's sort of self-explanatory. This quote is a great quote from a physician in St. Louis that "I think liability drives a lot of what we do." She concludes by saying "I don't want to be in litigation with anyone over a health care issue."

What underlies this is knowing the resident again. When there's a relationship and when they know the family, they can go a little slower in providing the care. They don't have to make a panic kind of decision. When there is not that relationship that's when the panic decision making occurs.

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So let me wrap up by identifying some of the ideas that emerge from the study. These ideas came from these providers, the doctors, the social workers, the nurses, the family members. The first has to do with managing transitions. We heard a little bit about transitions earlier. I haven't mentioned it in my presentation. It came up a lot.

A lot of the providers talked about ERs being black holes of information that the resident goes to the ER. They don't know what happens in the ER. They don't know what medications they're given.

They don't know what treatments are done and then they are sent back to the facility without a record accompanying them, with no phone call from a discharge nurse, with no communication between physicians. So clearly that is something that needs to be addressed or worked on as something the providers in the study mentioned.

Reviewing financial incentives and lack of disincentives for hospitalizations, it is clear that hospitalizing a resident, a long-term care resident who might have a medical need, is the path of least resistance. One of the reasons behind that might be around the incentives and disincentives that need to be explored.

Another idea is provide more support and training for staff. It's clear with the turnaround and the lack of training and not having protocols, a lot more needs to be going on in terms of in the facility training staff.

Lastly, is considering a philosophy switch and it's the point I made earlier: why is hospitalization so often the easiest path, the path of least resistance? There was an urge to really try and go slower and providing care and rethink the philosophy of how we care for people in long-term care settings. I'll stop there.

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TRICIA NEUMAN: That's great. You all have been very patient. I'm going to ask you to be patient because we do want to hear from you. We want your questions but I'm going to turn to our panel now. I'm going to begin with Toby.

Before I do, I just want to point out there's actually a third report in your folder that explores financial incentives with regard to hospitalizations for long-term care facility residents written by the folks at Health Policy Alternatives. So for those of you who are interested in that issue in particular, it's rather technical in nature but we thought it would be important to put out there. Toby?

TOBY S. EDELMAN: Thank you. One cause of the hospitalization of nursing home residents is that residents are discharged too soon from the hospital. Many hospitalizations occur within the first few days of the nursing home placement partly because the facility doesn't really know the resident but partly

because the person really does need to be in the hospital.

The physician issue, the lack of physicians in nursing homes, has been an issue for decades. The Senate Aging Committee in the 1970s, in its series "Nursing Homes' Failure in Public Policy" had one report devoted specifically to the absence of physicians in nursing homes. This absence of physicians was recently raised by the nursing home industry when the Drug Enforcement Administration began enforcing longstanding rules that require physicians to sign prescriptions for controlled substances.

Federal law requires nursing homes to have doctors on call for emergencies but nursing homes, the consultant pharmacists, and others argued that nursing homes can't comply because their doctors don't have offices. They practice out of their cars and they don't have fax machines. I recognize that there are multiple factors contributing to the hospitalization of

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nursing home residents but I want to focus on what I think is the most important factor and that's the lack of nurses, both the professional nurses and the para-professionals.

In 2001, CMS issued a report to Congress about inadequate staffing in nursing homes. CMS reported that more than 97-percent do not have sufficient staff to prevent avoidable harm to residents and 91-percent did not have sufficient staff to meet five key care processes that nursing home residents required.

There aren't enough registered nurses in nursing homes and there are many, many studies about the correlation of high registered nurse staffing with better quality of care for residents. There's not enough para-professional staff either. Money is not the issue for Medicare nursing home residents. The Medicare rate per day per resident is six to $700 a day and even higher. So the money is there.

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Resident acuity has increased certainly in the decade since the CMS report was issued but staffing hasn't changed. Staffing was inadequate then. It's more inadequate today. The lack of consistent assignment of staff to residents is another very important staffing issue.

The consequence of lack of consistent assignment is that staff don't know the residents very well. They don't know if the problem the resident is experiencing is part of the normal pattern or something out of the ordinary and two things happen. Two opposite things happen.

Sometimes nursing homes send people to the hospital who do need to go but, on the other hand, and maybe even more frequently, they ignore the acute needs of residents who do need to go to the hospital. There are many enforcement cases on exactly that point.

Largely as a result of inadequate staffing, there's a lot of poor care in nursing homes that leads

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to bad outcomes for residents that could have been avoided if better care had been provided in the facility.

Earlier this year, the Centers for Disease Control and Prevention reported that in 2004, eight-percent of residents nationwide had an emergency room visit in the prior 90 days and that 40-percent of those visits were avoidable. The leading cause was falls.

One of the most common reasons for falls is that a resident needs to be transferred with two staff members. There aren't enough people around. One staff person tries. The person falls. The resident falls, breaks her hip, goes to the hospital. I was reading a case about this yesterday --- happens constantly.

What the CDC said was that some of the conditions leading to the emergency room visits could have been more properly treated in the nursing home and other conditions should have been avoided by preventing the bad outcome. What this means to many advocates who

have been looking at this for many years is what we call the high cost of poor care.

We don't pay for care to prevent avoidable bad outcomes for residents. We pay for the bad results that should never have happened, avoidable pressure sores, avoidable incontinence, and many other bad things that shouldn't have happened to residents with better care.

In 1991, nearly 20 years ago, the Senate Labor and Human Resources Subcommittee on Aging issued a staff report that identified the high cost of poor care and quantified the costs citing the research literature.

It quantified, this is 20-year old reports, so the data's even older than that, but the cost for incontinence care, avoidable incontinence care, was over $3 billion. Preventing avoidable pressure ulcers, up to $12 billion a year, hip fractures for residents,

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$1 billion, and the fourth point they identified was hospitalization for nursing home residents.

This part of the report was based on the work of Dr. Jeanie Kayser-Jones, a nurse anthropologist at the University of California-San Francisco. In the 1989 article about factors contributing to the hospitalization of residents, she identified many factors generally the same ones we've heard today, lack of x-ray and pharmacy services in the nursing home, physician convenience, family pressures, which she identified. She found that almost half of the hospitalizations were not necessary.

Residents could have been cared for in the nursing homes. What Dr. Kayser-Jones identified 20 years ago as the predominant factor of hospitalization was what she called the insufficient number of adequately trained nursing home staff. Residents have gotten sicker and need more care since she did her research in 1985-88 and staffing hasn't changed.

I think until we solve the staffing problem, the nurse staffing problem in nursing homes, we will not be able to get the hospitalization issue under control. Thank you.

TRICIA NEUMAN: Thank you, Toby. Now I think we'll get a physician's perspective, Cheryl.

CHERYL PHILLIPS: Thank you. In addition to the organizations that you heard from, my clinical practice prior to being in On Lok has been a passionate journey through long-term care for the past 20-some years as an attending physician, a medical director, a teacher, a policy advocate, and a daughter. So I think understanding how each of us experience this continuum of long-term care plays into our understanding.

Let me take you a little bit of a journey because you're going to hear some common themes. It's 2:00 in the afternoon and a committed busy primary care physician is looking at 11 people waiting in her waiting room and there's a call from a nursing home.

She's made a commitment to following her own patients in the nursing home. She has seven patients in four different places.

One of the nursing homes calls and says Mrs. M doesn't look so good --- if I could get a nickel for every time that phrase gets started out in the conversation --- she has a mildly elevated temp. She has a cough. She's not eating well. By her own admission, she doesn't feel well. This physician is struggling with do I have all 11 people, those of you who spent your time off work to go visit your PCP, don't want to wait another four hours. She's also worried about the fact that Mrs. M can decline, knowing that she had been in the hospital six months ago.

So the easiest not out of convenience but the perception of best care is let's go ahead and send Mrs. M to the hospital and I'll wait and see what the ER finds. Let's now go to Friday afternoon. It's a relatively small nursing facility of about 100 beds and

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they have a small skilled unit. They've had three admissions that day.

The DON [Director of Nursing] is getting ready to leave for the weekend and two of the nurses for the weekend have called in sick. She is struggling, she is trying to pull in per diem nurses and one of the long-term care residents now is not eating well, is looking not so good, again that phrase "doesn't look very well." The nursing staff on that side is concerned and the DON says "you know what; I can't deal with another IV. We need to get an order from the doc to send them out."

The third patient, Mr. G, just got back from the hospital three days ago, unfortunately has a diagnosis of metastatic colon cancer. He was managed well with oral meds in the hospital. Nobody expected a pain issue. It's now 7:00 at night. He's in the nursing facility.

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The physician who follows him actually knows Mr. G very well. The nurse has called and said this person's really in significant pain. The family understands the diagnosis. They're not excited about a transfer but they are at the bedside.

The doc who is not doing this out of lack of convenience but actually tries to call the pharmacy with the 1-800 number and is told he is going to get a message back. Meanwhile he calls the nurse who has morphine in the facility but because of the DEA regulations that Ms. Edelman referred to, is not able to access. The family, in their frustration, says this is nuts. It's been 45 minutes. We don't know where this is going. Let's just send him out. We can't leave him uncomfortable.

Every one of those cases drives an outcome. None of it is driven explicitly by self-serving needs but there are common themes that you've heard. One is workforce, trained, skilled, onsite, adequate workforce

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that know how to assess, can manage problems, and can work in a very fluid way within the continuum of services, whether it's x-rays, labs, physicians, emergency room. The second is the need for truly team-based care.

Where you will hear the solutions that have been very effective and addressing this hospitalization rate and long-term care models like Ever Care, models like On Lok, the originator with the PACE program, it starts with a team-based, interdisciplinary, I like to say in California, we're transdisciplinary.

The difference being multidisciplinary is I do my job, you do yours and I might look at your note if I have time. Interdisciplinary says we actually talk together once in a while. Transdisciplinary says we fluidly blend. Those are the answers that help start this and certainly form follows finance when we pay providers to do units of service by visit.

That's what we get and we will get it in the most efficient place. If we can start thinking about models of payment that look at populations and accountability and a team-based approach, we'll have a very different outcome.

TRICIA NEUMAN: Thank you very much. I think Larry's going to tell us what we should do about it.

LARRY MINNIX: Alright, I come out of the provider world, been in that world for 40 years. What I'm hearing here today in these further studies really reinforce are five major strategies that we've put forward with our members and beyond to improve quality and to address the whole financial issue.

What I'm going to talk about today are things that can be done because people are doing them. So they hold a lot of promise. The issue is how do you collectively gather the information to say systemic change should be made around policy?

Dr. Berwick, I believe, CMS, HHS providing the kind of leadership at the top around system thinking. One of the points he made that I think really needs to be underscored, leadership systems thinker guru Peter Singhi has reinforced, that systems are perfectly designed to produce what they produce. So if we don't like the outcome, you can blame the people doing it but unless you go back upstream and change the system, we're going to keep getting something none of us like.

Another principle that Jim Collins has put forth and this is what I say to our members, leadership matters. There are people that are highly successful in the same environments in which others fail. So I have members that have had, I've got one member that has 13 years of deficiency-free surveys while somebody down the street can't get a break it seems.

So what is the person with 13 deficiency-free surveys doing around managing and leading better than the people that are having difficulty? I have members

that have 150-percent turnover employees and I have others with single digit or even, I've run across that have a waiting list to work there.

What's the difference? So those principles and here are the five major strategies that I think have been seen in the research and you have heard from other panelists and certainly signaled by Dr. Berwick.

We have to adopt a quality improvement management culture and a quality of life living culture. The most promising approach to that is coming together in the mechanism called advancing excellence; Dr. Mary Jane Koren chairs that effort. It is the most promising thing around improving clinical quality and also beginning to help nursing homes measure culture and deserves a lot more attention. There are groups like Greenhouses and hospice, emphasis on palliative care.

Now you hear terms like Eden Alternative, that's culture change. Now I've been in a lot of

places and I see a lot of fat dogs in bird cages. That does not necessarily mean there's a new culture inside the nursing home but culture change is working. It has to be complemented by quality improvement management culture. Second major emphasis is on talented people from bedside to boardroom.

The best proxy we have for quality is still staffing and it's direct care staffing. Those people often don't get enough respect because we don't provide them really good supervisors. We don't provide the clinical leadership through the right medical direction and the right support for gerontological nurse practitioners.

The presence of strong medical directors, strong nursing leaders has a huge impact on how you attract, retain, reinforce direct care workers.

On family attitudes, the single biggest reason the not-for-profit sector winds up in a court of law is bad relationships with families. It's not necessarily

because we've done something terrible or can't document something we have done and we don't train relationships. We tend to see people as commodities as opposed to the key to what actually occurs.

So we have to really reinforce, those people that have healthy cultures and low turnover are doing things like outstanding leadership development programs that include CNAs and people that work in nutrition departments and maintenance departments, career ladders, lattices, etc.

The third strategy is models that manage transition. There are plenty of those that do that well. They're just fragmented and they're under a lot of different labels. Hospice is the longest standing example. We can all learn a lot from hospice, PACE, SOURCE in Georgia, I remember in the early days of SOURCE program that I was involved in, it was a PACE-like program for Medicaid-eligible SSI recipients in an inner city community.

One of our first clients was a woman on 52 medicines including 12 inhalers. Now a doctor prescribed every one of those. She had gotten them from clinics plus some stuff she borrowed from neighbors. I would say that the right approach to the right doctor, the nurse, right case manager got that squared away.

The fourth area is finance and the incentives are misaligned all over the place. We have to come back and look at the integrated care that needs to be delivered and design the financing especially to attract and retain the people. In order to do that, you cannot deliver good nursing home care for $5 an hour, which is what about the rate is in Illinois for Medicaid. You just can't do it for that so somebody's got to look at it.

Finally, technology that pulls all that together. I sat next to a young soldier heading to Iraq and I asked him about his health care and he

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pulled out a card and said "if I get wounded in battle, they got my record right up here. I can be treated from Walter Reed."

And if you're a nursing home resident, leave a nursing home to go down the street to a hospital, you may or may not have come back with anybody that has your record or knows anything about you. If we can do it for that soldier and by George we should, we can do it for every Medicare beneficiary.

So what I'm hearing is stuff that needs to be done and it's not a resource issue. It's a leadership issue, not just at the national level, which I believe we're getting, but it's a local level. It means that everyone at the local level has got to be willing to do things differently together to solve these problems because until we do, we'll have any number of seminars and papers that quantify the problem and how much we don't like it.

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TRICIA NEUMAN: Okay, well as you're getting your questions ready, I'm going to, well actually why don't you join me in thanking everybody because that was really terrific [Applause]. I'm now going to take the prerogative of moderating this session. I'm going to throw out a few questions as you get your acts together.

My first question to really anybody who wants to answer it is this, the health inform law has a lot in it that is intended to improve the delivery of care. I'm thinking well we've heard about the Center for Medicare and Medicaid Innovations, there are efforts to reduce hospitalizations, preventable hospitalizations.

From your point of view, what would you see as the most promising parts of the health reform law? Are there provisions that could be used as a vehicle to address this issue or not? I'd love to have your thoughts. So who wants to take that?

CHERYL PHILLIPS: Well I think two important areas that we heard discussed already. One is a focus on workforce. The Affordable Care Act is by no means a panacea but it does start the dialogue of the value of the workforce both the health care professionals across the disciplines but also the direct care providers.

Then secondly are some of the very promising models and we use these words like jargon but they really are at the heart of the solution, person-centered, team-based, integrated care. When you can develop projects that demonstrate how that works and how it can be scaled to my community, your community to states, and across the country, the Affordable Care Act gives us some platform to start to do that. So workforce and models of person-centered, integrated care coordination.

LARRY MINNIX: Yes, we are very encouraged by what's in the Act. What it's done is unfreeze a very rigid encrusted approach to things. The question

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becomes how long will it stay unfrozen to make changes. If it stays unfrozen a couple of years, we're in for another decade of difficulty.

If however, what's been introduced allows for pilots and innovation over a period of time and we take, at the local and national level, more of an experimentation mentality, we can make a lot of changes.

I think you heard Dr. Berwick talk about any number of innovative things could fit into where health care is going but I think what the law did, in my world, is say let's think globally and give some room to act locally. It's a matter politically of how long we're willing to let that door stay open to get some good things done.

TOBY S. EDELMAN: I think the various efforts in the Affordable Care Act to coordinate care could lead to some positive changes for beneficiaries. One of the parts we haven't mentioned yet is the bundling

demonstration that makes hospitals responsible for what happens to the beneficiaries for a period of 30 days.

One of the problems in the health care system is that various providers can push the responsibility off on to another provider and if they're accountable together, if they're all responsible for the care of residents over a longer period of time, I think that could make a difference.

TRICIA NEUMAN: Okay, I have more questions but I'm wondering if you do too. So if you have questions, there are mics. So if you can get the attention of people with the mics, there's two and if you could stand up and introduce yourself, Tiffany or Judy.

JUDY PARIS: Hi, I'm Judy Paris. I'm a clinical social worker working on a transformation project with the Center for Practical Bioethics. I'd be interested in the panel's response to the role that advanced care planning could play. Even though it's

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just a small role and I know that coordinated care, interdisciplinary care is critical but particularly, and I know Mike Perry didn't look at the states that have the most, the physician orders for life sustaining treatment. What role do you think that that might help with the transitions?

CHERYL PHILLIPS: Well I would love to jump in on this one. I had warned Tricia that this could easily be an entire day symposia because one of my bullets that I think is absolutely essential is advanced care planning. It's not a, do you want CPR or no CPR decision. It's again person-centered, goal-based, what do you understand is happening with you and your illness? What would you like to happen?

What are your goals? The substantive discussion that is then shared and integrated into a forward-going care plan is really the essence of advanced care planning. That makes, by itself, a huge impact in the unnecessary and unwanted and expensive

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transfers back and forth between multiple settings when we start with a context of what is it that the person wants and what are the best services I can envelope around that help meet your goals?

Very often those conversations don't happen until the emergency room transfer and that is, talk about a day late and a dollar short. So polls smolls, we in California have now legislatively integrated it. It's now part of both our On Lok PACE model. We're also working at rolling it out across PACE organizations but it's not just a document. It's not just a check-off the box: do you want this or not this? But it's really a substantive discussion that starts that journey of where a person wants to go and how we help them to get there.

TRICIA NEUMAN: Larry?

LARRY MINNIX: Yes, I think this is a very hard topic to talk about because people immediately run to visceral kinds of issues. I had a friend whose

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grandmother died at 100-plus and lived with his mother and she had a routine every day and one day she said, I'm not going out to take my walk. The daughter said why?

She said because I'm going to go lay down. She said why? She said because I'm dying. She said oh my. So she called the sister who lived next door and they come over. Mother, we're going to call the ambulance and she said nonsense, I don't need an ambulance to help me die. She said what do you want us to do? She said well sit here and hold my hand. My time has come.

Now there is something that went on in that family or in that woman's mind that she made some decisions about that that were probably not codified in a living will or something but that's the conversation that needs to take place in America but people need to be able to talk about those things and to just open the

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discussion creates almost a political visceral thing like abortion where it freezes a room.

We got to get beyond freezing the room because there does come a time. Woody Allen said he didn't want to achieve immortality through his art. He wanted to achieve immortality through not dying [Laughter] and that's part of the American mentality but there comes a time and a place and both, we went through this with both my parents, my wife's parents. It's very critical that that not be a checklist box on the admission but a substantive discussion I don't think we found a way to have yet in this country but we must have it.

TRICIA NEUMAN: Mike, I know this was an issue that came up in your interviews, I don't know if you interviewed Woody Allen but I think others might have talked about this.

MICHAEL PERRY: It did. It did come up and it is touched on in the report. The way it came up mostly was the potential of advanced care planning. If done

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right and thoughtfully and updated frequently really could prevent hospitalization but that wasn't happening in the sites that we went to.

We had providers openly talk about their confusion about whether it was their role or not to be the one to really ignite a conversation around a family discussing, around decision making and updating, advanced care planning.

I will also say we did have a hospice nurse and a social worker who deals with hospice in the study too and it was fascinating to have them talk about the decision making around hospitalization for those residents were so much clearer. There were so many more conversations about what that individual wanted and didn't want and much more clarity around and much less, as you would imagine, hospitalization in those cases. But that's how it emerged in our study.

LARRY MINNIX: I have a follow-up question. I asked a group of lawyers once how many of you have

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living wills, advanced directives and a small percentage of the hands went up. How many of you have advanced directives, durable power of attorney for health care are living wills? Great. The rest of you, let the probate court and the lawyers work it out but it's about what, half the room here? We all have to face that.

TRICIA NEUMAN: Looked like a little bit more but this is not your average room, maybe given where we are.

HOWARD GLECKMAN: Howard Gleckman at the Urban Institute, actually Alistair Cooke said in America death is optional. Two questions, a very quick data question. Toby mentioned the CDC study and they looked at some of the diagnoses for these admissions.

Did you all look at that and could you tell us what you've found? The other question is more of a qualitative one, a lot of what's in the Affordable Care Act is going to drive patients out of hospitals. Many

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of them will be going into nursing homes. What are the results of the study and others tell you about whether nursing homes are ready to accept those patients?

TRICIA NEUMAN: Gretchen, do you want to take at least the first question?

GRETCHEN JACOBSON: Yes, I'll take the first one. So we did look at, as I explained, I mean it's a good question, of why they went into the hospital. We looked at the extent to which they were ambulatory care-sensitive conditions, which are conditions that have been identified as potentially preventable, and that's how we calculated that 24-percent of the admissions were for ambulatory care-sensitive conditions, which were potentially preventable.

The exact conditions I can't recall off the top of my head to be perfectly honest, or which ones were at the top of the list, but that's something that we could look at.

TRICIA NEUMAN: How about the next question about the capacity of long-term care facilities to take people coming out of the hospital and I'm going to throw another question on top of that one and ask about different types of facilities because there are nursing homes, there's assisted living, there's retirement communities, there's step-down facilities. So there's a whole range out there and what's the capacity out there to deal with people who are being shifted out of hospitals?

LARRY MINNIX: I would say that the best equipped, oftentimes, are continuing care retirement communities. There's some 1,900 of those and that's a model that manages transitions better than a lot of places. They're capable. They're specialized post-acute care facilities that can handle it. I think the broader question is I don't think people are going to be driven so much toward nursing home or long-term care facilities if they want to go home.

The bigger issue is how do we equip families when they walk out the door to be able to say, Cheryl could tell us but it's the first 48 or 72 hours when you get home, they're critical. So I think we have a huge public education job more than anything else. Some facilities can handle this and if they connect themselves to hospitals and have good doctors, they'll get even better at it. Those that remain isolated may have difficulty.

I worry about some settings of assisted living because they're not equipped to handle emergency responses oftentimes and yet they mean well. Then there's some that are not identified very well at all but most people want to go home.

So how is the health care delivery system, your Accountable Care Organization, going to prepare them beyond a list in the Yellow Pages that says you got 72 hours, find a place? That is not transition managed care that we need to have.

So we're all going to have to, it becomes a team approach. I'm convinced that most bed sores now occur in ambulances. They leave the nursing home, they didn't have a bed sore. They go to the hospital, they didn't have one when they left there. They get back to the nursing home, they got a bed sore. So it must have happened in the ambulance.

CHERYL PHILLIPS: All records are lost in the ambulance.

LARRY MINNIX: All records, so ambulances are a repository for a black hole of records and creation of bed sores. Please don't quote me on that [Laughter]. That is a tongue-in-cheek comment but the point is we have to take a systemic approach to all of that now at the local leadership level. We can no longer blame, fragment, pass off, Yellow Page. It's got to be a comprehensive community approach.

TRICIA NEUMAN: Toby?

TOBY S. EDELMAN: As concerned as I am about the nurse staffing in nursing homes, the problem is definitely far worse in assisted living. There are no federal standards for assisted living. They're all state standards. Some states allow assisted living just to have nurses on call. So there's no actual presence of a nurse in the facility. They really can't manage these problems. I could just say what the CDC found as the causes for emergency room visits.

Falls was the biggest cause, 36-percent, heart conditions, 19-percent, pneumonia, 12-percent, and other conditions combined, mental status changes, urinary tract infections, gastrointestinal bleeding symptoms, fever, metabolic disturbances, skin diseases, 33-percent.

But they also found that potentially preventable emergency room visits, residents had shorter lengths of stay in the nursing home before they were hospitalized, before they were sent to the

emergency room and they took more medications than other residents, 56-percent of the people were taking nine or more medications compared to 50-percent of other residents. So they're overmedicated, getting inappropriate medications.

Certainly one of the things that we're really concerned about now is the use of antipsychotic drugs with nursing home residents. Antipsychotic drugs for residents who do not have a diagnosis supporting the use of that medication occurs in like a third of the residents in the country, not a third, 25-percent of residents in the country nationwide are receiving antipsychotic drugs without a symptom, without a diagnosis justifying the medication and half of the residents who have dementia and behavior disturbances or behavior issues are getting these antipsychotic drugs inappropriately.

A physician from the Food & Drug Administration testified in Congress that he estimated

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15,000 people were dying a year from these antipsychotic drugs. So we're doing lots of things to people that shouldn't be happening.

BRETT KAUFMAN: Hi, Brett Kaufman with insidehealthpolicy.com. I wondered if you could talk a little bit about what you think the CLASS Act, which is contained in the ACA, how this will impact on long-term care, whether it will work, the funding mechanism, and also if you could, who's doing the best at home and community-based services in terms of states like Vermont?

TRICIA NEUMAN: Larry, you look like you want to take this.

LARRY MINNIX: Yes. We believe the CLASS Act, over the next decade, is the most transformational approach to financing all of this that's in the ACA bill. In other countries where that's been employed that's been the case because it's a voluntary self-insurance model.

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And I won't go into a lot of the details but the client can then use money on a cash basis to purchase non-medical services that they need to help them stay at home and that has a downstream effect positively on the Medicaid budget and an unknown effect on the Medicare budget and an unknown effect on the consumers' family budget who spends out-of-pocket that's not calculated anywhere.

So it reinforces the whole mechanism of choice we believe the bill is good. There's safeguards in it and it's part of the long-term solution. I think what it will do for home and community-based services is that it will force people to get entrepreneurial about packages of services that can help people stay at home by the daughter picking up the phone and saying I'm working and mom's home now from the hospital and I need help with things that are not covered in the basic health care delivery system.

I think the issue of helping with transitions there is going to be critical because of the vulnerable time coming out of the hospital. By the way, there's a group called Advanced Class, Inc, that's been created. It's a not-for-profit board that's designed to advance class and public education about these issues.

There's another group called the Long-Term Quality Alliance chaired by Dr. Mary Naylor at Penn that's going to be looking at things like community-wide innovative approaches to the integration and community approaches to care delivery. So keep your eye on those things because those are groups of people that are going to be making a contribution to this whole situation we face.

MALE SPEAKER: Thank you for the really exciting presentation. I think one of the most important points is that you just observed the fragmentation even between the long-term care system and population and the health care system, the fact

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that people who live in long-term care, all the different hodgepodge of kinds, are so expensive, so sick, and so ill-served, it is just really important.

The question I had though goes to the vision of improvement that Dr. Berwick laid out and thousand blooming flowers that I think Larry alluded to and my concern is that this population of people is going to be excluded from that agricultural enterprise of discovery.

Because certainly in other demonstrations, we've seen in the past that the coordinated care demonstration or even what came to be called the, it's also CCIP, the Medicare Health Support Study, residents in long-term care, at least some kinds of long-term care facilities, were excluded. In the medical home demonstration that's on hold, they're optional. So a physician doesn't have to cover those patients.

I'm not sure how the regulations are going to work out for ACOs but it seems to me it could be the

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case that those patients, those people living in long-term care won't have to be in the 5,000 primary care connected patient population that the ACO is accountable for. So I'm really worried that we're really not going to be doing the experiments and doing the innovation that's going to lead to better care for this population. I wondered if you all had any ideas or any sniffs in the wind.

TRICIA NEUMAN: I mean I will say that that was one of the reasons why we wanted to have this briefing because we did think this was an important way to frame the discussion and to focus attention on a population that can clearly benefit from delivery system reforms.

If we've heard nothing more than that today, I think that's pretty clear. Hopefully the folks working in CMS and the Centers for Medicare Innovation will be absorbing or thinking or expanding their work to think

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about how to include this population but I'd love to hear what the others have to say.

CHERYL PHILLIPS: Well I couldn't agree more Chris and I think that is a real concern we all face. These great innovations and models are just going to assume that long-term care is not part of the health care problem or part of the health care answer and we'll just do work arounds but there are some starting points that I think have some open windows for the thousand blooming flowers that at least we can see them.

One is shifting away from single disease entities. Part of the care coordination problem was you had to have a disease. That was great. Most of us who have chronic conditions have more than one and certainly the individuals that I care for have scores.

In part, that's why they end up with an obscene number of medicines because everybody has a best practice guideline that they're following with 12

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different diseases but the models are starting to look at that burden of co-morbid conditions, again more jargon but what does it mean to be a person with not just heart failure but dementia and diabetes and heart failure who also has osteoporosis and broke their hip and how do you create a person-centered quality care package that's not driven by disease models?

To do that, you will end up intersecting with the long-term care environment because many persons with functional limitations are somewhere in that continuum. So I think it is a starting place. I think that, as we focus at viable models of multiple co-morbid conditions, we have an open door. I've kind of coined a phrase polymanagement syndrome. We are so obsessed with managers now for each disease entity.

So if you happen to be that diabetic person with heart failure who left the hospital, you'll get a transitions coach. You'll probably get a heart failure coach. You'll certainly get a diabetic coach because

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there's not a hospital on the planet that doesn't have a diabetic coach.

Now you need a coach to manage your coaches and if heaven forbid you have a cognitive impairment, you don't know who you're talking to nor do you care with conflicting orders, instructions. So I think that as we start looking intelligently at a person with co-morbid conditions, we'll start to open that door for the long-term care continuum, not the complete answer but it's a start.

LARRY MINNIX: We were concerned, in our world, that all the Accountable Care Organizations and bundling and all that would be hospitals and doctors. There was flexibility in the law to allow for other entities.

Now what's beginning to happen, someone mentioned Vermont earlier, there is a low-income housing provider in Vermont, one of our members, Cathedral Square, working with the medical school, the

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medical center, and other agencies around a statewide approach using housing as a platform to do large-scale care management delivery.

I think what smart acute care systems are going to begin to see is that the really good long-term care aging services providers know an awful lot about care management because we do it every day of the year that somebody's not in the hospital.

So for example, in Columbus, Ohio, there is a new specialized housing program for homeless people and those who've come out of mental institutions. Their early returns are their significant savings by the housing organization managing the care and service delivery, some of those in Oregon.

So there are plenty of places where our world can play an important part in the larger world. In fact, it'll be the larger systems advantage to ask us to do that if we really know what we're doing and there are plenty of people that do.

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So I think there's room there as long as we get beyond the siloed thinking of the stereotypes of the big old hospital does this and the doctors do or don't do that and the nursing home is bad. We got to get beyond all that. There's plenty of work to be done and there are plenty of competent people in these institutions to do it if we're willing to work smarter, better, differently together.

JENNIFER FRIEDMAN: Hi, thank you everybody for a great panel. My name's Jennifer Friedman. I'm with the Committee on Ways and Means. Tricia mentioned at the beginning a lot of the delivery system reforms and in the Affordable Care Act, the policy to reduce preventable readmissions at the hospitals.

In the House-passed version of the health reform bill, we had expanded that policy to also include the post-acute providers and the physicians, our rationale being that it's not the hospitals. It's

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not the only one that bares onus for making sure that you avoid a preventable readmission.

The structure there had been a disincentive in building quality performance measures so we could build a structure for the post-acute providers that matched what's in the law for the inpatient hospitals.

So with that, my question for the panel was, I know there's another report having not read it because I've been paying attention not reading it while sitting here, I want to hear what folks thought about possible incentives and my boss typically more likes disincentives, incentives and disincentives that can be used in the post-acute world to try to encourage more integration of care and help to reduce preventable readmissions.

TRICIA NEUMAN: I know Cheryl has strong views about incentives and disincentives so I'm going to let her kick this off.

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CHERYL PHILLIPS: Well I won't make any snarky comments but only focus on the positive. However, there's a reason why we have an entire industry of hospital coders and they aren't bad people but when you say you can't be readmitted for the same diagnosis, you aren't, which is the starting point.

I think that what is interesting and I will use the halo effect we often talk about in research, not that we're all angelic and going to celestial discharges, but the halo effect being that you do one thing and it affects around.

The halo effect of the 30-day readmission actually is a good thing because it starts grabbing the attention that this matters particularly if you look at all-cause readmission and even if we have all the risk adjustments so that the actual financial impact to most hospitals will be negligible. Frankly, the reality is they start to look at it and it starts to matter.

A rather pathetic but very real example, 15 years ago in a hospital that I won't mention, we started an early heart failure program and it was paid for by the hospital, which after six months unpaid for it because we were reducing readmissions for heart failure. That's how skewy, not that any of these were evil people, but that's how skewy all this is.

So if the 30-day readmission starts getting the attention of hospital administrators to say what happens post-discharge matters, that in the sacramental community, 27-percent of persons who go to skilled nursing home are readmitted within 30 days that's not acceptable. That's not a good thing regardless of the cause, regardless of the diagnosis.

So if nothing else, this inclusion in the act of 30-day readmission by itself won't solve the problem but it escalates the awareness that having people go in and out of hospitals is not a good thing. It's a very,

very bad thing. It's a costly thing. It's a wasteful thing.

I would say it's even an abusive thing to be totally provocative because it is driving services by where it is easiest for us to do them rather than where they need to be delivered. It's complex, as you've heard, but I'm hoping that at least the 30-day discussion will get us in a partnership with the players in the continuum of care that says this really does matter.

TRICIA NEUMAN: What would you say about incentives or disincentives for the nursing home or long-term care facility staff in terms of sending people to the hospital because I think what we've heard is that there are no disincentives there that there's every incentive to, as Mike said, take the path of least resistance if somebody falls, you send them to the hospital. If somebody looks, what did you say,

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somebody's not looking right, send them to the hospital. What would you say about that?

CHERYL PHILLIPS: I'm not sure that we are connected enough to have disincentives that actually matter. So not defending the nursing home industry but if you're paying $5 an hour and you say I'm going to pay you less, well that's not exactly going to enhance care nor will it open the door for more admissions.

You'll just have a much tighter less well-run but if you start looking at populations, so if in a true accountable care organization, right now we don't really know what that is or to whom they're accountable but if I were queen and we defined what accountable care was, accountable care would be truly accountable for a population across settings of care so that the end financial incentives were distributed across that setting or settings.

Now we realize it's, at this point, quite naïve because everybody has their separate P&Ls. I'm

concerned that disincentives will close the door for adequate care, not enhance it.

But if we can start looking at rewards across a population through an organized, integrated system of care and there are some models where that works very well from hospital outpatient, ancillary services, home care, nursing home care, and hospice when there is an alignment and there's a responsibility for the population, for the individuals within that population then that starts to work. So maybe it's a new way of looking at the financing model.

When you pay for widgets, you get widgets. When you pay for visits, you get visits. We have a system that's driven to do that. We really can't blame the players in that game because they learned the rules.

TRICIA NEUMAN: Time for one more question I believe. So I think there's a question in the back.

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FRED DECKER: Yes, Fred Decker with the National Center for Health Statistics. We've sort of been talking about it but the elephant in the room is the Medicaid payments and the Medicaid program and to what extent to the things you've talked about and change can occur without also some change in what we pay for in terms of the Medicaid program?

LARRY MINNIX: Well I can respond to that from a long-term care standpoint. In many places, we know that the Medicaid budget is skewed toward institutionalization. So nursing homes are getting less and less for a level of care that's for which more and more is demanded and people don't like. So you got to come back and say okay, how do we spend our money differently?

Nursing homes have to get better. The key to getting them better is attracting and retaining good leadership and direct care people that we respect enough to pay a living wage and benefits.

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So if we want healthy nursing homes, we got to make them healthy nursing homes. Secondly, we got to invest more in the home and community-based services. The AOA programs and the Medicaid waiver programs are largely rationed. Politicians will say well if we pay for more of those services, you have the woodworking effect.

The woodworking effect is already there, 80-90-percent of nursing home care in America goes on in families' homes, it is just we've chosen not to help with part of it but with only a part of it.

This is where down the road, class comes in because if people are voluntarily putting into an insurance pool and getting a cash benefit that will help them get what they want to stay at home, it changes the whole dynamics in the market place, should free up Medicaid dollars to either reduce the overall cost of health care or decide we're actually going to

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invest in really good quality institutional care because some people will need that.

There's simply some people that cannot be cared for in a home setting and I tell our members if you're going to stay in the nursing home business, you've got to decide to get really, really good at it regardless of the circumstances at the time. You cannot do it half-way anymore. So we have to invest in the nursing home. We have to invest in home and community-based services. The long-term financial strategy of that in my mind is to help pay for it is class.

TRICIA NEUMAN: Toby?

TOBY S. EDELMAN: I'm just a little bit concerned about the question because I think it's assuming that Medicaid rates are always inadequate. I don't think that's necessarily true. They're definitely lower than Medicare. They're lower than private pay but it doesn't mean that Medicaid rates are

not sufficient to provide decent care. It depends upon how the facility chooses to spend the money. A lot of money goes to all kinds of things we would probably agree are not appropriate uses of Medicaid reimbursement. So I'm troubled about that.

CHERYL PHILLIPS: I do want to add one piece as well. It's not so much the rates although in some states, they truly are a challenge. It's that we have not just disintegrated care but disintegrated payment. So I became really good as an early physician working in a nursing home because the DON told me what got Medicare payment and what maximized Medicaid payment and how to manage the individual's care to optimize that.

When you have two different buckets that don't speak to each other, so integrating care but integrating finance and again, PACE is a very good model but several states and some counties are starting to look at in the dually eligible population, how you

can truly have an integrated payment that is driven by the services needed at the place and setting and time that they're needed not by who covers what benefit. We could spend all kinds of time talking about the science of maximizing Medicare versus Medicaid at the nursing home level.

TRICIA NEUMAN: Alright, well I'm going to have to cut off the questions. I have to say that I've seen a lot of people nodding their heads during the session today and I think it's because a lot of people know folks living in nursing homes and care deeply about this issue.

I thank you all for coming. Please join me in thanking the panelists before you slip out [Applause] and we will all continue to work on better care, better health, and lower costs for the most frail beneficiaries living in long-term care settings. Thank you so much. Bye-bye.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.