

**NWX-HRSA OA**

**Moderator: Tom Morris  
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11:00 am CT**

Coordinator: Good afternoon and thank you for standing by. All lines will be in listen-only until the question and answer portion of the call. At that time to ask a question to press star then 1. Today's call is being recorded, if you have any objections you may disconnect at this time. Mr. Morris, you may now begin.

Tom Morris: Thank you, Operator. My name is Tom Morris and I'm the director of the Office of Rural Policy and I want to thank everybody for taking the time to be on this call. Less than two weeks ago HHS kicked off a national campaign to improve patient safety. Here at the Health Resources and Services Administration and within the Office of Rural Policy we've been happy to be a part of planning for this initiative for the past few months.

That's been led by Dr. Becky Slifkin who's the Director of our Office and planning and analysis and evaluation along with Samara Lorenz and Dr. Paul Moore, our Senior Advisor in the Office of Rural Policy. And we've been pleased to work with our colleagues from CMS and across the department to help bring the rural perspective to this issue. So thanks for the opportunity, you know, to talk about this today.

Since the kickoff happened only recently we wanted to very quickly turn around and reach out specifically to rural hospitals and providers to make sure they're a key part of this moving forward. In essence this is really your call; we wanted to reach out specifically to you all and those who work with rural hospitals. We wanted to provide a overview of the initiative and then we wanted to turn the call over to you and find out about how we could make sure you're a key part of this moving forward.

So really this call is about gathering feedback from you all and helping us move that into our planning because this is a long term initiative and priority for the department. I'm going to have a pleasure to introduce the two kickoff speakers today.

You'll first hear from Dr. Mary Wakefield; she's the Administrator of the Health Resources and Services Administration. A nurse by training Dr. Wakefield is a long time champion of rural health interests and quality improvement. More broadly she asked me not to get into the full details of her bio since she probably knows about half the people if not more on this call.

Joe McCannon will be the second speaker. He's the Senior Advisor to CMS Administrator, Dr. Don Berwick. He came to CMS after serving as Vice President of the Institute for Healthcare Improvement which he joined in 2001. At IHI he directed the organization's major domestic initiatives including the 100,000 lives campaign and the 5 million lives campaign which involved over 4000 hospitals many of them rural hospitals.

He's worked with a number of other countries on quality improvement efforts including England, Japan, Canada and Denmark. Started his career in the publishing industry and is a graduate of Harvard University and was a Reuters and Merck Fellow at Stanford in 2003 and 2004.

So with that let me turn it over first to Dr. Wakefield.

Dr. Mary Wakefield: Thanks so much, Tom. And thank you for your leadership at the helm of the Office of Rural Health Policy. It's a real privilege to be able to work with Tom Morris and our other colleagues that deal directly in rural health that staff out the Office of Rural Health Policy.

The US Department of Health and Human Services Innovation Center in Medicare and Medicaid is, as Tom indicated, launching the Partnership for Patients initiative. It's designed to ensure that the care that every American receives helps them and doesn't of course unintentionally injure them.

With the new Partnership for Patients Initiative hospitals and physicians, nurses, employers, unions, patient advocates, health plans and other stakeholders are being brought together to improve the safety of healthcare across the nation.

And it should come to - come as no surprise I should say to any of you that from my vantage point we believe that rural hospitals can and should be playing a key role in making this initiative a success.

Now that it has been officially launched we wanted to conduct some special outreach to you, to rural hospitals and I greatly appreciate, as Tom indicated he does as well, all of you taking the time to join us on this call.

By assembling this partnership and committing to really quite an ambitious but an achievable set of goals we are sending a clear message that we all want and are committed to a healthcare system in which every American regardless of where they live gets the very best possible care.

The Partnership for Patients Initiative is all inclusive and it impacts all of HRSA's populations and programs ranging from how we train our healthcare workforce to the care provided in children's hospitals to the care provided in rural hospitals and so on.

This initiative also aligns well with HRSA's mission that focuses on improving health and achieving health equity through access to quality services through a skilled health workforce and through innovative programming.

I know that all of you on this call know that the need for this initiative really isn't new but clearly the opportunity to fully engage it is right now. You look back and think about patient safety in the context of rural care and rural health care delivery and when each of us does that we look back at this topic from our own vantage points.

One of the markers for me personally was the 2004 IOM committee that I chaired on the future of a rural health care which many of you on the call would be familiar with; it produced the report Quality through Collaboration: The Future of Rural Health.

That was a marker from my vantage point that really spoke strongly to an intense focus and a need for a focus on healthcare quality and patient safety specifically in and across rural healthcare delivery.

That IOM report identified back in 2004 five strategies to address the quality challenges facing rural communities and it really put an extra intense focus around patient safety issues in a rural context.

The IOM report found widespread patient safety challenges across the healthcare sector though at that time there were only limited studies of rural healthcare providers.

We did find in the production of that report that one study for example found that rural hospitals had lower rates of potential safety related events for of about 14 of 19 different indicators looking at issues like decubitus ulcer, infections associated with medical care and so on.

And also in the production of that report we found another study of rural health clinics that identified a wider range of medication errors. So my point is that the concern around patient safety and quality in a rural context isn't necessarily new; what's new is that we now have an opportunity before us to be part of a very significant initiative that has the potential to markedly improve the care, the safe care that's given to patients regardless of where they are receiving that care.

I can tell you that since the release of the IOM Report for example since that particular report data that have been collected confirm that patient safety is a major concern in rural settings not just in urban settings.

For example the result of a national - the results of a national survey of critical access hospitals revealed that medication safety and prevention of patient falls are the most frequently cited patient safety related set of issues.

And over half of all critical access hospitals prescribe medication safety as their top patient safety priority. So again patient safety, a topic of conversation now for a number of years since the early 2000 - early 2000 at least and increasingly we have additional data that are telling us that there is a real need to focus in this particular area.

So going forward in tandem with the Partnership for Patients Initiative we really do have the opportunity now to assure that rural America benefits from the many changes that are unfolding in the healthcare sector and especially from efforts to redesign healthcare to deliver the highest care quality including the safest care.

And this Partnership for Patients Initiative is a very significant vehicle to help all of us who are concerned about healthcare quality in rural America advance this agenda going forward.

So with that I want to turn the call over to Joe McCannon to discuss some of the Partnership for Patients Initiative details with you and then I'm going to come back and say just a couple more words about patient safety in the context of rural healthcare. Joe.

Joe McCannon: Well, Dr. Wakefield, thanks so much and really thank you to the whole team at HRSA, to Tom and Becky and Paul and Samar and others who have been such great partners in this work so far.

It's really a pleasure to join you today to share more detailed information about this initiative with this audience in particular. My own experience with quality improvement and safety from around the country is that rural facilities have a tremendous ability to move very quickly and be quite creative and innovative when it comes to introducing practices and processes and systems that are much more reliable and safer for patients and in many cases really create ideas and concepts that are helpful and offer guidance to the rest of the country.

So to have the chance to speak with all of you and work with all of you again is a real privilege and I'm very much looking forward to it.

I think what you've said, Dr. Wakefield, is exactly right which is that this initiative represents a turning point and really I think a new big opportunity for change. In the last year or so with the introduction of the Affordable Care Act we've spent a lot of time talking about insurance reform and access to healthcare for very good reason.

But now our focus really expands or shifts to think about really what can we do to transform the healthcare delivery system itself? How can we make the delivery system higher functioning and deliver more value and satisfaction and better outcomes for patients and their families?

And in that journey really our first step, our first area of focus here across the department is patient safety. Why patient safety? I mean I think the reasons are pretty clear for those of you who have been at all involved in this field as Dr. Wakefield was suggesting.

We have a national problem; we have a health care system that's rife with waste and complication and harm. And, you know, I probably don't need to recite the litany of data but, you know, we certainly know that tens of thousands of Americans die unnecessarily each year in the course of their healthcare.

We know that millions are harmed in the course of their healthcare. And we can do better. I think that equally though the impression I don't want to give is that we don't have hope or we don't have reason for optimism. When we look around the country in fact what we have are pockets of exceptional success where if you look at any adverse events you can find numerous examples of

organizations that have driven infection down to zero or reduce medication errors by 40% or reduced surgical complication vary significantly over the course of the last several years.

So really what we need to do here is move from these pockets of success to really making this standard of performance much more ubiquitous, making it a part of the experience of care for every American.

I'd also want to suggest that when we think about the problem we also really emphasize the fact that this is not a problem of negligence or uncaring clinicians in any way; far from it. This is a problem or a challenge of very complex systems.

And we are all human and operating in chaotic, complex, overwhelming systems puts us in a position to feel quite challenged and confused and to make mistakes on occasion. And so what we need to do together here is again devise systems and processes drawing from the best, drawing from great examples of success that will be much more reliable and deliver better results for patients and families.

So with that as kind of a prelude, a serious problem but also lots of reason for optimism and lots of reason for hope based on the work we've seen in the last decade we launched the Partnership for Patients. And the Partnership for Patients says it's going to try to accomplish two things nationally over the course of the next three years.

The first is to reduce preventable harm by 40% in hospitals around the country. This means targeting adverse events like infections and medication errors and surgical complications and falls and pressure ulcers, all of the things that we know about and have been working on for some time now.

But it also means expanding our focus and looking at all forms of harm across the facility, discovering perhaps forms of harm that we haven't seen before but becoming very good at assessing in every facility what's really happening and where the greatest burden of harm lies and being able to prioritize that and take action upon it.

We believe that if that first aim is achieved we have an opportunity to avoid about 1.8 million injuries to patients over the course of the next three years which would of course have significant benefits in terms of outcomes and in terms of costs as well.

The second objective for the initiative is to try to reduce readmissions by targeting preventable readmissions by 20% over the next three years as well. And the idea here is that week now that transitions in care can be quite complex and confusing and frustrating for patients and families and can also introduce situations where there isn't a sense of confidence and people are worried and they feel that because of harm that they're experiencing that they need to return to the hospital.

Of course there are many cases where that is so but there are also cases where we know if we can manage the care transition better, if we can provide home visits and clear discharge plans we can reduce confusion and reduce worry and in turn reduce preventable readmissions as well.

So with that goal achieved we believe that we would have the potential to avoid about 1.6 million readmissions and again in turn there would be significant benefits in terms of cost savings to the system too.

Together we think this initiative if we're successful has the potential to avoid about 35 million - excuse me, \$35 billion in cost for the US healthcare system overall with significant savings to Medicare and Medicaid specifically. So we think this again represents a terrific opportunity to really make change and drive the country forward.

The next question of course if we talk about (unintelligible) is well okay how will we do it? And the first answer to that question that I always hear is that really we won't do it; you'll do it. And I think we know the reality is that this is very hard, very painstaking work that happens out at the front lines of care and we can exhort all we want and we can introduce incentives and certainly there are incentives coming as a part of the Affordable Care Act.

But what we really know is that we need to in the immediate term introduce tools and resources and support that will really help hospitals around the country to figure out how they can introduce those reliable systems and processes that will make care safer for patients and for families.

And so with that what we are planning to do across the department and of course to leverage all the fantastic programs and activities that are already on going from HRSA, from ARC, from the CDC and many other federal agencies but also through the Innovation Center at the Centers for Medicare and Medicaid Services introduce sort of two primary forms of support.

The first being \$500 million through the Community Care Transitions grants - excuse me, Community Care Transitions Program that will hopefully support work in improvement in care transitions over the next five years for as many as 2000 communities around the country engaged in community-based organizations but also hospitals in the process of making the continuum of care operate more smoothly.

And then in support of our focus on reducing hospital harm there is a - as much as \$500 million more which will be focused on creating local support, regional supports at a state level or a system level that will actually provide technical assistance to hospitals around the country in making change.

The primary focus here again will be at a local level bringing together 100 or 200 hospitals at a time, bringing together hospitals of similar type; for instance rural hospitals to work together but really creating learning opportunities and tools and resources and expert guidance and assistance to drive the change forward.

We're also going to support the creation of what has been called an advanced participant group essentially a self selecting group of organizations from around the country who can raise their hands and say we're going to go after this goal of all caused harm very aggressively and very boldly and try to solve problem in a shorter timeframe and do so by marking our progress very publicly and sharing our progress with the rest of the country.

That's not a requirement in any way but of course, you know, we do want to incentivize a group like that to really be at the vanguard and kind of move the means forward.

There'll be supports for patients and families that we'll be introducing. We want patients and families to be more aware of the problem but also and importantly very closely involved in the process of redesigning care and closely involved in the process of making their care safer through things like better discharge plans and medication cards and other tools and resources of that sort.

So there's really a great deal that this initiative will offer in the way of tools and resources. I think this is unprecedented but I think our shared concern and our shared intent across the department is that we really find a way to make change real that again we move from a few outstanding examples of performance to helping every organization in the country find ways to redesign care and provide care more safely.

And so our intent will be to track our progress against those goals very publicly and make sure that we are really making the week to week, month to month, year to year change that patients (unintelligible) around the country really deserve.

I would I guess just simply say in closing that we are very, very excited about the initiative and right now focused mostly on raising awareness about it and engaging organizations around the country and taking part. Specifically I'd encourage you if you're interested in taking part in the initiative to pledge to the initiative.

If you go to [healthcare.gov](http://healthcare.gov) the Website you will find links to the Partnership for Patients and you can find the pledge there. And we would again encourage you and welcome you to do that. We need your help. We won't get this work done unless you're pulling with us.

And I'd also encourage you if you have questions or clarifications or want to know some more information before taking part to email us at [partnershipforpatients - all one word - @hhs.gov](mailto:partnershipforpatients@hhs.gov) and we'll certainly get back to you from that email address as well.

I think the only thing I'd say before turning things back to Dr. Wakefield is really what I said at the start which is I realize and I think the initiative

realizes that if we're serious about transforming care in the country that we have to make a place in this initiative for every type of hospital and we have to be very, very serious about the unique needs and requirements and skills and abilities that we find in different types of facilities across the country.

I think rural hospitals again in my experience have been a source of wonderful innovation and partnership and I'm just hoping we can once more kind of make the adaptations and develop tools and content and resources that will be specifically useful to you and the patients and families that you serve.

So with that let me turn it back to Dr. Wakefield.

Dr. Mary Wakefield: Thanks so much, Joe, both for your commitment but also for your leadership. And just intense leadership on the Partnership for Patients Initiative. So appreciate your participating in this call now but I also appreciate your ongoing work with this initiative.

As Joe indicated we know that capitalizing on the unique strengths - on very unique strengths, rural communities and healthcare systems can certainly meet the expectations that are associated with delivering the highest quality and the safest care possible.

But we also know that historically many quality initiatives in the United States have been developed with urban healthcare features in mind and as a result they've not always been directly applicable to rural healthcare settings. So from our vantage point the key is making sure that as we move forward with these activities that we make them as relevant for rural hospitals as we do for large urban hospitals.

And as I mentioned before I think that this initiative is uniquely positioned to do just that. Partnership for Patients is reaching out to urban and rural, to public and private partners working together to help hospitals and their staff to learn how to make care safer and to adopt the best known practices as quickly as they possibly can.

And we have a lot of examples of different rural hospitals across the nation that have driven different kinds of patient injury close to zero. Let me give you just a couple of examples of where this has been happening in rural communities across the country.

Just a few years ago leadership at Parkview Hospital in the Texas panhandle was concerned about medication errors in their critical access hospital. So what did they do? Well they implemented a remote pharmacist review of all orders within 24 hours in addition to their weekly onsite consultant pharmacist.

What happened? Well in one year the medication error rate decreased by 83%. That's pretty clear evidence of what hospitals can do when they get focused, when they learn from each other and how they can benefit from better-aligned incentives.

We also know that getting broader stakeholder engagement (unintelligible). Not sure what just happened there but some of the rest of you might have heard that sort of odd interruption. Let me go on.

We also know that getting broad stakeholder engagement - as I was saying - on this initiative requires a true partnership between HHS, hospitals and a variety of other groups that are all working together.

We've got good examples of public private partnerships in rural America too. One of them is the Maine Critical Access Hospital Patient Safety Collaborative that was formed with the support of the Office of Rural Health Policy's flex fund with the Maine Center for Disease Control and Prevention Office of Rural Health and Primary Care, the Main Quality Forum and the Maine Health Access Foundation as well as the Muskie School of Public Services, Maine Rural Health Research Center and 14 of the 15 Maine critical access hospitals signed a memorandum of understanding with the Maine Quality Forum to participate.

The activities that they've focused on and have been focusing on include medication reconciliation, interventions related to high alert medications, enhanced patient education around medications and tele-pharmacy to expand pharmacist consultations.

So while we have these and other great rural-based examples as Joe noted we know that we can do better, we know that we can certainly do more. And to do that we also know that we've got to all be in this together. None of this will happen without the serious commitment of leaders; not just leaders at HHS but even more importantly leaders of local boards of hospitals, clinical leaders, executives in all systems across all hospitals.

And we know too that it will not happen without the energy and the commitment of literally all the major stakeholders including consumers, health plans, employers, providers and others. And while the type of change that we're talking about today isn't easy we really feel that it can be done best if we're working in partnership together.

So at this point we'd like to hear from those of you who are on the call. It would be helpful for us to hear your thoughts about both advantages and

barriers that you see through your participation in this initiative. We want to provide you with an opportunity now to share with us any aspects of moving toward more patient safety that are particular issues for rural hospitals and that we need to be aware of.

So, Tom, I'm going to hand it back to you so that I guess you can open it up for questions and comments from the call participants.

Tom Morris: Great. Thank you, Dr. Wakefield. Operator, I think we're ready to open up for questions. Let me try that again, Operator?

Coordinator: Yes sir.

Tom Morris: We're ready to open it up for questions.

Coordinator: Thank you. At this time to ask a question to press star then 1. One moment. (Rick Foster), you may ask your question.

(Rick Foster): Good afternoon. I want to thank you for giving the opportunity to the rural hospitals to be involved in this very important project. I represent all the hospitals in South Carolina through the Hospital Association and Quality and Patient Safety. And I want to commend our rural hospitals for the work they've already been doing to improve the safety of patient care.

And they've been actively involved in many of our projects and in some cases have led the way. One of my questions is around the care transition program. Any insight that you could give to our rural hospitals and others on how they could maximize their opportunity to tap into the grants on the care transition where I think it's going to be really important for them to develop their

capabilities to coordinate are across the continuum for patients with chronic illnesses.

Dr. Mary Wakefield: Joe, do you want to speak to that? And we can add in from the Office of Rural Health Policy.

Joe McCannon: Sure. I'm happy to do so. I think the note I'd make there is that the vision for the community care transitions program, Section 3026, is that we are really hoping to support the creation of community coalitions. And the idea is that the goal here is to identify community-based organizations that can sort of be the point organizations and leading the work but that critical access facilities, rural hospitals and others should be central parts of this community coalition.

So first up that I'd suggest is really kind of looking at the local stakeholders, looking at all of the different organizations and entities that have a stake in the care process and beginning to come together. I think the good news is that we know that in many communities around the country particularly rural communities these connections - these forms of connections and the - sort of the mapping of how patients travel through the healthcare system is already well advanced. And so that creates an interesting opportunity here.

Tom Morris: Yeah, this is Tom Morris from the Office of Rural Policy. I think that, you know, the program is a great opportunity I think for not just rural hospitals but rural hospitals, urban hospitals, you know, the full continuum of care as I think Joe indicated.

You know, it has some fairly strict criteria about who is the eligible applicant; you have to be a Subsection D hospital obviously a PPS hospital or an area agency on aging but the idea behind it is also to form a much larger network and which we'd hope that they'd use it as an opportunity to really think about

that broader continuum at which point you can bring in all different levels of care, critical access, you know, anybody else that helps smooth those transitions.

So we do think it's an opportunity for rural hospitals in general but also for, you know, more regional systems of care to talk about those transitions and to make sure they do them right.

Operator, next question.

Coordinator: (William Discardo), you may ask your question.

Dr. (William Discardo): Hey, yeah, it's Dr. (Discardo) up in (Sarneck) Lake and we're pretty rural. Thanks for your time and I guess I need to ask a more basic question. And I heard - I guess the idea is we're going to decrease admissions and safety but I didn't hear any specifics about exactly what this program is, how it is we're supposed to apply it; I just heard there at the end the mention of an PPS in an applicant. I don't know if I missed a call earlier but could you please back up a little bit and explain exactly what this program is, how to access it, what the rules are or what exactly the specific goals are?

Tom Morris: This is Tom Morris again. I guess I'd like to let Joe speak to the broader thing. It's not one program or one point of entry it's a multipronged effort tacking advantage of a number of different HHS programs. And the one we just referenced was just one of the tools in the tools box, the Community Based Care Transitions grant.

And that was in response to the previous question so we were speaking more to that. But I think what I'd like to do is let Joe talk a little bit more broadly about how this is really a much broader effort than just one program.

Joe McCannon: Yeah, again I mean, the initiative here is - the first thing I should say is it's a public private partnership so we're joined in this initiative by tens of health plans, hundreds of employers, associations, patient and family groups. There's really sort of everyone coming together behind these two goals.

And the two explicit goals again are, one, to try to reduce preventable harm in hospitals by 40% over a three-year period, and, two, to try to reduce admissions by 20% over a three year period by targeting preventable readmissions.

The how of how that gets done is by tapping into private programs and tools and resources that are out there but also by tapping into these federal resources that I described. Again the first set of resources is what currently exists across the department, a whole universe of programs and resources which are linked from the Partnership for Patient Website.

But then in addition to that these two sources - major sources of funding which I described; first \$500 million from the Community Care Transitions Program which focuses on improving care transitions and that's what we were just referencing.

And then second \$500 million - up to \$500 million in support from the Innovation Center at CMS which will create local and state level support - essentially local and state level collaborative activities that will bring together organizations to learn from each other.

Equally it will support systems or affinity groups like rural hospitals to come together and learn from one another in very structured learning environments

to sort of take on and focus on all of the adverse events that we're targeting here.

There is a list of nine adverse events on the Website that we're targeting initially that we think are kind of the basics that we should all be able to introduce at this stage. And then there's a - a broader call here to again look at all cause harm, all forms of harm and target that in the course of the work as well.

In terms of getting started the way to do that is to pledge to enroll to the initiative. You go to the Website, there's a very quick form that you fill and commit to the initiative and its aims and then you're thereafter part of a set of communications and have access to information about all of these different programs and resources that we're rolling out that you can tap into over time.

Dr. (William Discardo): And so that Website again was the partnershipforpatient...

Joe McCannon: Just - if you simply just type in healthcare.gov into your browser which is the public Health and Human Services Website on healthcare.gov on the main landing page you'll find a link right dead center to the Partnership for Patients Initiative and that will take you to lots of detailed information about the partnership and also a link to be able to pledge your involvement.

Dr. (William Discardo): I don't mean to belabor, one final - I'm here with my quality manager too and she said that we actually did - apparently we've gone on and actually signed this pledge. Did we get any communication back then at that point in time or that just allows us to access the services and wander through there or what's the next step after that I guess?

Joe McCannon: The next step after that is, I mean, again a couple of things I'd say immediately; one is we're trying to encourage folks to learn more about the Community Care Transitions grants that we just described.

Dr. (William Discardo): On the Innovation...

Joe McCannon: Right. And the forthcoming Innovation Center resources. But there'll also be a series of kind of getting started activities which will in addition to the tools and resources you can link to from the Website which will be sort of calls and Webinars where you'll be able to tap into experts and leaders from around the country again as we were suggesting earlier not just urban organizations but peer organizations where you'll start to be able to do this learning.

And then our expectation is that rolling out over the course of the spring and the summer will be these new funding opportunities that will create local learning.

Dr. (William Discardo): (Unintelligible). Thank you very much.

Tom Morris: And just to add to that, you know, this is - we're at the very beginning of this and that's why we wanted to very quickly do the specific rural hospital call just to let people know about it, get as many pledges as we can, make people aware of it and then hopefully get broad participation.

But we hope to be coming back to you; maybe we'll do another call this as more information is available. We'll also work through our State Offices of Rural Health, our state flex programs and the State Hospital Association to continue to share information as it comes up in tandem with what you'll get once you sign up through healthcare.gov. Operator, with that let's take the next question if we could.

Coordinator: (Richard Perry), you may ask your question.

(Richard Perry): Hi. This is (Richard Perry) in Oklahoma and the previous two questioners have answered my question. Thanks very much.

Tom Morris: Next question operator.

Coordinator: (Allison Hughes), you may ask your question. (Allison Hughes), your line is open. I'll go to the next caller. (Nanette Hiller), you may ask your question.

(Nanette Hiller): Yes. This is (Nanette) from the State of Idaho and I think I got my question answered. I was wondering what the steps were in the pledging of your partnership and if there were specifics where the hospital association and if there were any specific things that we needed to do once we signed the pledge.

Joe McCannon: Well, for hospital associations in particular I think one of our great hopes is that you will begin to first of all pledge to the initiative and join us but begin to either create or amplify the current learning opportunities that you have already begun to introduce in alignment with the initiative.

We know that there are a number of state hospital associations and QIOs and state patient safety agencies and right on down the line that have already done a tremendous amount of work in improving safety. Certainly we know that the rural extension agencies have done similar work in a number of states as well.

And so I think you know, we want to simply encourage that to continue, encourage you to carry that work forward. And as we say, these resources that we're introducing, almost \$1 billion in new resources should create

opportunities for or have been attempted to create opportunities for you to orchestrate local work.

I'd also offer our own expertise and resources. You know, we are really right now crisscrossing the country going to all sorts of regions and events and meetings to spread the word about the initiative and what it entails in slightly lengthier formats and certainly would offer ourselves there as well.

Tom Morris: Operator, next call.

Coordinator: (Edgar Mash), you may ask your question.

(Edgar Mash): Yes. This is (Edgar Mash) in Michigan, actually in Harbor Beach, Michigan. I'm also the chair of the Micah Quality Group, which are 36 critical access hospitals in the State of Michigan.

I think one of the barriers that I see to the program is my individual hospitals already participate in over seven or eight different programs including MHA Keystone Surgery Project, the new Michigan Patient Safety Organization, Blue Cross Blue Shield Pay for Performance. We have a regional IHR Triple Aim initiative that's been undertaken and we're participating in.

And I think that it's really important and I don't know how you could take a leadership role in threading so many of these things together so that this doesn't just become another duplication or an additional work responsibility. I think there needs to be some way to coordinate across these different activities so that you can have a singular link for the station safety and the focus you have versus one additional measurement project or one additional performance improvement project.

Joe McCannon: I think that's a helpful point and I think our goal here is not to create duplication but actually to align well with existing initiatives. And you know, I think one important thing that that prompts for me is to suggest that this is not a measurement initiative.

This is an initiative that really is meant to provide technical support to help people figure out the problem of how you again design more reliable systems and introduce change. I know that several of the programs that you mentioned are doing that. What we're not doing here is saying this is a new set of measurement requirements or we're going to be creating another comparison chart and comparing people.

Again, we have more than enough of that happening. Of course we know that certain sections of the Affordable Care Act will introduce more accountability through payment incentives and by putting payment at risk as well. What we're saying here is we want to create an environment where there are things that we don't know.

For instance, there are very few organizations that really think in terms of all cause harm reduction or where there are new forms of harm that we haven't figured out how to solve or where we simply haven't spread things that we know how to do. We want to sort of be an amplifying force there and an accelerant that is complementary.

I think that despite all of these activities that are happening around the country, which are terrific and many of which are actually providing these pockets of success that I mentioned, we still haven't really seen the change in national rates of harm. We know that standard rates of harm have not really budged in the last decade or so.

And for that reason I think we're trying to figure out how we can take those good examples but really push ourselves harder and farther again in a non-punitive way.

Tom Morris: Joe, I might add just responding to (Ed)'s point is that we're also looking for rural hospitals that could be exemplars and could be models for others. And certainly the work they have done in Michigan shows that it can be done at any size hospital. And so we'd love to hear more about those folks who feel like they have really done some interesting things that might be transferrable to other hospitals. And so if folks are interested in submitting to that maybe Paul, you could give them your email address and if folks want to send those models to you, that'd be great.

Paul Moore: Absolutely. You can just - (Ed), we're not interested in another thing to do or another program. It's a matter of taking all the things we are doing and weaving them together in a tapestry to enhance patient safety, to enhance the quality.

You're familiar with the third phase of our Medicare beneficiary quality project that we have with the federal office. And when you look at the things that we're going to be measuring and doing in that third phase there, they fit right in with the emphasis on patient safety with the medication reviews, the medication errors, the transitions of care.

So we're not looking for something else to do but we're looking how to weave what we are doing and you're an exemplar of the programs going on, weaving that into the overall picture. I would love to hear from you and from others and so my email address is pmoore - M-O-O-R-E 2 at HRSA dot gov.  
pmoore2@hrsa.gov.

Man: Operator, if we have another question.

Coordinator: (Kristen Shultz), you may ask your question.

(Kristen Schultz): Yes. I'm calling from St. Peter, Minnesota and just wanted to tell you that this sounds real exciting and refreshing to me because what I hear you saying again, it's not a new measurement initiative.

Rather, you're going to help us manage quality and patient safety and that's the piece that we really need help in sustaining and actually having a very practical approach where we have immediate results. So I welcome this and I just feel that you're on the right track and thank you.

Joe McCannon: Thank you very much.

Tom Morris: Next question if there is one.

Coordinator: (Don Suplet), you may ask your question.

(Don Suplet): Thanks very much and it's great to be on the call to be able to support and reiterate our support from the AHA for the partnership for patients. And we do believe that this is a recognition of the numerous steps that a culture of safety that has taken place within organizations including rural hospitals today.

We think it represents a huge commitment of hospitals to improve care and we're proud to support the efforts of the partnership for patients and look forward to working with Dr. Wakefield and you Tom and your staff during the course of this partnership.

Tom Morris: Thank you (John). Operator?

Coordinator: There are no further questions at this time.

Tom Morris: Then we'd like to pose one if we could. Dr. Wakefield alluded to in our opening remarks what other sort of barriers there might be out there or what things should we be aware of and what would make this initiative as relevant as possible. And so we'd love to hear that if any folks have any thoughts on that.

Coordinator: Again, to respond press star then 1. Mr. (Perry), your line is open.

(Richard Perry): Hi. This is (Richard Perry) and I do have a question. I am looking at a document from the Web called solicitation for applications, community based care transitions program.

Are you open already for applications or ideas or proposals that you want to see put in writing and forwarded to you now?

Tom Morris: Joe, are you still on? I think Joe had to go.

Joe McCannon: Yes I am. Sorry. Yes, that is a live solicitation and we're welcoming incoming information. I would suggest that you link from the partnership for patients site to the community care transition site to get all the detailed information about how to apply.

(Richard Perry): Yes and when you look down at that list of things to link to and so forth there is a list of hospitals that you include that have high readmission rates. Are you targeting those hospitals to be applicants or can a hospital that's not on the list also apply?

Tom Morris: (Richard), I think that there is targeting. You have to have met those readmission rates because again I think they have identified those as the ones that really are the factors that drive cost and lead to injury.

So that's sort of the first door you have to go through in order to be eligible for the grant.

(Richard Perry): Okay. So if you're not on the list it means you're sort of doing okay as far as readmissions and this program is not really going to target you.

Tom Morris: I'll defer to Joe on this but it's my understanding that that's driven by the statute, which specifically set a threshold for the readmission rate and then the guidance sort of flowed from that.

Joe McCannon: That's correct and excuse me - I'm just in a slightly unexpectedly loud place but that's correct. Having said that, there are many points of entry for doing work on care transitions and other sort of programs and tools and resources on care transitions really from several of the agencies across HHS.

But I think that that threshold is meant to initially provide support in those places where there is those rates are highest and it's meant to do targeting in that respect. But equally if you don't find yourself eligible in that respect there are a number of other programs and resources that are linked from the Web site that you can tap into as well.

(Richard Perry): Thanks.

Tom Morris: Operator, do we have any more questions come up?

Coordinator: We have three more at this time.

Tom Morris: Great. Why don't we go ahead and go through those?

Coordinator: Okay. (Rick Foster), you may ask your question.

(Rick Foster): Yes. I appreciate the opportunity to have some follow up here because it's relevant to my earlier question and the fact that in South Carolina we're fortunate because we've created a statewide network and we've had some local funding resources to help really get down to the level of the rural hospitals.

And I think one of the potential barriers is that as these programs roll out even the care transition it's that how do we find effective ways to really get the resources, not just the dollars but the actual resources from the dollars to those rural hospitals so they really can make the improvements they need to make?

And sometimes there are so many layers before it gets to the rural hospital level I think that they don't actually get to see the real benefit from the money that's being allocated. So I think that's one of the things we really would like to work with you on, to find ways to make sure that rural hospitals that are actually sometimes doing the best work get the help that they need to be able to spread that across their entire systems.

Tom Morris: This is Tom Morris and I think that's a great point. I know in particular I'd love to hear examples of maybe whether it's HRSA guidance or other programs where maybe there are ways we could revise the guidance through grant programs to better address that issue.

Sometimes it's statutory but sometimes it may just be the way it's structured. So if anybody on the call has any ideas about that or some examples, we'd like to factor that in as we move forward.

(Rick Foster): If you can still hear me, in South Carolina some of our smaller rural hospitals are serving as mentors even to larger hospitals because they're doing it with very limited resources.

And so I again commend them for how much they have done even with the most limited resources. So I think if we can find ways to get those resources directly to those hospitals that in some cases can actually drive the types of improvements we'd want to see more quickly, I think that would be a great benefit to everyone.

Tom Morris: I agree. And it's amazing to us what folks do with limited resources sometimes. But there are some grants even in our office that flex grants might be used towards this end.

And as Paul mentioned with the Medicare beneficiary QI program and the voluntary program restarting and we're also competing our outreach grants next year. And I think a well crafted outreach application could definitely get at this. And those grants in particular are really designed with small scale and size and they're sort of start up funding for good ideas.

And I think that might be another opportunity. So we'd be happy to connect you with those folks if we could if this has some interest to you.

(Rick Foster): Thanks very much.

Man: Operator, next question.

Coordinator: (Jeff Spade), you may ask your question.

(Jeff Spade): Yes. This is (Jeff Spade) and thanks Mary and Tom and Joe and Paul. This is an exciting program. We're proud to sign up. We signed up as soon as we heard about it.

And I'd encourage any other leadership groups that are onboard with this call that as soon as this teleconference is done at least sign and pledge to be involved with this important effort.

I do have some ideas along the route that you were speaking of Tom, just now in thinking about some of the programs that ORHP supports like the flex program, the shift granting program, the rural network programs as well where there could be a possibility for some alignment of the partnership with goals of those programs.

And I'd like to help in any way I could to think about that a little more and think about how those programs could place an emphasis on the reducing harm pieces in particular so that we can start aligning some of those great resources that have been built over time in the flex program. The flex coordinators for instance can become more knowledgeable about how to support harm reduction in the rural hospital networks.

And trying to start to develop some kind of national and regional expertise that can support and provide technical assistance to rural hospitals, that's what we could do easily. And the North Carolina Center for Rural Health innovation performance, we'd be one of the first that would volunteer to be in the vanguard group to bring our expertise to the table and our knowledge about improvement methods and our working relationships and partnerships

to extend this into the broader field of North Carolina rural hospitals but rural hospitals nationally. Thanks.

Man: (Cap), thank you so much and I couldn't agree more about the alignment. It would be great if we could create more incentives to the same entity in the state is sort of getting the flex and the ship dollars.

And when ship got reauthorized it mentioned a lot of the programs and the key things going on in the Affordable Care Act. But for too many years I think we've sort of had those programs split off. The ship funds were on one side and the flex on the other and we really ought to think about them as two programs that are already very, very tightly aligned in helping move this forward.

So I think we have got some ideas on how to use the ship funds more strategically and then encourage flex fund coordinators to think about those programs not as one but as certainly two parts of one. And so we'll do that and then when we put the outreach guidance out this year.

And for those who are not familiar with rural health outreach grants, that's about \$375,000 a year over three years to improve access to care. So it's very broad. We may want to add some language about how it flows out to patient safety and this initiative because it might give people some ideas about ways you could do that too.

(Jeff Spade): And one other thing - there is some immediate opportunity to share information about the program. For instance, the National (Help) Association meeting is next week so hopefully that's a great forum.

Otherwise another year goes by before we can talk to a large group of people. You know, our programs meetings or flex coordinator meetings are coming up too. So hopefully we think about how we can provide some information at those important sessions that are coming up pretty soon here. Thanks.

Man: I'm going to put it in my presentation next week. Paul is speaking on the Medicare beneficiary QI project and he's going to talk about it. But we need to be talking about it at every step. I agree with you.

I also didn't mention the idea of sharing the knowledge that's out there either through formal or informal networks. I think that's critical. The earlier caller from Michigan and some of the things you guys have done there, what Mary cited about the project in Maine - we have got some great models out there that speak directly to the themes Joe laid out that are important for the entire country.

But we've got wonderful models in rural and we've got people who are willing to do that. What we've got to do is sort of share that expertise as broadly as possible. And so we need to give that some thought and maybe it's regular conference calls or learning or webinars. But I think the next year or two we've got to really beat the drum on this in order to broadly share that knowledge.

(Jeff Spade): Thanks.

Tom Morris: Operator, is there another question?

Coordinator: Yes. One more - (Jess Hyatt), you may ask your question.

(Jess Hyatt): Thank you. I'm calling from rural upstate New York and our community has been working on developing more effective care transition and with the effort to reduce readmissions.

And one of the roadblocks that we continually run into is the lack of frontline home care workers in the form of CNAs, home health aids, personal care aids. And I know that there are - there is some funding for special projects to train and certify more of those workers and I wondered if the upcoming or the available grant opportunities have any funding for that?

Tom Morris: This is Tom Morris again. Thank you, yes. I think you could certainly build that into an outreach grant and I could probably connect you with the folks to do that and to start thinking about it.

It would have to be part of a broader sort of health improvement project but still, you can't do it if you don't have the frontline workers. The other thing that comes to mind for me is some of the initiatives going on through the Workforce Investment Act programs operated by the Department of Labor. They really are focusing on those sort of for lack of a better term paraprofessionals on up to LPNs and even AD nurses.

And that might be an opportunity too to target those jobs because they have to target high growth areas and all of those sort of labor statistics show that some of the highest growth areas are all the professions you just mentioned. So there is no one way to get at what you're talking about. Everybody is trying to get at this and the resources are scarce especially in the current economic climate.

But it may be that the Labor Department Workforce Investment dollars might be a start. Our grants might be a little bit of an opportunity and then the

Department of Ed might also through some of the funding they do for community colleges. But all that might be an option. I would also mention that one of the things we're putting out later this spring/early summer is a community health worker toolkit.

One thing our outreach grants as I mentioned have really focused on over the years is community health worker programs whether it's a (promatura) model on the border or just a lay health worker model. And so we've learned a lot about what works and what doesn't in setting those programs up and we think that toolkit will have some resonance for folks.

And so that will be up on the rural assistance center Web site probably by late June/early July and that might be a resource too. Again, no one solution there but maybe some resources we can bring to bear.

(Jess Hyatt): I believe that the hospitals will be most successful in their efforts if they are able to transition care to effective home care.

Tom Morris: I couldn't agree with you more. Operator, is that the end of the calls or are there other questions?

Coordinator: We have one more question.

Tom Morris: Great.

Coordinator: (Edwina Drucker), you may ask your question.

(Edwina Drucker): Hi. This is (Edwina Drucker) here in Maine. I have a question about how we share the learning and I'm getting more and more excited every time

(unintelligible) - and what I really haven't heard is how we're going to share what we learn in our little trials all over the country.

And the point of this is that we learn from each other. So is there a formal process to develop that we can all come together through conference calls, with say webinars to learn from each other from this project that we're doing?

Man: Yes. I think that's a great point and I think (Jeff) sort of hinted at it and you hit the nail right on the head. In addition to it is what sort of mechanisms are going to work best for that?

You know, we all go to a lot of the regular meetings and rural - there is the state hospital association meetings, state and rural health association meetings, we have flex meetings, sometimes states together and those are effective mechanisms for the face to face. So I think that is sort of a network we could tap.

But then the next question is what do we do in between those meetings and how do we have to look at now when people are back in their communities? And so I'll take that back to our staff and we'll give it some thought on how we might be able to do that more formally. Maybe we could do it in partnership with (John)'s group at AHA.

And maybe the folks at AHA, the national cooperative health networks - I think there are some resources out there that we could look at. But thank you for the suggestion.

(Edwina Drucker): I'd like to continue on that then. A lot of those meetings, a lot of staff now because of state cuts are not allowed to those meetings.

The travel has been stripped (unintelligible) - it's totally restricted for the flex conference and the other. So I think you will also need to find a mechanism to support people being able to attend those meetings.

Man: You know, that's not a bad idea either and whether it's scholarships or things like that, I know the state travel restrictions are very tough right now for folks. Becky, you had a thought?

Dr. Becky Slifkin: Yes. Hi. This is Becky Slifkin from HRSA. There in addition to the community transition grants that Joe spoke about, there are going to be a series of other contracts that are going to be coming out from the innovation center over the next six months.

And some of these will deal explicitly with creation of learning institutes and TA and hopefully we'll get at some of your concerns.

(Edwina Drucker): Thank you.

Coordinator: You have one further question. (Tom Martin), you may ask your question.

(Tom Martin): Yes. As I listened I didn't hear any reference to the development of rural models for ACOs and care coordination across the continuum between rural communities and urban centers. And I was wondering will the innovation center be targeting that in the future?

Dr. Becky Slifkin: Yes. This is Becky again. That's a slightly different topic. We are engaged in discussions with the innovation center now and I would encourage you to take a look at their Web site, which is live.

And it lays out some of their preliminary thinking on other initiatives that they are thinking about rolling out. But I believe it also has a mechanism where you can submit ideas and suggestions.

Tom Morris: And this is Tom Morris and I guess I would add that what you're asking about is obviously an important next step of it whether it's ACO or gets more focus on coordinated care because as we know, often these patients are being transported over a distance.

And it's from a rural area to an urban or back and so we'll continue to work with our colleagues to see if there may be some opportunities there. And as we get that, as new opportunities come up from the center for innovation that we think speak to your issue we'll certainly work with our partners to get the word out about that. But I think you're right on target.

(Tom Martin): Well, I appreciate that. I think there is a significant opportunity for us to address not only our own readmission rates within our own hospitals in the rural communities.

But as we coordinate care for our transfers of patients into the urban areas, assuring that we're doing that in a timely way in coordination with those urban centers will affect their readmission rates. And so clearly I think there is application there and there are some models and thinking in the rural communities about how to achieve some better results using virtual medicine and other things.

So I strongly encourage people to be thinking in that direction. I know there is a lot of people interested in testing the systems that we're now working on and being able to demonstrate that they're effective.

Tom Morris: Yes. I think about things like EICU and eEmergency and there are some real opportunities to bring technology to bear here too. I should also mention that on the care transitions there is going to be some information calls where folks can.

CMS will hold calls where folks can call in and ask questions about the program and get into probably a broader level of detail than we could today in this call. So I would stay tuned to their Web site as those calls are announced.

(Tom Martin): Thank you.

Coordinator: There are no further questions at this time.

Tom Morris: I think we'll just close by saying thank you very much for everybody taking the time to be on the call. This is not a one-time only thing. I think we'll come back to you as we have more information.

And our goal here at HRSA and the Office of Rural Policy is to make sure that rural is a key part of this initiative going forward and we'll need your help in doing that. So we look forward to talking to you down the road.

Coordinator: This concludes your conference call. You may now disconnect.

Tom Morris: Thank you.

END