Administration on Aging
Affordable Care Act Webinar
Million Hearts
February 28, 2012
2:00 - 3:30 pm Eastern

Coordinator: Good afternoon and thank you for standing by. All parties will be able to listen-only until the Q&A portion of today's conference. If you'd like to ask a question during the Q&A portion, you pay press star 1 on your phone. At that time you'll be prompted to state your name. To withdraw your question, you may press star 2. Today's conference call is being recorded. If anyone has any objections, you may disconnect at this time.

I would now like to turn today's call over to Ms. Marisa Scala-Foley. Ma'am you may begin.

Marisa Scala-Foley: Thank you Crystal. Good afternoon everyone, good morning to those of you who are on the West coast and Hawaii and elsewhere. My name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development at the Administration on Aging.

We thank you for joining us for this month's Webinar, our latest in a series of Webinars focused on opportunities for the aging network both state and local agencies within the Patient Protection and Affordable Care Act otherwise

knows as the Affordable Care Act or the ACA. Our Webinar series is designed to provide the aging and disability networks with the tools that you need to participate in ACA related efforts in your area.

So today we are taking a break from care transitions and we have an eye toward another key issue within the ACA and that is prevention. So since we're in American Heart Month for about another 36 hours or so, we are taking advantage of that and taking a look at HHS' Million Hearts campaign as well as an innovative partnership between a health system and a Chronic Disease Self-Management Program in South Florida that targets people with cardiovascular disease. So we have an exciting lineup for you today.

So just a couple of housekeeping announcements before I turn things over to our wonderful panel and that is first, if you have not yet done so, please use the link included in your email confirmation to get on to WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through the chat function in WebEx.

If you don't have the access to the link that we emailed you, you can also go to www.webex.com, again that's www.webex.com. Click on the attend a meeting button at the top right corner of the page and then enter our meeting number, which is 935271758. Again that meeting number for WebEx is 935271758.

It prompts you for a pass code. The pass code is AoAwebinar and that is all one world. If you have any problems with getting into WebEx, please call WebEx technical support at 1-866-569-3239. Again that's 1-866-569-3239 for technical problems with WebEx.

As Crystal mentioned, all of you except for our speakers of course are in listen-only mode. However we welcome your questions throughout the course

of this Webinar. There are two ways that we can - that you can ask your questions. First through the Web using the chat function in WebEx. You can enter your questions. We'll sort through them and answer them as best we can when we take breaks for questions after each presenter.

In addition, after the presenters wrap up, we will offer you a chance to ask your questions through the audio line. When that time comes, Crystal will give you instructions as to how to queue up to ask your questions.

If you think of any questions after the Webinar or have any questions you'd like us to follow up on, please email them to us at affordablecareact@AoA.hhs.gov.

As Crystal also mentioned, we are recording this Webinar. We will post this recording, slides and a transcript of the Webinar on the AOA Web site at www.AoA.gov and just lick on the health reform and the aging network box on our page. We'll post those as soon as possible likely by early next week.

You cannot print the slides out through WebEx. So we - as I mentioned, we will post them online. If you need them before next week, please feel free to email us at affordablecareact@AoA.hhs.gov.

Okay. I think that's all the housekeeping announcements right now. So we are thrilled to have with us today a wonderful panel of speakers. Leading us off today on our sort of journey through Million Hearts is Janet Wright who is the Executive Director of the Million Hearts initiative in the U.S. Department of Health and Human Services.

So with that, I will turn things over to Janet.

Janet Wright: Thank you Marisa. It is a privilege for me to join you all today and to share with you a Million Hearts. The subtitle here is Community Leaders Making a Difference. And I know that this is a fact. We are very delighted that Million Hearts is one of Secretary Sebelius' priorities. But we also know that unless this is meaningful at the individual level and at the community level where we live and work and play that we will not achieve our goal.

And speaking of that goal, you will see the fingerprints of Dr. Tom Frieden from CDC and Dr. Don Berwick, the previous Administrator of CMS. You'll see their fingerprints all over the design of Million Hearts because it has an explicit goal and a definitive timeline.

Million Hearts goal is to prevent a million heart attacks and strokes in five years. The clock started ticking January 1 of this year and we will count up heart attacks and strokes prevented by January 1 of 2017.

The initiative as you see on this slide is co-led by the CDC and CMS but executed really by many federal and state agencies and partners and a number of private sector and community organizations. Next slide.

Here you see the declining death rates from heart disease and stroke over the last 20 years. They are dramatic. And we hope that they continue - this decline continues.

What is of great concern of course is the fact that obesity and diabetes are on the rise and those contribute dramatically to heart disease and stroke deaths. So Million Hearts is actually proposing to add an extra million on top of this decline and hopefully be able to reverse what we think would be an increase due to the obesity and diabetes epidemics. Next slide.

You see on this slide that heart disease and stroke, despite that decline you saw over the previous 20 years, it is still the cause of one out of every three deaths in the country. Over two million heart attacks and strokes each year, 800,000 deaths.

It leaves our families ravaged. It leaves holes in our communities. And it also is costly for the country in terms of healthcare treatment costs and lost productivity. It's also the single greatest contributor to the racial disparities in life expectancy. Next slide.

Sorry. This one is a little animated. Keep going and we'll get to the next one. So you all are familiar with this. And you can just keep hitting the button a couple more times until we get to the top of the pyramid.

The point I want to make here is that the most dramatic impact on health can be had at the lower portion of that pyramid or triangle addressing the socioeconomic factors.

Million Hearts is actually focused on the next layer up looking at reduction of trans fat and sodium in the foods, changing policy around tobacco use. And then a step up from that focusing on smoking cessation. And then up to the clinical interventions area of the pyramid, looking at high blood pressure and cholesterol control.

Of course our advice includes more general messages around physical activity and healthy nutrition beyond sodium and trans fat. But most of our focus is on those three levels below the peak of the pyramid. Next slide.

Here you see that over that 20-year period the decline in mortality from heart disease and stroke really encompassed contributions form the clinical side of

health to the community or public health portion of contributions. The reason that's important is that Million Hearts is going to address its attack on heart attack and stroke along two lanes.

One is a set of community effort and the other a set of clinical efforts. And we predict that by the end of that five-year period we're actually going to see a long awaited and much desired integration of the community and clinical efforts. So those are no longer siloed.

It think any national framework could execute that integration but Million Hearts happens to be one of the first out of the gate but I think will contribute to the integration. Next slide. So if you would just blink through these too. I apologize if these are a little bit annoying.

But I'll make the point that I started on the other slide and that is that Million Hearts is working in these two lanes of clinical and community efforts. On the community side we're focused on reducing exposure to smoke and reducing tobacco use through policy changes, reducing sodium and trans fats in the food supply. A lot of that work is ongoing at CDC and FDA and working with the food industry and the restaurant industry.

On the clinical side you'll also see this principle of focus. The first is focusing on the ABCS. And the ABCS stand for aspirin for those at risk for heart disease and stroke; B stands for blood pressure control; C for cholesterol management; and S for smoking cessation.

Our work here will be to focus the healthcare professionals on the ABCS and focus individuals on the power of preventing heart attack and stroke through excellence in the ABCS. I'll go over each of these in a little bit more detail in a moment.

But the other components on the clinical side are the full deployment of health information technology and taking full advantage of the innovations in care that are currently available. Next slide.

This slide is going to show you - thank you for keeping on - that's fine right there. It will show you the current status around the country for us as Americans as a population on these very basic elements of care. Aspirin for those at risk; only 47% of us are actually getting the aspirin.

Out of those of us with high blood pressure, less than half of us have that blood pressure controlled. And then under cholesterol, we're barely making a third who have high cholesterol having that effectively managed.

And this last one scares me the most because this statistic refers to people who have already decided - they've already committed to stopping cigarette use and only 23% of them are being offered the treatment, that being counseling and replacement therapy that have been shown to be highly effective.

So this slide shows you that we - the earlier slide showed you we have a very important and significant problem for the country; affects us personally in our lives and as a country as the economy.

Secondly we know what to do. These are not scientific black holes. We know treatments that are effective and fortunately for blood pressure and cholesterol many of the medicines are generic and of low cost and in some systems no cost.

And the final nail here is that we are not performing at the levels that we could. So there are lots of opportunities here for Million Hearts to make a difference. Next slide.

This is just an example -- and one more, thank you -- of what's happened in New York City and New York State as they have used policy levers to affect a habit of tobacco use. You see here that over the period from the year 2000 to 2010 these are just the taxes applied to the price of cigarettes.

So on the next slide you'll see the impact of those high taxes in New York City and New York State. So on this slide you see a decline in smoking over a period of time that started with the tax increases and was propelled or accelerated by other policy letters.

The availability of three patches, very hard-hitting media campaigns and then additional tax increases. Currently New York City has the lowest smoking rate of any city across the country. That applies to both adults and youth smokers. Next slide.

So also on the community slide we're looking to reduce sodium in the foods. And as most of you know, 90% of us take in more sodium than we should. Most of the sodium that we get, the excess sodium comes not from salt added at the table but from the food supply from restaurants and from processed foods.

So the work is to work with the food industry, gradually reduce that sodium intake. As it turns out, when we reduce our sodium intake, our taste buds adjust in a period of about 5 to 12 days. And then we don't miss the salt. So this is something that can be done and it will have a huge and lasting impact on the prevalence in the control of high blood pressure. Next slide.

Also for trans fat I can tell you I've practiced cardiology for a long time, 23 years, and didn't really have trans fat on my radar screen. As it turns out, it's a bad actor. It raises the bad cholesterol, lowers the good cholesterol. And our efforts here will be eliminating artificial trans fat from the food supply.

In 2003 FDA required that companies list the trans fat content on the food label. And shortly after that ruling, companies voluntarily reformulated the foods. So we're on the way there. Next slide. I think we'll just pass on. It's just a map showing where some trans fats regulations are and it's certainly not happening in enough places around the country yet. Sorry, next slide.

So we'll move over to the clinical part of the family and again, I expect over time those will not be separate areas. But in the clinical side, we are working to make sure that for those folks who do need to be in care in a medical system that they get high quality, they get good access and they achieve great outcomes.

And where it's going to do that by focusing again the health system on the ABCS and individuals on the ABCS in terms of their power to affect them. Making sure that we make the most of health information technology and the innovations in care. Next slide.

I just want to say that as being co-led from CMS and CDC, you know, that CMS is the largest purchaser of healthcare in the world. It pays $1.5 billion in benefits each day. And CMS is fully committed to the success of Million Hearts because it knows that this will not only help save lives but it will actually help improve care and reduce costs. Next slide.

And then, as you know, I think it might have been referenced a little earlier, this is the CMS three-part aim. Better health for the population, better care for each individual and lower cost through improving quality over time. Next slide.

Oh on the ABCS, the work for Million Hearts and many other agencies is to create a simplified and uniform set of ABCS measures. So that for those practitioners and professionals out there, we are reporting clinical measures the same way and uniformly across the system.

We want to make sure that we're focusing on the measures with the greatest impact and those are the ABCS. We also wanted to create the systems to extract the data for these measures but within the workflow of care so it is not an additional burden. And then finally, incenting performance on the ABCS. Next slide.

This slide talks about health information technology. Now we're asking doctors, nurses to take care of a population of patients. That's so odd for those of us who've been doing that job. You take care of one person at a time. But when looking across and making sure that you're not missing an opportunity for good care, you need to look across say my population of people with high blood pressure. That requires a registry function.

Second, we want to make sure there are decision support tools embedded in the flow of care so that you don't miss an opportunity when you and a patient are in a room together.

And then finally for those of us who take medicine, we need reminders and queues and nudges that help us remember to get a blood pressure check or a

cholesterol check, get a medication refilled and ideally to go out and take that brisk walk. Next slide.

We're living in a fantastic time where new care models are being launched and tested. Some of those are health homes or patients in a medical home, accountable care organizations. Our work is to try to get the ABCS embedded into those models and make sure they're incented and then make sure that the key members who work in those new models are fully deployed.

We have for years underutilized a whole slew of professionals starting with pharmacists. They're terrific behavior change agents and experts in medication use.

Cardiac rehab teams are very effective at changing behaviors towards healthy patterns. And then heal coaches and lay workers and in mental health care wellness specialists.

Many other new team members have rounded out our ability to help support folks as they take medications and change their lifestyles from sort of the cultural norm in the United States to one that is heart healthy. Next slide.

So here's where we are now under baseline for the ABCS, sodium and trans fats. The middle column under target is where we want to be by January 1 of 2017. For those of you who know these statistics and epidemiologists, you know, that that is a big leap. This is an audacious amount of change in a short period of time.

The clinical target column refers to those folks who area already in a healthcare system and compared to the general population we would be holding those systems to higher target levels. Next slide.

So it is clear that everybody holds a piece of a puzzle. The community organizations, where we work and live can have a profound impact on heart attack and stroke and can do so in a short period.

By engaging members around pretty straightforward approaches of offering places for blood pressure checks and cholesterol screenings, reinforcing the ABCS measures, all the components of the healthy lifestyle that you already know link to excellence in the ABCS, you can contribute to saving lives. Next slide.

These are public sector, family members frankly. When we look across all of these agencies, there are about 50 different activities going on across the agencies that will directly contribute to reducing the risk of heart attack and stroke. They've devoted that work to Million Hearts and are clearly the drivers and partners in this effort. Next slide.

These are a subset of the private sector supporters so far. In fact today the state of Maryland signed on as a Million Hearts partner. We hope to get other states in the future. Each of these organizations have committed a specific body of their work to preventing heart attack and stroke and joining u sin the fight for 2017. Next slide.

So let's look. A little sneak peak at what the future could look like. First of all that lower sodium foods are everywhere. They're inexpensive and in fact it's hard to find something that's high salt. And by the way, our taste buds have adjusted. This tastes like normal food to us.

Second, blood pressure monitoring is not something you have to go into a doctor's office for necessarily. I can do that at home. I get coaching over the

Internet or over my consultant, with my physician. We are - and pharmacists. We are in more constant fluid contact.

And I keep monitoring it until I get it under control. The data from my home or my workplace to my professional of choice flows seamlessly between these two settings. It doesn't have to wait for an appointment.

Finally, no or low cost medicines are available. In fact when I go back to that blood pressure monitoring, I want to say we've actually gotten to a place now in this future not too far away where blood pressure monitoring is really simple.

Currently there are blood pressure cuffs that are just push button as many of you know. It inflates and deflates. But there's still a bit of an obstacle in interpreting the numbers.

So in this near future the numbers are going to come back but there'll also be a sort of red, yellow and green to be an easy read on whether you're under control or not.

We know that adding Web based pharmacist care to home blood pressure monitoring increases the control of blood pressure by more than 50%. And this was actually in a high - a very high level of blood pressure set of folks. People go very high levels of blood pressure. So the ones that needed the control the most. Next slide.

I just will close by showing you the logo and actually have a place on our Web site for pledging. The pledge for individuals means that you commit to reducing your risk of heart attack and stroke, that you want to contribute to good care and the ABCS.

If you're an organization and you take the pledge, we'll be circling back to you to find out what within your body of work would help reduce heart attack and stroke risk and get us all to goal. Thank you very much.

Marisa Scala-Foley: All right. Thank you so much Janet. We've gotten in a question through chat so let's pose that now and then we'll turn things over to the team from Florida.

So the question that we got is how are you all working with many of our senior centers within aging network through education on nutrition and food labels and so forth? How are you partnering with these groups and other kinds of community-based providers on the non-clinical side of your work?

Janet Wright: Well I'd say the first element of our partnership has been with AOA who has just been - has been a - AOA has been a partner since pretty much day one and has opened up all of its channels of communication and networks of action to us.

So our job now is to help provide content and then help connect the areas on aging with other activities in certain communities whether that's through the quality improvement organizations or the beacon communities, schools of pharmacy and nursing and medicine in their areas and help identify certain actions that everyone can contribute a little bit to that can move the needle in a big way.

Marisa Scala-Foley: Okay. Terrific. That is - let's - oops. We got one more question in from Chantelle who asks what is Web based pharmacist care?

Janet Wright: You know, what I can do is provide the reference for that study. I don't have it in my head but it is an additional overlay of - as it says, contact with pharmacists that can provide additional guidance on blood pressure control.

Marisa Scala-Foley: Okay. That's great. If you can get that to me, I will make sure that Chantelle gets it.

Janet Wright: Will do.

Marisa Scala-Foley: Okay. Great. Thank you. We got another question in from Adriana who asks how are you addressing - how are cardiovascular health disparities being address on the clinical side of your work particularly among Hispanics, African Americans and Native Americans?

Janet Wright: You know, I'm so glad that you asked that question. And we are in the process of formulating our strategy. The great news is that the Department of Health and Human Services and across all of the agencies that are within HHS have developed a national strategy to address disparities.

Million Hearts will be plugging into that strategy and helping execute it. We know, and as I mentioned earlier, that cardiovascular disease not only kills Americans, it kills us unfairly, unjustly. And the outcomes are much worse for African American and Hispanic and Native Americans than whites.

And so our early efforts -- I failed to mention this -- are over focusing now on high blood pressure because we know that that is the immediate and greatest problem within the ABCS. And it is particularly true in African Americans. And so we will be over expressing our work there in the first - at least in the first couple of years for Million Hearts.

Marisa Scala-Foley: Okay. Great. We got another question in from Catherine, who asks what the - what are the specific performance measures for this campaign?

Janet Wright: Right. There are specific performance measures and in fact even since our launch in September there's been significant alignment of those measures. As I was pointing out earlier, that is a goal to harmonize and make uniform that said.

So for those of you who do measures work, you know that they come with a certain number attached. I'd be happy to send out to the entire group the clinical quality measures for Million Hearts. There is indeed an aspirin measure, blood pressure control measure, smoking cessation, which the offering of cessation - the screening for tobacco used and then the offering of cessation interventions.

In terms of cholesterol measure, as many of you know, the National Heart, Lung and Blood Institute will be issuing in midyear due guidelines for cholesterol, blood pressure and obesity. And the specific measure that will be used in Million Hearts will depend upon the guidance that we get from NHLBI.

So right now we are looking at a cholesterol management measure. I can to into more detail and would be happy to either offline or, as I said, I can send out the specific measures. But the cholesterol one will really depend on what we learn from NHLBI.

Marisa Scala-Foley: Terrific. If you can send those to me, again I'll make sure Catherine gets those.

Janet Wright: Great.

Marisa Scala-Foley: And I think that we are all caught up in questions in chat. So thank you Janet so much for a wonderful thought provoking presentation. And now we will turn our attention to our team from Florida. As many of you may know with funding through the American Recovery and Reinvestment Act a couple of years ago, AoA was able to fund Chronic Disease Self-Management Programs in partnership with the National Council on Aging around the country.

But ours wasn't - our Chronic Disease Self-Management Programs or CDSMP, which is based on the Stanford model weren't, you know, in a lot of states were partnering with public health networks that were already working in this area.

And with our next team from Florida, we have an example of one of those already existing networks that have sort of come together to target people with cardiovascular disease. So we've got a team from Baptist Health South Florida as well as the Health Foundation of South Florida.

Our first speaker will be Martha Pelaez who is the Healthy Aging Regional Collaborative Director from the Health Foundation of South Florida. Next on this team to speak will be (Allison Bivin) who is a Grants Administrator with Baptist Health South Florida's Center for Research and Grants. And finally sort of batting cleanup for the team is Jackie LeBoeuf who is the Administrative Project Analyst at Homestead Hospital.

So with that, I will turn things over to Martha.

Martha Pelaez: Thank you very much. I'm really delighted to be in this call and share what we are learning and also what we plan to do in response to the Million Hearts Campaign.

Following the excellent presentation by Janet, I would like to showcase a new partnership between the Health Foundation of South Florida and Baptist Health Hospital in Homestead, Florida.

The Foundation is a public charity founded in 1993 with a mission to overcome the obstacles to better health in South Florida. And we have focused on preventive health, primary care, healthy lifestyles or health and since 2008 on healthy aging.

The transition of care clinic that has been created by Baptist Health for the purpose of improving the cardiovascular health of an underserved and vulnerable population in Homestead is an example of the types of partnerships fostered by the Foundation.

The healthy aging regional collaborative started by the Foundation in 2008 worked with community partners to offer the Stanford CDSMP workshops in South Florida. We have about 150 sites in any given year offering this program.

During the past three years we have offered over 3000 participants with one of the self-management workshops. We're including living healthy.

In Janet's presentation we've shown how important it is to bring together clinical interventions and reduction of risk factors. In our experience for the majority of burnout patients who are suffering from poor health and limited

access to healthcare services, self-management workshops have helped to turn them into proactive individuals.

In the words of a participant, she said, "I've learned in this workshop that I still can make decisions." That is, she was regaining control. The majority of our CDSMP participants increase their level of physical activity. They say they are able to control symptoms so they can go on with their activities. They make a practice to replay roles; great deal of emphasis on those sodium products.

They make a practice to really become active partners with their healthcare providers to learn how to really work with them in managing their medication and in identifying barriers to their care.

So while our community works on policy changes and we've recognized that those are essential and our clinicians work on innovations in cardiovascular health, we as community partners are doing our part and meaning we are -- and I'll tell you who we are -- doing out part to turn burned out patients into proactive patients or actually patients that have no idea how they translate what they hear they have to do into things that they want to do and can do.

So the collaborative offers our partners and we - co-partners are community agencies that are interested in being part of this - part of the solution. So we offer the agencies that become members of the healthy aging collaborative a centralized system of training. We provide a multiple program license, uniform data collect and data analysis systems.

But we also offer a staff at the Foundation that is working with them for developing sustainable partnerships with healthcare provider. We want to be as successful as we need to be.

We have designed our program in very close association with the Administration on Aging and the National Center for Healthy Aging and the National Council on Aging.

I have to say that we have benefited tremendously from the huge investment of AoA in training and in the community that they have actually built through all of our states' Departments of Health and Aging units to make self-management accessible to our community.

We have really benefited from what they've started and we at the Foundation have brought our resources to mend the resource of this wonderful movement to improve health.

So who are our partners? We partner with the Department of Health, with the area agencies on aging, in our community with the YMCA, with other local community foundations and community centers as well as with federally qualified health centers, hospitals such as Baptist Health and Medicare Advantage programs.

Our goal is to make it easy for someone who is interested in their hearth health to access evidence based clinical preventive services as it is for them to access a self-management workshop and vice versa. So we need - we would try to working making sure that we all know how we complement each other.

And we've learned that if we focus on those people with multiple chronic condition and those with worse risk factors for cardiovascular disease, then we need to focus on providing them with a comprehensive care package that takes them from where they are to where they can truly become proactive and work in overcoming obstacles to health.

So the program Jackie will describe has received funding from the Health Foundation and it's now part of her healthy aging regional collaborative. And she will hear CDSMP's only component but we hope that it will be a very important component in the - in cardiovascular health as well.

The program is targeting an adult population. That - but we know that it will definitely contribute to healthy aging. We are delighted to present to you the Baptist Health model and we hope that this is just one of many opportunities to improve the cardiovascular health in our communities.

So Allison, I'll pass it on to you.

Allison Bivin: Great. Thank you so much. I really appreciate it. We're really thrilled to be able to share all this information with you all today. And some of the primary points that we want to touch on for you are noted here. Specifically we'd like to give you a little bit of an introduction to Baptist Health South Florida and in our system of hospitals, specifically Homestead Hospital.

The other thing that we're looking to be able to share with you is what drives the need for the clinic. And that's the community that we serve. Who are our patients or our clinic care philosophy, our approach? We think we have a model approach to the challenges that we face in our community and you'll hear more about how we're planning to resolve that challenge.

Of course as Martha expressed earlier, the Stanford Chronic Disease Self-Management Program is a vital component to the program that we are offering to our patients. And so what we also want to do is share a little bit more about that relationship that we have with the Health Foundation of South Florida and the use of the Stanford Chronic Disease Self-Management Program.

And then of course we want to share with you what our goals and our expectations are for the program, the outcomes that we hope to see and for the program as well as the patients.

Our next slide is a little bit about who we are. Baptist Health South Florida is a non-profit faith based system of six hospitals. We also have several urgent care centers. We're located in South Florida and our locations are comprised of three counties within South Florida, which includes Miami Dade County, Broward County and Monroe County.

Miami Dade County is where we are centrally located and it is the sixth largest county in the country with over 2.2 million residents. We are the largest healthcare system in South Florida. And we currently employ of 13,000 people.

To give you a little bit of feeling of our community and our community demographics, we have a extremely poor community that we're serving here in Homestead. Our per capital income is 53% below the national average. Our ethnic makeup is 52% Hispanic, 28% Caribbean and/or Creole speaking and the remainder is white and other ethnic groups.

Our Homestead Hospital is located in the city of Homestead, which is the second oldest city in the county. It's a agriculturally based very poor community. Our hospital offers a 120-bed facility and that is in addition 40 bed emergency department.

As far as patient service utilization, we see here on an annual basis to our emergency department about 80,000 visits. That makes us the third busiest emergency department in Miami Dade County.

And we're seeing an increase in our Level 1 visits. And our Level 1 visits would include visits for earaches and sore throats, which has brought to our attention the need to transition primary care that's being sought by our patient base in the emergency department to a transitional center for our patients. And that thus is the base for the clinic and the relationship with the Health Foundation.

We have a very high readmission rate for patients with chronic disease and specifically here we're talking about this clinic is addressing heart failure as well as diabetes patients. And we will be detailing some of the specifics about those patients in our presentation at a latter part of the presentation.

We stated a little bit about our patients earlier but we have a very, very unique patient base. We have very high illiteracy rates and we have a patient base that is a primarily Spanish speaking patient base. And that's why the Chronic Disease Self-Management Program was instrumental in the success of this program because it is one of the only programs that we found that offers a training program for our patients that is offered in Spanish.

We also find that our patient base are very culturally centric. And what we mean by that is that the patient based culture plays an enormous role in the success of their treatment. And recognizing that, we're using that as another foundation for how we provide services through this transitional bridge clinic.

The next slide that you'll see is about our unemployment rate. And we know that this plays an enormous factor in the success and the provision of services for out patient base in Homestead. And Miami Dade County is suffering a very high unemployment rate.

Right now we have - Miami Dade County has a 12.2 unemployment rate. And that's compared to the state's unemployment rate of 10.7, which is then compared to the United States unemployment rate at 9.1%. So you can see there's a very large gap with our patient base and with the patients that we serve as far as unemployment trends.

Financial hardship we also have an enormously high foreclosure rate in Miami Dade County. You're talking about 19% foreclosure as compared to 4% at the nation.

The next slide gives you a feeling for the patients and their - the poverty level that we are addressing. We have an enormous need in our community. The federal poverty level is $22,350 for a family of four. However, we have 39% of just Miami Dade County residents that live below that level. In Homestead, Homestead Hospital's population is 53% below the federal poverty level. So the need for care of this nature is very evident.

The medically underserved areas - I'm sorry, this is the next slide. The medically underserved areas we noticed that we have a very significant distress safety net as far as patient care. And what we're seeing is based on the fact that our national legislation is limiting what they're going to cover. And the majority of our patients if they do have any medical coverage have Medicaid.

So what we're seeing is that the days that would be covered for a hospital stay are being reduced from 45 to 23 days. And our emergency department visits are limited to 12 per year. That has a huge impact on the delivery of services and the care that we provide our patients because they use the emergency department as their - currently as their primary source of care.

I'm going to pass the next slide on to Jackie who's going to share with you some specific information about our program and how we justified the need for the program. Jackie.

Jackie LeBoeuf: Thank you, Allison. Our program was in the planning stages for a couple of years. So we were very pleased when we learned that the project was approved for our current fiscal year budget.

When we were performing the needs assessment, we knew that we needed to decompress our emergency department and we understood that we needed to bridge the gap between when patients were discharged from the hospital and from when they were able to seek care with a primary care physician or at a permanent medical home.

We looked at our readmission rate specifically for heart failure and our readmission rate for heart failure is at 13% and the national benchmark is 8.16%. And we also looked at the readmission rate for diabetes. And our readmission rate for diabetes is 11% and the national benchmark is 6.28%. So clearly we have a serious problem with the readmission rates for those chronic diseases.

And important to mention, our patient base of 65 and older is experiencing significant growth in the area and we expect over the next five years an 18% growth rate in patients 65 and older.

And also a major part of our needs assessment was of course caring for our indigent community. And in Miami Dade we have 32% of our residents as uninsured. And that's compared to only 16% nationally. No nearly double. And let's see - moving on to the next slide. We also - oh I'm sorry. Can you go back one slide?

When we preformed our needs assessment, we also looked to the community clinics that we support. We support four clinics in the area financially and those clinics reported that they were overburdened.

And when in fact that patients were waiting up to six to eight weeks for follow up visits at the clinics. And so that's why they were returning to our emergency department for care. And as the previous slides illustrate, our primary service area is medically underserved.

And most importantly our patients trust Homestead Hospital for their healthcare needs. So we knew that we needed to find a way to best bridge the gap between when the patients are discharged from our facility and when they're seeking primary care. The next slide. Thank you.

And Baptist Health South Florida our philosophy centers on providing patient and family centered care. And when the Health Foundation of South Florida extended an invitation for us to attend Dr. Eric Coleman's presentation on care transition programs, we were pleased to learn that Dr. Coleman's extensive research validated our approach of patient family centeredness in our care.

And we learned that the multifaceted approach is essential to our program's success, which again it supports our operational model. And as Janet mentioned that everyone holds a piece to the puzzle. So we look to our partnerships with the community such as Florida International University.

Florida International University's advanced registered nurse practitioner students will be performing their clinicals at the clinic. And also again we really appreciate our opportunities that we have with the Health Foundation South Florida.

And now I'm going to pass it on to Allison, who's going to talk more about our approach.

Allison Bivin: Thank you, Jackie. Okay. So our next slide talks about the clinic care philosophy and our approach. And as Jackie mentioned earlier, this is a very unique setting. We're very pleased to be able to offer the services through an ARNP managed clinic.

And our ARNP will be providing services that ensure the continuity of patient care from the acute care setting. We'll also have additional staff that include registered nurses who are experienced in case management and specifically chronic disease management.

Our clinical staff will meet with patients in the hospitals to introduce the clinic prior to their discharge. And this is a really important component to the services that we provide because as I mentioned earlier, we have a very culturally centric patient base here. And the trust factor associated with the service provision is really important.

So the face that we can approach them in the hospital setting where they already have an established relationship is very important to the success of the clinic and also the success of the patient and that's what we're really looking at here.

The patients are going to be scheduled to follow up with our clinic within 48 hours after their discharge. The clinic visit will be comprised of a medication review, teaching, focus groups on disease management. And caregivers will also be encouraged to attend the focus groups.

Many of our patients are supported by family members and the family members play a very important role in the success of their independence and be able to self-manage properly. So recognizing that, we know that offering that opportunity for the caregivers to participate in educational components is really, really important to their success.

Patients will be followed up with on a weekly or as needed basis to monitor their progress. Initially we anticipate that we'll be working with them on a weekly basis. And as they become more successful with the program that the follow up care will start to dwindle down a bit.

The coordination and the transition of our patients to their primary care physicians is a really important component of this program. We recognize the need for the program based on the fact that our local clinics were overburdened serving the uninsured population. And that was why we were seeing a lot of the patients that they could not see coming to our ED.

So one of the things that we feel is really important is that we work with the patients to attempt to identify a primary care physician and to help them make that successful transition.

Of course as we stated earlier, the Stanford Chronic Disease Self-Management Program is a key component to this program and the service delivery. We're so pleased to be able to offer this to our patients and particularly because as I spoke of earlier, the majority of the patients that we serve do - are Spanish speaking. They're not bilingual. They are Spanish speaking only.

So what we're going to be offering is a 2-1/2 hour workshop that will be taught by a lay person who is chronic disease - who has a chronic disease and that person will be paired with a medical professional in order to be able to

present these classes. And the classes will be offered to the patients over a six-week period. And the main focus of course is in promoting self-efficacy.

The next slide indicates a little bit more about our clinic care philosophy and approach. The workshops as I discussed earlier will be taught by a layperson who has a chronic disease who's also paired with a medical professional.

We are very fortunate to have supported the Health Foundation of South Florida and the healthy aging regional collaborative. They have agreed to help train our master trainers as well as our lay people. And we will be leading the workshops and collecting data relevant to the success of the program in the past in other environments.

The other thing that Jackie touched on earlier was the fact that we have a very unique relationship with Florida International University and their ARNP students. They will be participating in clinical rounds with our patients.

We're an unusual facility. We are a non-academic affiliated hospital system actually until this past year and we established a relationship through our newest hospital, which is less than a year old, our West Kendall Baptist Hospital facility.

And they have partnered with Florida International University's Wertheim Medical School and their medical students are doing clinical rounds. But we have this very, very deep-rooted relationship with Florida International University School of Nursing and Health Services.

And they are playing a crucial role in the success of the program as well and it all ties back to the fact that we can't do this alone. We need the partners and the partner agencies in order to make this successful for the patients.

Our next slide indicates what we can surmise I think is benefits and limited barriers at this point. The first thing that we want to share is that we have a plan right now to open the clinic as of April 2. With that in mind, some of the things that we have had to look at is how are we going to generate income.

Generating income and supporting the clinic obviously for sustainability purposes is extremely important. And we found that our ARNP direct billing will result in an 85% reimbursement.

One of the things that we have found to be a benefit is recent conversations that we've had with managed care. Many of our major health plans are actually expressing a significant interest in our program model and have expressed the idea of amending our existing contracts to include our program patients should they carry insurance, which is a huge - has a huge impact to the success of the program financially.

Patient participation. We know that understanding our patient population and their unique needs is going to be a critical component of the success of the program. And we are proactively planning for challenges such as the history with local clinics. As we indicated earlier, there's a significant problem with the overburdening of the clinics.

And then there's also challenge with the fact that the patients have a tendency to not be compliant in those settings. So our model includes incentives for program completion and other initiatives that we'll be using in order to promote the completion of the program and also compliance from the patient standpoint.

We're also proud to say that we put a lot of energy into identifying the appropriate location for our clinic. Our clinic is strategically placed on a free trolley route, which was - has a major impact for the compliance of our patients and ensuring that we actually will see the patients and that they will be able to follow through without any challenges that they - we know they faced in being able to seek services in other locations.

So those are some of the benefits as well as limited barriers that we found to the success of our program and the implementation of it. And we're very pleased to have been a part of this Webinar today. And we hope that our example of what we've put together to address the needs of our patients is something that perhaps maybe can serve as a model to the rest of the Webinar participants.

We thank you very much. And we do have some contact information here in case you all would like to contact any one of us to ask us about various questions clinically or from a funding standpoint, from an administrative standpoint. So thank you very much.

Marisa Scala-Foley: All right. Thank you so much to Martha and Allison and Jackie for a wonderful presentation on an exciting program in South Florida. Before we do - we turn things over and answer the last few questions that have come in through chat and open up our audio lines, I just wanted to spend a couple of minutes going through our last few slides.

First we've got a few resources for you all, the Million Hearts Web resources for you all. The Million Hearts Web site we have listed up here as well as information about the CDSMP programs that the Administration on Aging funds.

We also have a link to the National Council on Aging Center for Healthy Aging Web site and COA partners with the Administration on Aging to serve as a resource center for chronic disease self-management programs as well as other healthy aging programs around the country.

Our next training. Our next training in March will - we will continue our series on care transitions and long-term supports and services with a topic to be named later, very soon. We have - please watch your email in early to mid March for registration information.

And as always, we invite you to send - if you - we are going to open up the lines for questions in just a moment but if you would have questions that you think about or if you have suggestions for future Webinar topics, we invite you to submit them to us at AoA@affordablecareact@AoA.hhs.gov.

So with that, Crystal, why don't you let people know how to queue up on the audio line for questions and then we'll - while they're doing that, we'll take the last couple of questions that have come in through chat and then we'll see who's on the audio line.

Coordinator: Thank you. If you would like to ask a question, please press star 1 at this time. Un-mute your phone and state your name. To withdraw your question, you may press star 2. Once again, any questions, please press star 1.

Marisa Scala-Foley: Okay. So we got a question for Martha and Jackie and Allison from Karen who asks in terms of financial sustainability, is there a charge to the patient to attend CDSMP workshops? Also what financial support is made available to partner agencies who may have contributed resources to the SMP program - or I'm sorry, CDSMP program.

Martha Pelaez: At this time our partners and all of our agencies that are partnering with the Health Foundation to implement CDSMP we see funding from the Foundation. So we are presently not charging individual participants for the workshop.

We are working very closely to ensure that we have not only collaborative of people who are able to deliver the program but we also built up a collaborative of healthcare providers that find part of their mission within their own care models to support a partnership with the community these programs in the future.

So to make it very simply, right now we are actually just offering the program under the funding of the Foundation. The community also is offering many CDSMP workshops with funding from the Affordable Care Act from the - our funding of Administration on aging, with the Department of Elder Affairs and lead agencies in the community.

And we look forward to finding the formula of what does it take for hospitals like Baptist Health and Medicare Advantage programs and other who have major investment in maintaining people healthy to see the value of self-management as a component of the package of services that are needed to do so.

So I hope I'm not too vague about what we're doing. But I think there are potential avenues to make this program sustainable. We've seen it around the country. So we hope to duplicate it here in South Florida as we move forward.

Marisa Scala-Foley: All right. Along those lines with regard to financial sustainability, we got a question from Jonathan who wanted to hear a little bit more about the ARNP billing for CDSMP workshops that you all are doing. Can you talk a little bit

about that? Are you billing the patient's insurance or Medicaid or other payers?

Jackie LeBoeuf: Hi Jonathan, in response to your question, we are able to bill for the professional component for the nurse practitioner seeing the patients. So we're billing directly on behalf of the ARNP. So we're able to receive 85% reimbursement of what the physician would have received.

And we're also in the process of amending managed care contracts because they've expressed interest in our program model and it behooves them to, you know, have their covered lives be cared in the clinic setting rather than the more expensive hospital setting. And we're also in the process of looking for more educational codes to see if we can bill for the chronic disease self-management program.

Marisa Scala-Foley: Great. Crystal, have we gotten anyone queued up on the audio line?

Coordinator: At this time there are no questions.

Marisa Scala-Foley: Okay. Well we've gotten a couple more questions in through chat so we'll take those and we'll open up the audio lines one more time and then if not, we'll close things out.

So we got a question in from Anna, who asks how do you get referrals to the program and where are the programs held? I think she's talking about the CDSMP.

Martha Pelaez: In general the CDSMP is being offered as I said in 125 locations in the community. It is our partners who go into places where older people

congregate. They have connections with the healthcare partners that find - that are the ones who are actually referring the patients to the program.

So we have multiple avenues from which a patient or an individual in the community may learn that the workshop is offered. In Baptist I will let Allison talk a little bit more about it. But in their model it's going to really be very much considered case management, the charge planning and Allison, why don't you say a little bit more about that?

Allison Bivin: Sure. Thank you, Martha. Basically what we have is patients that will be discharged from the hospital will be then transitioned to the clinic setting where they will be - and that's basically how the service provision will occur.

In addition to that we have talked to the local clinics about the possibility of referring patients as well. But right now we're going to be solely relying on patients that will be referred to the clinic from the hospital setting.

Marisa Scala-Foley: Okay. We got another question in from Alma, who asks what do you do with non-compliant patients? So how do you encourage them to come back in for follow up?

Allison Bivin: So the question was what do we do with non-compliant patients and how do we encourage them to come back for follow up. Correct?

Marisa Scala-Foley: Yes. That's correct.

Allison Bivin: Okay. Great. Thank you. Basically, you know, this is as we said earlier, it's a model program. And the challenges that we have encountered have been based on service provision from the hospital setting and also feedback from the clinics that are providing service for patients currently.

As far as encouraging them for follow up care, I think I touched on it briefly but we are offering various incentives that will be tied to completion of various phases of the CDSMP classes and as well as some of the various components of the service provision that we're providing, which would be about coming in and seeing the diabetes or heart failure educators and things of that nature.

The other thing that we are also offering the patients are vouchers for their prescriptions. And some of the things that we would be offering would be gift cards incentives and that would be based on completion of four of the six classes that they are required to complete for the CDSMP.

Marisa Scala-Foley: Okay. Great. Crystal, any questions through the audio line?

Coordinator: At this time there are no questions.

Marisa Scala-Foley: Okay. We've gotten two more questions in via chat and then we will go ahead and wrap things up. The first one comes from Malka who asks do you have volunteers already trained and committed to lead CDSMP? Their experience has been that we - that they've trained volunteers but sometimes after leading one or two groups, the commitment becomes too much and they drop out. So she wanted to hear about your experience with that.

Martha Pelaez: Yes, you're right. And that's why we have developed a centralized training and - training and coaching program for the collaborative because it is a challenge to not only maintain good instructors, good volunteers but it is also a challenge because many of these individuals are dealing with their own health programs and family responsibilities. So they're not always available when you need them.

So the pool - developing and increasing and nurturing that pool of volunteers is one of the most important parts of what we offer to the collaborative in terms of (rapid) accessible training programs.

The training of volunteers occurs in the collaborative on a regular basis. We offer them throughout the year on a regular schedule with a training calendar that everybody knows about. And we also do refresher trainers and we do incentives for our volunteers. And we provide them with monitoring and coaching.

We have had volunteers now that have been with us for - have been with our partners for three years. And they are extremely committed and they are best resources. But it is a challenge to keep that pool of volunteers fresh and to keep it committed and for them to feel that you're providing them - many of our partners provide volunteers with stipends and various types of incentives. And that is critical for this work.

Marisa Scala-Foley: Okay. We got one last question in from Ruth who asks how are you working with younger populations with your CDSMP programs? What kinds of agencies are you reaching out to and how are you recruiting younger adult populations?

Martha Pelaez: We have not had a history or as much of a history with younger populations as we have had with the older adults. Our first experience with younger populations was with the Minority Development Corporation Empowerment that targets minorities within Broward County.

And they have been - they have already been very successful in attracting younger participants by offering the classes in the evening, by doing

workshops in the weekends; in other words, by doing the workshops at times that this population really needs the workshop. So I think the flexibility seems - it has been key to making it successful for this - in their success.

And now with Baptist Health we - and the transition clinic we'll be also serving a working population whether they're 55 or older or younger. But they're going to also have to be very flexible in terms of scheduling and offering the program at the time that individuals who are working can actually - I mean places are accessible to these individuals.

Marisa Scala-Foley: All right. With that, Crystal, one last check in to see if we've gotten any more questions or any questions through the audio line.

Coordinator: There are no questions.

Marisa Scala-Foley: All right. With that then we have caught up in chat so we will close things out. First of all, thank you to our wonderful speakers, Janet, Martha, Allison and Jackie for your terrific thought-provoking presentations. And thank you to our participants for your great questions.

If you think of additional questions, if you have suggestions for future Webinar topics, we want to hear from you. Please email us at affordablecareact@AoA.hhs.gov. We do want these Webinars to be as useful to you as possible so we do very much welcome your suggestions.

We thank you all for joining us today and we look forward to having you with us on future Webinars. Have a great day.

Coordinator: Thank you for joining today's conference call. All parties may disconnect at this time.

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