Readmissions Action Team

NATIONAL QUALITY FORUM

Web Meeting

Tuesday, April 29, 2014

3:00 pm – 5:00 pm ET

Telephone access:

Dial: 1-866-599-6630; Enter Confirmation Code: 23974567

Web Access:

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2. If you are already logged into the meeting and experience a problem (slides stop advancing, streaming audio stops/fails, etc.), try clicking the "refresh" button in your web browser. It looks like a circle with arrows.

3. Clear the cache in your web browser. Then close your web browser completely. Open your web browser again and try logging into the event/archive again.

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5. Make sure you do not have pop-ups disabled in your internet browser settings.

6. Make sure that your internet browser is Active X enabled.

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Agenda

NATIONAL QUALITY FORUM

Agenda

Readmissions Action Team Public Web Meeting
April 29, 2014
3:00-5:00 pm ET

Instructions

1. Direct your web browser here
2. Under "Enter Meeting" type the meeting number **473891** and click "Enter."
3. In the "Display Name" field type your first and last names and click "Enter Meeting."
4. **Action Team:** Dial **1-866-599-6630** and use confirmation code **23974567**.
   Public participants: Dial **1-866-324-4482** and use confirmation code **23974567**

Objectives

1. Present Readmissions Action Pathway
2. Feature success Learn from fellow action team members' work as it relates to the Action Pathway
3. Share Action Pathway Resources and Strategies

Agenda

3:00pm **Welcome, Roll Call, and Meeting Objectives**

Lois Cross, American Case Management Association, Action Team Chair

- Introduction and review of today's agenda and meeting objectives

3:05pm **Action Team Pathway Overview**

Lois Cross

- Synopsis of the action team pathway: vision, goal, and strategies

3:15pm **Cross-Team Learning: The PACT (Preventable Admissions Care Team) Program**

Maria Basso Lipani, Mount Sinai Hospital

- Overview of the Preventable Admissions Care Team (PACT) Program
- Sharing transitional care best practices in urban communities to reduce readmissions
- Action team discussion

3:55pm **Cross-Team Learning: Sharing Community Care Transitions in Rural North Carolina**

Karen Southard and Eleanor Everett, The Carolinas Center for Medical Excellence

- Overview of the Community Care Transitions Program in North Carolina
- Sharing transitional care best practices in rural communities to reduce readmissions
- Action team discussion

4:35pm Discussion: Sharing Resources and Strategies to Reach our Goal
Lois Cross

4:45pm Public Comment

4:55pm Wrap Up and Next Steps

5:00pm Adjourn

Supporting Materials

PowerPoint

Action Pathway Graphic

Resource List

Roster

Tab 2

Web Meeting Presentation

Readmissions Action Team Public Web Meeting

April 29, 2014
3:00-5pm ET

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Welcome and Roll Call

Lois Cross RN, BSN, ACM (Chair) American Case Management Association	Sandy Markwood National Association of Area Agencies on Aging
Osman (Ozzy) Ahmed, MD, DrPH Magellan Complete Care,	Debra McGill, RN Maine Medical Partners
Sumita Bhatia, MPH, MS Kaiser Permanente	Diane Meier, MD Center to Advance Palliative Care
Sarah Callahan, MHSA America's Essential Hospitals	Amy Minnich, RN, MHSA Geisinger Health System
Pamela Carroll-Solomon, MJ, RHIA, CPHQ CHE Trinity Health	Armando Nahum Safe Care Campaign
Maureen Dailey, PhD, RN, CWOCN American Nurses Association	Stacy Ochsenrider, MSN, ANP-BC Bronson Methodist Hospital
Elizabeth Davis, MD San Francisco General Hospital	Ranjit Singh, MA, MBBChir, MBA American Board of Family Medicine
John Fastenau, MPH, RPh Janssen Pharmaceuticals	Thomas Smith, MD, FAPA American Psychiatric Association
Lisa Freeman Patient Advocacy of Connecticut, Fairfield, CT	Karen Southard, MHA, RN The Carolina's Center for Medical Excellence
Tejal Gandhi, MD, MPH, CPPS National Patient Safety Foundation, Boston, MA	Alissa Zerr, RN, BSN, MPH Cerner Corporation
Antony Grigonis, PhD Select Medical, Mechanicsburg, PA	

NATIONAL QUALITY FORUM

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Agenda at a Glance

- Welcome, Roll Call and Meeting Objectives
- Action Team Pathway Overview
- Cross-Team Learning
- Team Discussion
- Adjourn

Meeting Objectives

- Present Readmissions Action Pathway
- Feature success Learn from fellow action team members' work as it relates to the Action Pathway
- Share Action Pathway Resources and Strategies

Action Team Pathway Overview

Readmissions Action Team Pathway

Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

Cross-Team Learning: The PACT (Preventable Admissions Care Team) Program

Maria Basso Lipani, LCSW
Director, PACT

Mount Sinai

The Mount Sinai Hospital

Founded in 1852

- 1,171-bed tertiary-care teaching and research Hospital
- 183 Hospital based practices
- 3,500 Physicians, residents, and fellows
- 2000 Nurses
- 200 Social Workers
- 58,000 Discharges
- 95,000 ED visits
- One million ambulatory visits in hospital clinics and
- Family Practice Associates

Our Community:
Cultural, socio-economic, ethnic and religious diversity

East Harlem: Lower than median household incomes; documented health disparities exist among the predominantly Latino/Hispanic and African American populations

Upper East Side: One of the nation's most affluent communities

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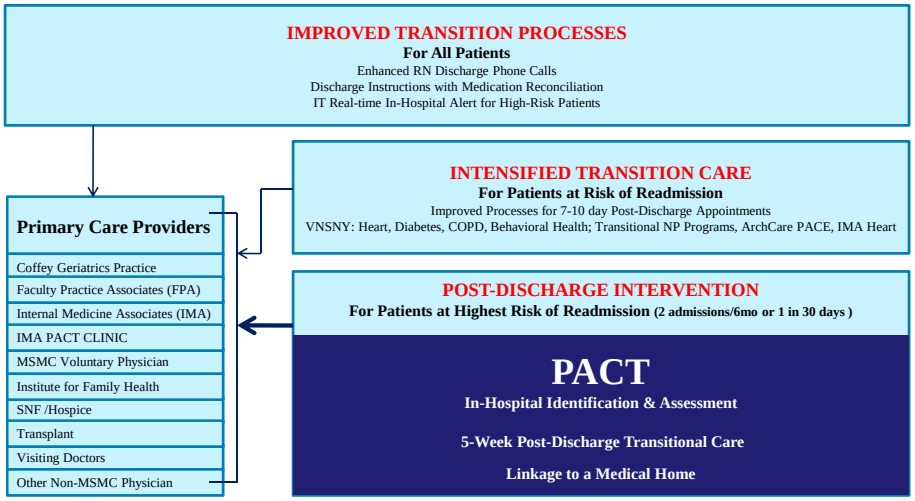
Mount Sinai Medical Center Transition/Readmission Initiatives

Objective: Reduce 30-Day Readmissions of All Adult Patients



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Overview

PACT is an intensive, transitional care program utilizing social workers to target patients at high risk for a 30-day readmission

- Emphasis is on engagement at hospital bedside to identify for each patient the areas of psychosocial strain that compound readmission risk
- 35-day post discharge intervention is titrated to address each psychosocial driver; delivered through phone calls, accompaniments and home visits when necessary
- No exclusions for: homeless; non-English speaking; substance abuse; mental illness; dialysis; dementia
- Three funding sources enable application of the PACT Model to different populations (Funding: CMS as part of CCTP; a NY-based managed care company; MSH)
- Integration & coordination w/other CMS-funded initiatives at Mount Sinai

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Who does PACT reach?

PACT targets patients at high risk for a 30-day readmission

Patient identification methods:

2010-2011: Utilization history at same hospital

2012: Modified HCC score*

2013: Risk flags embedded in EMR, driven by score + utilization history to same or other hospital

2014: Same as 2013; PEP Score testing underway**

PACT patient characteristics:

6045 patients enrolled 10/12 – 3/14 (all payors)

56% female; 44% male

51% African American/Hispanic/Other; 42% Caucasian; 7% Not reported

Ages 21-107

Majority have 3+ comorbidities; high incidence of diabetes; dialysis; documented mental illness

65% require a HIGH intervention vs. 35% MODERATE

*Modified HCC Score was created by Mount Sinai's Department of Health Evidence & Policy using 2010 Medicare claims data
** PEP score (Predicted Effect of PACT)was created by Mount Sinai's Department of Health Evidence & Policy and is derived from monthly data analysis of PACT outcomes

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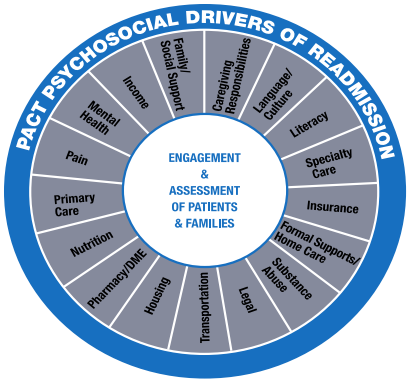
PACT Assessment & Intervention:

- What areas of psychosocial strain impact the risk of readmission?
- In what areas is the patient open to receiving support?
- What resources can help the patient to sustain the outcomes?



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PACT Interventions

Require strong engagement, assessment & advocacy skills; creativity, collaboration & perseverance - ***"Anything & Everything"***

Standardized approach that is individualized for each patient HIGH; MODERATE; "Watch"

- **Joe**: 76; Caucasian male; venous stasis ulcers of lower extremity, weakness, HTN, chest pain, HLD, CAD umbilical hernia, and "social problem"
  - Six month-Pre-PACT utilization: 1 MSH admission in 6 months prior + 3 ED visits/week, multiple weeks
  - 30-day Readmission Risk: HIGH
  - PACT Intervention Type: HIGH
  - Areas of psychosocial strain addressed: Housing; Primary Care; Formal Supports; Insurance
  - Six month-Post-PACT utilization: None
- **Mark**: 65; African American male; COPD, CHF, DM; anxiety
  - Six month- Pre-PACT utilization: 3 MSH admissions in 30 days for shortness of breath
  - 30-day Readmission Risk: HIGH
  - PACT Intervention Type: MODERATE
  - Areas of psychosocial strain addressed: Formal Supports; Mental Health
  - Six month-Post-PACT utilization: None

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The Impact of PACT

The blended risk of a 30-day readmission for all PACT patients is 29.2%

Most have a <u>39%</u> risk of a readmission within 30 days

Condition or Characteristic	Coefficient	Odds Ratio	95% CL for OR		Risk Score
Chronic Kidney Disease	0.3869	1.5	1.399	1.809	2
HF	0.2569	1.3	1.058	1.580	1
Osteoporosis	0.3374	1.4	1.040	1.888	1
COPD	0.6851	2.0	1.485	2.651	3
Depression	0.5553	1.7	1.277	2.377	2
Stroke	0.9292	2.5	1.590	4.035	4
AMI	0.8912	2.4	1.639	3.628	3
HIP Fracture	1.055	2.9	1.306	6.316	4
Alcohol Abuse	0.7603	2.1	1.100	4.160	3
Breast Ca	0.8597	2.4	1.124	4.967	3
Dual Eligible	0.279	1.3	1.104	1.583	1
Black	0.4201	1.5	1.228	1.887	2
Hispanic	0.2914	1.3	1.078	1.661	1
CKD & AFIB	1.1159	3.052	1.756	5.305	4
CMD (<65 yrs)	0.5437	1.722	1.220	2.431	2

Score	Patients at Each Score	Patients/ Group	Avg Risk/Group	Blended Risk
2	1717	2883	20.6%	29.2%
3	1166			
4	809	2509	39.0%	
5	572			
6	535			
7	281			
8	146			
9	67			
10	56			
11	21			
12	17			
13	3			
14	2			

Source: Mount Sinai's Department of Health Evidence and Policy. Based on analysis of 2010 claims data.

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PACT Pilot Hospital Utilization & Readmissions

All Payors ***(These results have been replicated across 6045 patients enrolled 10/1/12 – 3/31/14)***

Hospital Utilization*
For Patients Who Completed PACT 5-Week Intervention (N=615)
(September 2010 – August 2012)

	Pre	Post	Reduction
Admissions excludes index admission	952	546	43%
ED Visits	1707	789	54%

Patients with no Readmissions at Mount Sinai at 30, 60, 90 days (N=615)**

# of days from Index Admission	# of patients	# of patients with hospitalizations	# of patients with none	30-day readmission rate (%)
30	615	106	509	17%
60	499	73	426	28%
90	472	104	368	34%

Source: TSI (Mount Sinai's cost accounting system) 9/1/10-8/31/12
*All patients are their own controls. The "Pre" time period has been adjusted to match the "Post" period on a per patient basis.
** Excludes patients who died post-discharge or were lost to follow-up.

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PACT Patient and Staff Feedback

"Y'all have taken such good care of me, I feel like I should take care of me."

"I was afraid you wouldn't call me because my cell phone turned off but then I said no, she'll track me down, and you did!"

"We typically don't tell people about our family problems. And we certainly don't let them into our house like this. We are very private people. But this is good and I feel it is helping us talk about those things we don't usually talk about."

"Thank you for continuing to call us. I didn't expect you to keep calling for so long. I appreciate how closely you are taking care of my husband, but I really love that you ask about me, too. This has been very difficult for both of us and I felt like I was falling apart a few times there, so thank you for always checking to see how I'm holding up."

"How do I get my patient into the program? Can I request that she be admitted to a specific floor? Tell me what I need to do."

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Cross-Team Learning: Sharing transitional care best practices in rural communities to reduce readmissions. Community Care Transitions in Rural NC

Karen Southard, RN, MHA
Eleanor Everett, LCSW

April 28, 2014

Facts About Rural Health Care

- Nearly one in five Americans – live in rural and frontier areas.
- Rural Americans reside in 80 percent of the total U.S. land
- There are 4,118 primary care Health Professional Shortage Areas (HPSAs)
- The average median income is $40,615 compared to $51,831 for urban residents.
- Approximately 15.4 percent live in poverty

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Challenges of Care Transitions

When leaving the hospital:

- 1/5 Almost **one in five** elderly patients return within 30 days
- 1/3 patients can't explain their medications
- 3/4 Three-fourths of chronically ill patients wouldn't need a return trip it **if they had a plan for follow-up care**
- 1/2 patients can't state their diagnoses

Robert Wood Johnson Foundation

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Quality Improvement Organization (QIO)

QIO Mission: Improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries

Fast Facts-

- Sections 1152-1154 of the Social Security Act
- 53 QIOs
- Support the National Quality Strategy

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For the Nation

Partnership for Patients – Care Transitions

"Safe, effective, and efficient care transitions require thoughtful collaboration among health care providers, hospitals, nursing homes and other facilities, social service providers, patient caregivers, and patients themselves."

Partnership for Patients

PARTNERSHIP FOR PATIENTS

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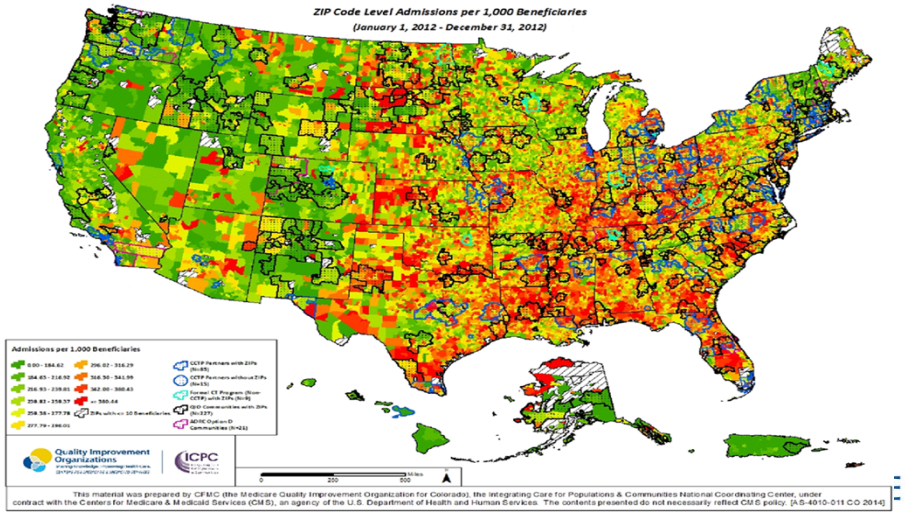
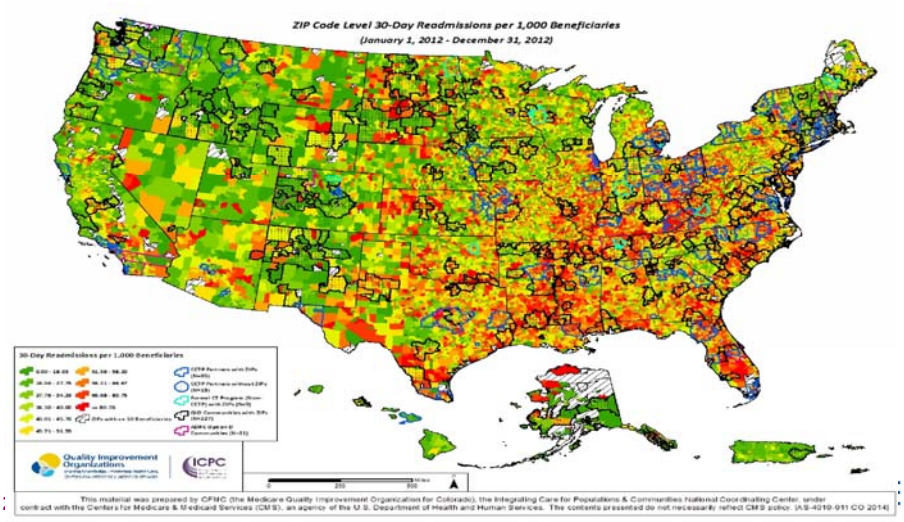
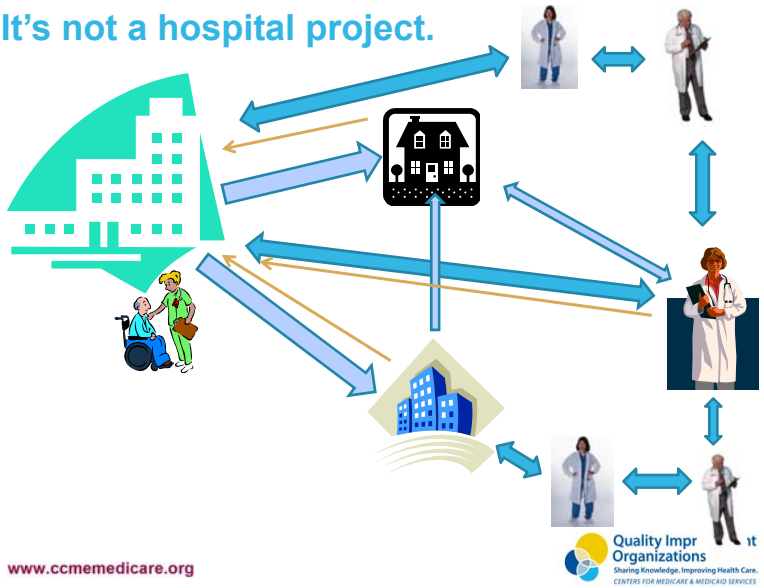
US Admissions



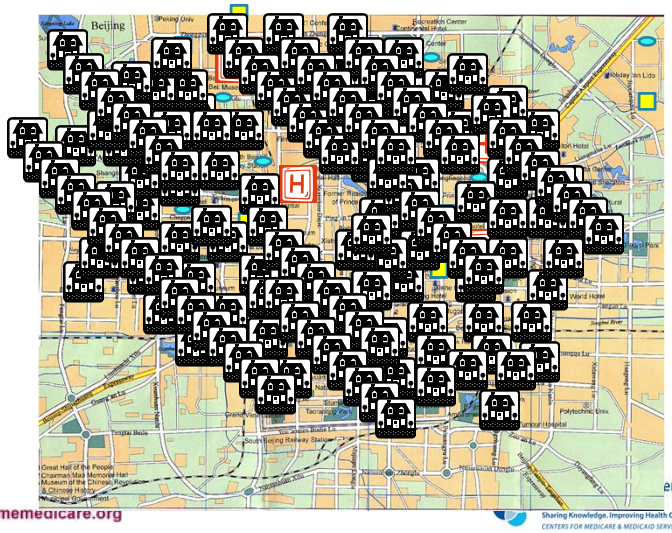
US Readmissions



It's not a hospital project.



It's a Community Problem



What is Community Engagement

Community Engagement or Community Coalition-
"A coalition brings together individuals and organizations with diverse skills and expertise to address a specific issue."

CDC

So Many Partners Flying Solo

- Changes in government policy and law
- P4P
- Change in payment model
- Competition for market share
- Consumer advocacy

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Community Engagement

Improving communication and understanding each other's contributions

Setting Goals, RCA, selecting interventions and developing measures

Building a Coalition, improving community outcomes

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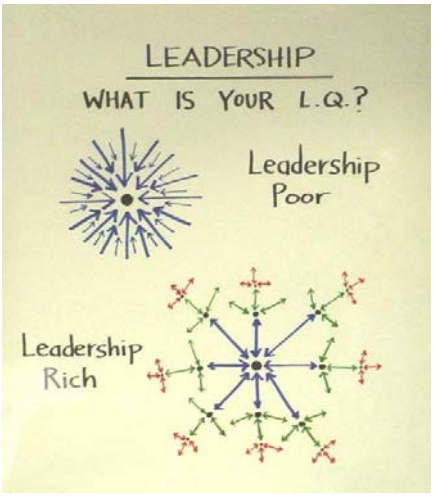
Community Organizing Techniques

- Tie participation to values
- Include personal narratives
- Intentionally develop other leaders
- Intentionally develop relationships
- Develop flexible tactics

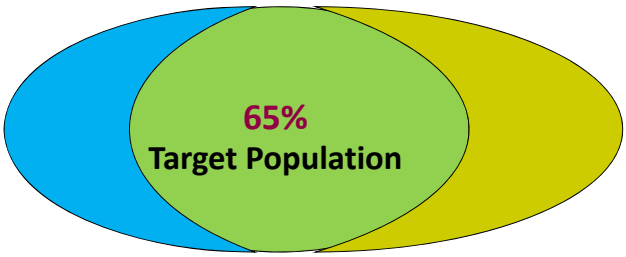


Providers Pair

- Providers pair and do separate interventions
- Informal leader
- Coalition formed on sharing best practices
- Consensus based decision making

The 'Zip Code Overlap' Community Definition

FFS Medicare beneficiaries
living in zip codes of interest



FFS beneficiaries discharged
from hospitals of interest

Community identity supports both social and economic sustainability

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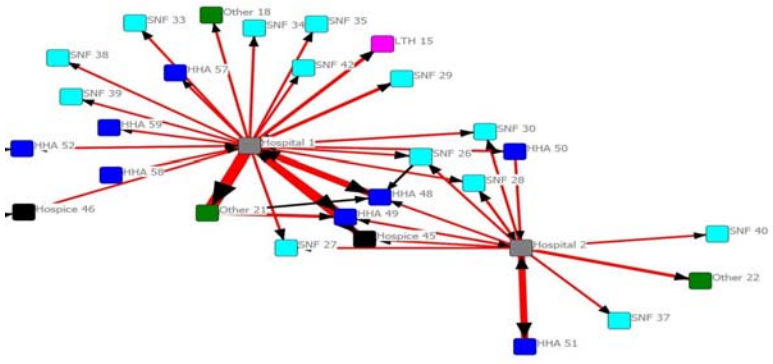
Social Network Diagram: ≥ 30 Transitions



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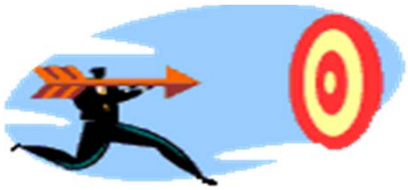
A Community SWOT Analysis

Strength	Weakness
Knowledge/Skills	*Lack of resources*
What is working	*Silo efforts*
Common Goals	
Opportunity	**Threat**
Drivers of readmission	*Competing priorities*
Mobilize interventions	*Culture, beliefs and values*

Community Specific Root Cause Analysis

- Data Analysis
  - ✓ Proportion of Transitions Table
  - ✓ Coalition Readmission rates
  - ✓ Coalition Admission rates
  - ✓ Hospital Admission/Readmission rates
  - ✓ Emergency Department (ED) visit Rates
  - ✓ Observation Stay Rates
  - ✓ Mortality Rates
  - ✓ Post acute care setting readmission rates
  - ✓ Disease specific readmission rates
- Process Mapping
- Readmission Tracers
- Chart Reviews
- Patient/Stakeholder feedback

Moving Into the Community Coalition Interventions



Care Transitions in Rural North Carolina
Eleanor Everett, LCSW

Facts about Hickory, NC

Location: Foothills of The Great Smoky Mountains
Population: 40,093
People > 65: 14%
Percent below poverty: 20%
White: 74.9%
African American:14.3%
Hispanic: 11.4%
Business: Manufacturing

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Hickory Community Tackles Readmissions

- Community Leaders completed a needs assessment for the senior population in 2010
- Palliative Care Center & Hospice of Catawba Valley became lead force in care transitions
- Goal: Apply for the Community Based Care Transitions Funding
- Develop a community based care transitions program

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Characteristics of the Community

- Strong community leader
- Actively participating in HEN
- Demonstrated high reliability
- Focused on one goal
- Strong community partners

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Community Assessment for Care Transitions

- Community had first meeting in the February of 2012
- Completed Root Cause Analysis in May of 2012

Results of RCA

The major issues identified were:

- Lack of communication at time of discharge or transfer
- Lack of medication reconciliation
- Lack of timely medical follow up
- Lack of patient and family understanding of medication and the disease process

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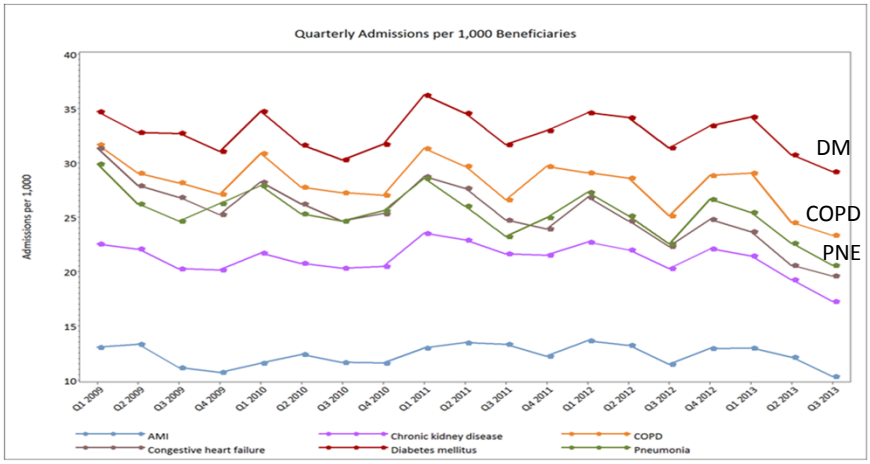
Hickory Community Admissions



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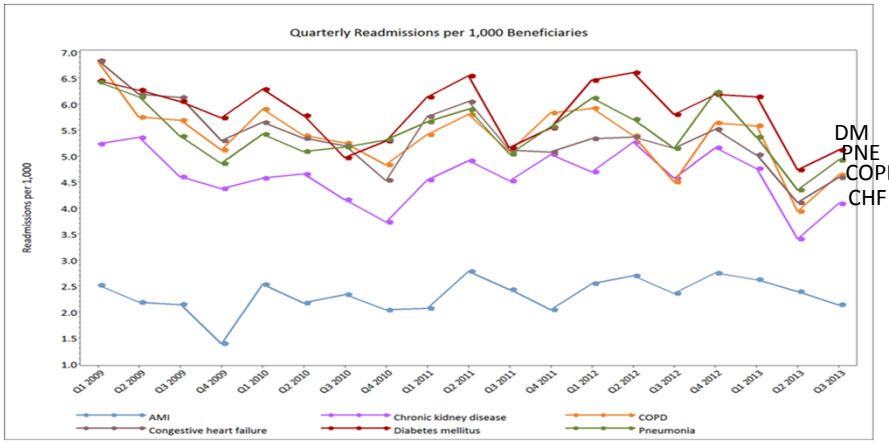
Hickory Community Readmissions



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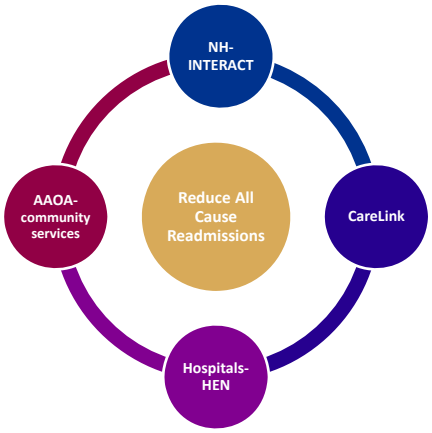
Community Coalition- Target Readmissions



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Targeting the RCA- CareLink

Navigators see identified patients in hospital:

- Home visit
- Follow up phone calls
- Social needs assessed and coordinated
- Medication reconciliation

Patient Referred to CareLink in the Hospital → CareLink Navigator Hospital Visit → Patient is Discharged → CareLink Navigator Home Visit → PCP Visit (CareLink Navigator May Attend w/ Patient)

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Benefits of the Intervention

- Monthly referral, >100 patients
- Reduction in hospital readmissions
- Increase in the hospital patient satisfaction scores
- Patients social issues are being addressed
- Improved communication and hand offs
- Improved adherence to medication regimen

Funding for Program

- Funding is a **major** issue for the program
- Community did not get CCTP funding but chose to start the program on hope funding would come
- Program did eventually get funding through a grant for part of the program

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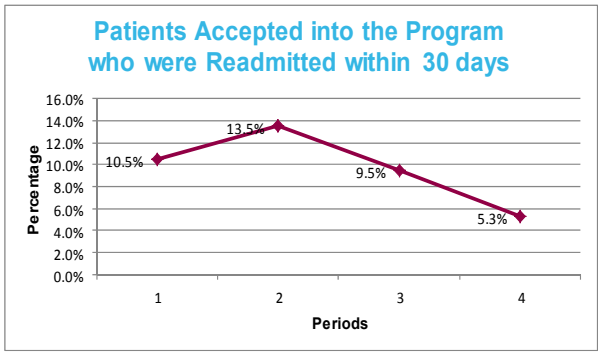
Results of CareLink Intervention

- For the first four periods there has been an average of 9.6 percent of patients readmitted within 30 days after participating in the program.



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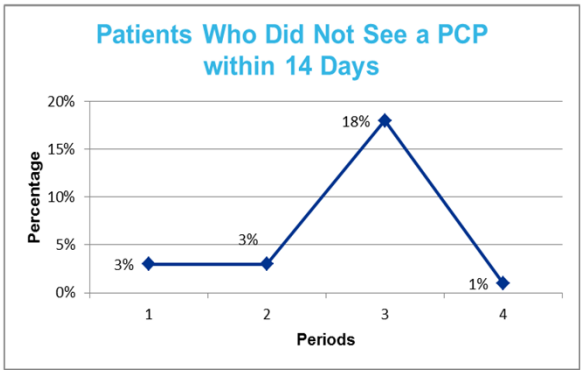
Results of the CareLink Intervention

- For the first four periods there has been an average of 6.3 percent of patients who have NOT seen their PCP within 14 days of discharge.



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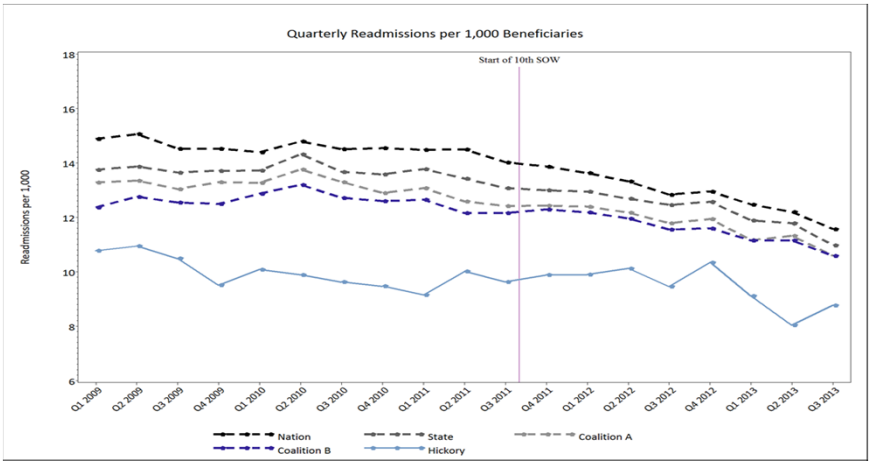
Hickory Community Readmission Rates



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Expanding CareLink to the Next County

Community formation in Iredell County

- Poorer county
- Limited resources
- Hospital with high readmissions
- No community senior assessment
- Community partnership-weak

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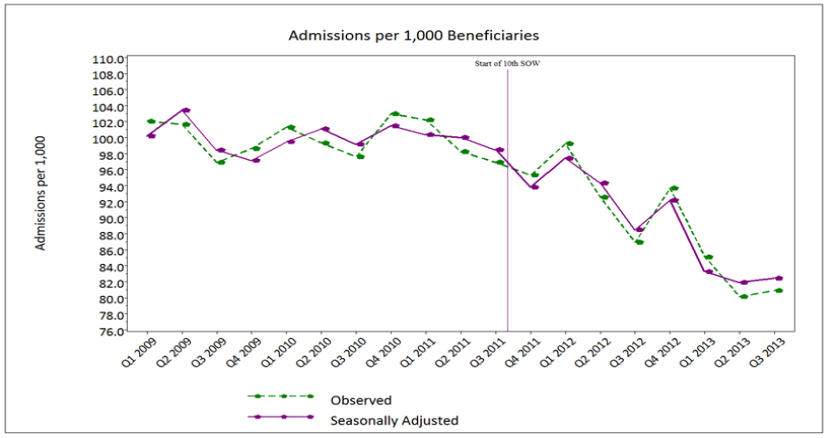
Community Assessment for Care Transitions- Iredell

- The RCA took eight months to complete with the same issues noted in the Hickory RCA
- CareLink was introduced to the community members from health care agencies that worked in both communities
- Since Iredell did not have the resources to develop a program, they asked Hickory to provide CareLink services

Iredell Community- Quarterly Admissions



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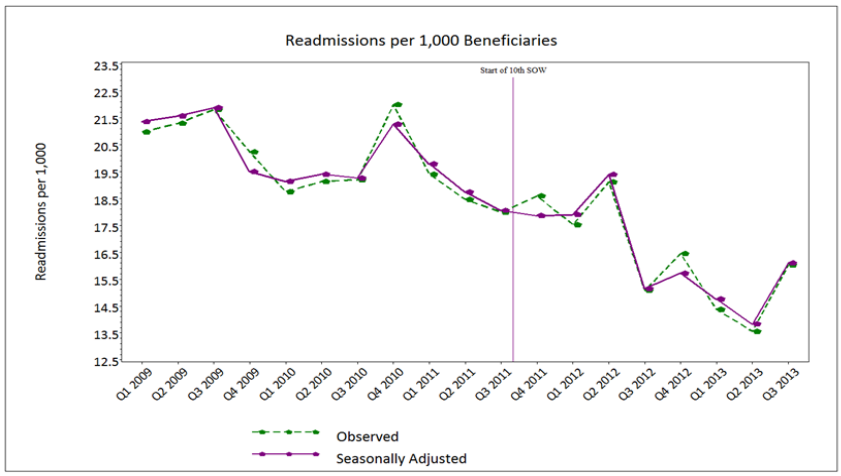
Iredell Community- Quarterly Readmission



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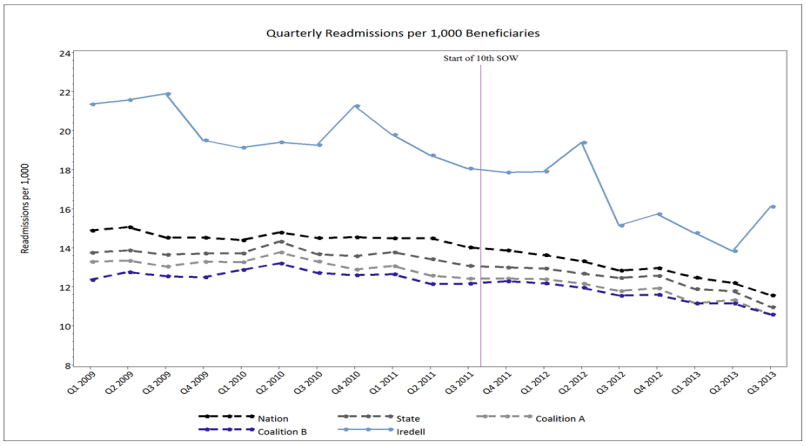
Iredell Community- Readmission



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Current Issues for CareLink

- Referrals from some hospitals to CareLink is still slow
- Program expansion is challenging with limited resources
- Lack of physician access in Iredell community is a challenge for follow up
- Hospitals support the program but their operating margin limits financial support
- Lack of funding in Iredell for community based services

Conclusion- Lessons Learned

- Leadership commitment is key!
- Communities need time to build relationships and trust
- Disparities, lack of resources and manpower will impact outcomes of the program
- Social determinants always impact care transitions
- Community based transition program is a business
- Local government will impact the success of care transitions, especially in rural setting

Questions?

The Carolinas Center *for* Medical Excellence

www.ccmemedicare.org • (NC) 800-682-2650 • (SC) 800-922-3089

This material was prepared by The Carolinas Center for Medical Excellence (CCME), the Medicare Quality Improvement Organization for North and South Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Product Number Needed

Discussion: Sharing Resources and Strategies to Reach our Goal

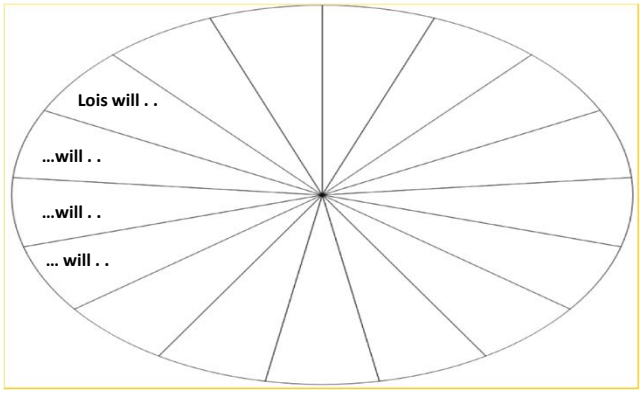
Goal: Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

- What specific things can you do to model, build on, or help to spread your fellow action team members' work?
- What work are you doing that your fellow action team members can model, build on, or help to spread?

Next Steps: Commit to Action

- **Systems Improvement**
- **Collaboration**
- **Patient and Family Engagement**

Readmissions Action Team Commitments:



"The whole is greater than the sum of its parts." - Aristotle

Public Comment

Wrap Up and Next Steps

Thank you!

Tab 3

Action Pathway Graphic

Promoting Person-Centered Care for Vulnerable Populations to Safely Reduce Avoidable (Re)admissions

GOAL

Support the Partnership for Patients in reducing readmissions by 20 percent by:

- leveraging patient, provider, and community partnerships
- identifying and addressing psychosocial needs

Tab 4

Resource List

Systems Improvement

Share promising person-centered tools and resources

Team Member	Resources
Alissa Zerr	• Technology (Trends, strategies, research, network, care teams, clinical workflows)
Amy Minnich	• Population health initiatives specific to members with special needs including high risk pregnancy, children with complex medical needs, specific diagnoses including HIV/Hepatitis C and other chronic health conditions
CMS	• Sharing data
Debra McGill	• Research around the impact of social determinants of health and adverse childhood experiences (SDOH + ACE) and the importance of relational theory approach to patient care • Statistically significant outcomes around the impact and effectiveness the primary care provider's role in care transitions • Access to large amounts of data • Care transition and care management resources • Part of a regional Accountable Care Organization
Elisabeth Davis	• Knowledge about and experience working with interventions to reduce readmissions
John Fastenau	• Lead research projects exploring the direct costs of schizophrenia and available treatment options. These studies have focused on the cost of relapse, delaying time to hospitalization, and continuity of care across clinical settings • Provider and payer prospective and their incentives
Maureen Dailey	• Person-Family Approach o ANA's Nursing Alliance for quality care will engage in informing strategies (NAQC's Principles of PT Engagement/ White Paper) • ANA will confer out specialty nursing organization to TD evidence-based strategies to effectively address psych-social factors
May-Lynn Andresen	• Gather best practices from Dvelopmental Disabilities and Integrative Health that can be considered as strategies for toolbox
Ozzie Admed	• Health Information Technology (HIT)
Pamela Carroll-Solomon	• Access to health system data/model practices across continuum of care • Measurement/data analysis • Lean Six Sigma black belt • Predictive financial penalties model
Sarah Callahan	• Bring the collective learnings from our membership to share with others at our national meeting focusing on reducing readmissions
Stacy Ochsenrider	• Bronson Methodist Hospital (BMH) Care Transitions Coach Program • Experience/ insight across the continuum of care

Systems Improvement

Share promising person-centered tools and resources

Sumita Bhatia	• Measurement • Sharing best practices amongst regions • Experience in sharing some of Kaiser's strategies to reducing readmissions
Tony Grigonis	• Literature Reviews on psych-social factors and hospital readmissions that may be useful for the action team when deciding directions for ultimately making recommendations to reduce readmissions. • Literature Review of measures for psych-social factors and community partners
Vickie Sears	• Experience with 22 Safety-NET Hospitals in working on Best Practices to Reduce Readmissions • Process Measures SIT • Hospital Tools
Ranjit Singh	Research infrastructure for testing evidence-based interventions. This includes: a practice-based research network composed of primary care practices; grant-writing expertise; research personnel; access to community partners.
Lois Cross	• Share current readmission reduction programs from Sutter Health (example-Wellspace, Advanced Illness Management) • Share Health Literacy tools • Healthcare system perspective

Collaboration

Leverage partnerships, networks, and relationships

Team Member	Resources
May-Lynn Andresen	• Communicate with health care teams
Sumita Bhatia	• Collaborate and partner with senior leaders and regional clinical leads to help monitor specific Readmissions metrics, quarterly
CMS	• Networking • Spread Pacing Events • Conduit/facilitator
Pamela Carroll-Solomon	• Connections across continuum • Access to health system data/collaboratives across the continuum • Person-centered care/strategies
Elizabeth Davis	• Work collaboratively with experts to develop tools to integrate medical systems and community programs
Tejal Gandhi	• Dissemination network via our webinars, membership groups, etc.
Sarah Callahan	• Bring the collective learnings from our membership to share with others at our national meeting focusing on reducing readmissions
Debra McGill	• Connection w/ Dave Wendberg (Health Dialog/ NNEACC) • Strong Connection with large Health System and Health Community
Amy Minnich	• Work in collaboration with other leaders in health services including medical management, pharmacy, quality improvement and wellness teams to build a comprehensive population health approach focused on patient engagement, care coordination and overall case management. • Health Plan background and perspective • Data analytics- understanding reason for admission, readmission by different trends diagnosis, age, and population.
Karen Southard	• Access to 53 QIO's who have expertise in community coalition building > spread NQF Readmission Action goal and promote the strategy • Need a measurement set around community intervention > work with National Coordinating Corner for care transitions to research evolving data instrument to measure community interventions
Sandy Markwood	• Access to CCTP and Other community-based care transition models that can serve as informative models of partnerships • Through network of 6/8 Area Agencies or Aging: Title VI Tribal Aging programs that reach over 12 million older adults disseminate patient education information on patient/caregiver engagement to prevent readmissions
Lois Cross	• Access to network of Case Managers through American Case Management Association to spread Readmission reduction programs • Access to Intermountain HEN Readmissions Team

Patient and Family Engagement

Engage patients and families to catalyze change

Team Member	Resources
Ozzie Admed	• Consumer Activation • Care Management • Enablement tools
Pamela Carroll-Solomon	• Patient experience perspective, vendor relationships, data across the continuum • Person-centered strategies • Always events
Elisabeth Davis	• Primary care perspective • Safety net perspective
Tejal Gandhi	• Health literacy tools • Patient engagement tools/ upcoming white paper on readmissions
Stacey Ochsenrider	• Engage patients in their health and healthcare and help them to understand the impact of their lifestyle and choices, with coaching toward change as they are ready.
Tony Grigonis	• Patient-centered approach for critically III Pts: and end of life decisions • Issues of Post-Service Communication
Armando Nahum	• Tools on “How To” partner with patients, communities, ETC…
Tom Smith	• Knowledge of person-centered approaches and strategies for screening, assessing, and referring for behavioral health conditions
Stacy Ochsenrider	• Equipping patients with the right tools and resources to succeed • Real time patient experiences • Engage patients in their health and healthcare and help them to understand the impact of their lifestyle and choices, with coaching toward change as they are ready.
Ranjit Singh	Our team has experience with creating 'Patient Action Teams' that engage patients in practice improvement in PCMH's

Tab 5

Action Team Roster

NATIONAL QUALITY FORUM

Action Team Roster

Patient Safety Collaboration: Readmissions

Lois Cross RN, BSN, ACM (*Chair)*
American Case Management Association, Dixon, CA

Osman (Ozzy) Ahmed, MD, DrPH
Magellan Complete Care, Miami, FL

May-Lynn Andresen, RN
Quality in Healthcare Advisory Group, LLC, Cold Spring Harbor, NY

Sumita Bhatia, MPH, MS
Kaiser Permanente, Oakland, CA

Sarah Callahan, MHSA
America's Essential Hospitals, Washington, DC

Pamela Carroll-Solomon, MJ, RHIA, CPHQ
CHE Trinity Health, Wilmington, DE

Maureen Dailey, PhD, RN, CWOCN
American Nurses Association, Silver Spring, MD

Elizabeth Davis, MD
San Francisco General Hospital, San Francisco, CA

John Fastenau, MPH, RPh
Janssen Pharmaceuticals, Titusville, NJ

Lisa Freeman
Patient Advocacy of Connecticut, Fairfield, CT

Tejal Gandhi, MD, MPH, CPPS
National Patient Safety Foundation, Boston, MA

Antony Grigonis, PhD
Select Medical, Mechanicsburg, PA

NATIONAL QUALITY FORUM

Action Team Roster

Sandy Markwood
National Association of Area Agencies on Aging, Washington, DC

Debra McGill, RN
Maine Medical Partners, South Portland, ME

Diane Meier, MD
Center to Advance Palliative Care, Washington, DC

Amy Minnich, RN, MHSA
Geisinger Health System, Danville, PA

Armando Nahum
Safe Care Campaign, Atlanta , GA

Stacy Ochsenrider, MSN, ANP-BC
Bronson Methodist Hospital, Kalamazoo, MI

Ranjit Singh, MA, MBBChir, MBA
American Board of Family Medicine, Buffalo, NY

Thomas Smith, MD, FAPA
American Psychiatric Association, New York, NY

Karen Southard, MHA, RN
The Carolina's Center for Medical Excellence, Cary, NC

Alissa Zerr, RN, BSN, MPH
Cerner Corporation, Overland Park, KS