

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Independence at Home Demonstration  
Monday, December 13, 2010  
1:30 PM – 3:00 PM EST  
Conference Call Only

The Centers for Medicare and Medicaid Services (CMS) is holding a Special Open Door Forum (ODF) in order to solicit stakeholder input for the design and development of the Independence at Home Demonstration. This Special ODF will be a “listening session” in which CMS hopes to gather information from stakeholders about issues that will affect demonstration design and implementation.

This demonstration was mandated by Section 3024 of the Affordable Care Act to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.

CMS is interested in holding this Special ODF to gather input related to the design and implementation of the provision. CMS will not be able to respond to comments at this Forum but intends to consider the information we obtain as we develop this demonstration.

CMS is especially interested in information and feedback in the following topic areas:

- a. How do physicians and nurse practitioners with practices solely providing care in the home obtain referrals?
- b. Do the practices have relationships with hospitals and emergency rooms and if admitted to the hospital who follows the patient and who is the physician of record? Do primary care/admitting physicians/hospitalists refer patients to home care physician practices?
- c. What level of integration do home care physician practices have with electronic health records, remote monitoring, and mobile diagnostic technology?
- d. What are home care physician groups measuring to track their own performance? What quality metrics are meaningful for this very vulnerable population?

For a more information, please see the demonstration website:

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240082&intNumPerPage=10>

We ask that all interested parties who wish to present their positions or comments prepare to speak for no more than 2 minutes.

CMS requests that interested parties prepare their comments or input in written form and submit this information to [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov).

#### Open Door Forum Instructions:

*\*\*Capacity is limited so dial in early. You may begin dialing into this forum as early as 1:15 PM ET.\*\**

Dial: 1-800-837-1935 Reference Conference ID 30308336.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

If you cannot participate during the live event, the encore feature will be available approximately 2 hours after the completion of this call and end 01-13-2011. To access encore, dial 1-800-642-1687, and use the Participant ID listed above.

An audio recording and transcript of this Special ODF will be posted to the Special ODF website at [http://www.cms.gov/OpenDoorForums/05\\_ODF\\_SpecialODF.asp](http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp) and will be accessible for downloading on or around January 13, 2011 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: <http://www.cms.gov/OpenDoorForums/>.

Thank you.

Audio File - <http://media.cms.hhs.gov/audio/IndependenceAtHomeDemo121310.mp3>

**Centers for Medicare & Medicaid Services**

**Moderator: Barbara Cebuhar  
December 13, 2010  
12:30 p.m. CT**

Operator: Good afternoon. My name is (Steve) and I will be your conference operator today.

At this time, I would like to welcome everyone to the Independence at Home Demonstration Open Door Forum. All lines have been placed on mute to prevent any background noise.

If you should need assistance during the call, please press star then zero and an operator will come back online to assist you. Thank you.

Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Good afternoon, everyone. My name is Barbara Cebuhar, and I work for the Office of External Affairs and Beneficiary Services here at the Centers for Medicare and Medicaid Services.

CMS is holding a Special Open Door Forum to solicit your input on the design and development of the Independence at Home Demonstration. Through this listening session, CMS is seeking to understand your experience with delivering care in the home -- to Medicare beneficiaries -- and is hoping that we can learn more from your experience to inform the design of this demonstration.

Section 3024 of the Affordable Care Act asks that CMS test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable beneficiaries.

I thought it might be helpful to outline some of the ground rules of these listening sessions. Because CMS is in the process of designing this demonstration, we are not able to answer questions so much as we are interested in seeking your input about the best ways to design a demonstration that is organized around providing care to Medicare or Medicaid beneficiaries at home. CMS will not be able to respond to comments at this forum but

intends to consider the information we obtain as we further develop this demonstration.

If something occurs to you that you would like to submit comments about for our consideration, please send information to the following email address. It's IndependenceAtHomeDemo@cms.hhs.gov. Let me repeat that. IndependenceAtHomeDemo@cms.hhs.gov. We're accepting your comments and insights until the end of December, so we'd really appreciate your help.

Before we get started with the questions where we need your input, I'd like to introduce Linda Colantino of the Office of Research, Demonstration and Information who will go over the slide deck that was provided as part of the announcement about this session. If you're at your computer, you can find the slides at [www.cms.gov/opendoorforums/05\\_ODF\\_specialodf.asp](http://www.cms.gov/opendoorforums/05_ODF_specialodf.asp).

Linda Colantino, if you could go ahead and get started with the slides, that would be a big help.

Linda Colantino: Thank you very much, Barbara, and welcome to all the Open Door Forum participants on the line. I am Linda Colantino, and I'm the team lead for the Independence at Home Demonstration. And I, along with others from the Demonstration Group, look forward to your comments today.

I will briefly cover the following before we open the session for comments. I plan to give a brief overview of the legislation and the demonstration design as it is stated in the law; also, a brief overview of the demonstration payment structure and the current status of the demonstration.

If you don't have a copy of the slides, I think Barbara gave you the information where you can find them. And if not, please know -- you can let us know by accessing our email address that I plan to give you at the end of the slide presentation.

As Barbara stated, this demonstration was mandated by Section 3024 of the Affordable Care Act with the goal of testing a payment incentive and a service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams. It is designed to reduce expenditures and improve

health outcomes in the provision of items and services to applicable beneficiaries, and I'll describe an applicable beneficiary in a moment.

The goal of the demonstration is to test whether an Independence at Home model is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinate the healthcare across all treatment settings, showing results in reducing preventable hospitalizations, preventing hospital readmissions, reducing emergency room visits, improving health outcomes, improving the efficiency of care, reducing the cost of health care services, and achieving beneficiary and family caregiver satisfaction.

The Independence at Home medical practice per the legislation is considered to be a legal entity if it is comprised of an individual physician, a nurse practitioner, or group of physicians and nurse practitioners that can provide care as part of a team. They will have experience providing home-based primary care to applicable beneficiaries. They should be able to make in-home visits. They are available 24 hours a day, 7 days a week, and furnish care to at least 200 applicable beneficiaries.

The group uses electronic health information systems and, per the law, meets additional criteria as determined appropriate by the Secretary, meaning that in addition to what is in the law, there may be additional criteria.

The team includes physicians, nurses, physician assistants, pharmacists and other health and social services staff.

The definition of an applicable beneficiary, as stated in the law, is a beneficiary who is entitled to Medicare benefits under Part A and enrolled for benefits under Part B. They are not enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly. The beneficiary has two or more chronic illnesses and has had a non-elective hospital admission within the past 12 months. The beneficiary received acute or sub-acute rehabilitation services within the past 12 months and has had two or more functional dependencies requiring the assistance of another person. And again, may meet other criteria as determined appropriate by the Secretary.

There will be quality measures on which the demonstration is measured and the IAH, which is the definition we're using for Independence at Home, medical practice shall report on quality measures for the monitoring and the evaluating of the demonstration. The incentive payments are subject to performance on quality measures.

The Independence at Home Demonstration is mandated to begin no later than January 1, 2012 and is to cover a three-year period. The preferences for the design include a location in high-cost areas, experience in furnishing healthcare services to at least 200 applicable beneficiaries in the home, and using electronic medical records, health information technology, and individualized plans of care. Demonstration is limited to the participation of 10,000 applicable beneficiaries.

Each of the Independence at Home medical practices will be evaluated on best practices, including coordination of care, expenditures, access to services and quality of services. CMS will also monitor data on expenditures and quality of services after an applicable beneficiary discontinues receiving services through an Independence at Home medical practice.

The spending targets for the demonstration include an estimated annual spending target for the amount estimated that would have been spent in the absence of the demonstration for items and services covered under Parts A and B furnished to applicable beneficiaries for each of the medical practices. This will be determined on a per capita basis and, per the law, it will include a risk corridor. New targets may also be adjusted for other factors as determined appropriate by the Secretary.

The demonstration includes incentive payments. These payments are subject to performance on quality measures. An Independence at Home practice will be eligible to receive an incentive payment if actual expenditures for a year for the applicable beneficiaries enrolled are less than the estimated spending target. The payment shall be equal to a portion of the amount by which actual expenditures for applicable beneficiaries under Parts A and B for such year are estimated to be less than five percent less than the estimated spending target for such year.

Obviously, per the sounds of what I just said, this is the law, somewhat less than what is written. However, we're hoping that by giving you this information, it gives you the parameter to go by in forming your comments today.

We're currently in the process of the design phase of the demonstration and on schedule to begin on or around January 1, 2012 as mandated. Today, we are seeking stakeholder input on the demonstration design and request that you submit it if you do not get a chance to speak today any comments, which you're not able to make, to our email box at Independence, with a capital I, At, capital A, Home, capital H, Demo, capital D @cms.hhs.gov. I'll repeat that -- IndependenceAtHomeDemo@cms.hhs.gov.

You can also find information on the demonstration by accessing our website at -- and I think this is written as well, so -- I will say but I think you can find it on the information that Barbara gave you -- <http://www.cms.gov/DemoProjectsEvalRpts/MD/list.asp#topofpage>. Now, that's long. If you got it, good. If not, I'm sure we'll be able to get it to you.

Thank you very much and I'm now going to turn this back over to Barbara.

Barbara Cebuhar: Thanks, Linda.

CMS is interested in hearing more from you about the following questions. Our first question is, how do physicians and nurse practitioners with practices solely providing care in the home obtain referrals?

(Steve), could you please instruct the callers on how to get into the queue to provide their statement.

Operator: Ladies and gentlemen, in order to respond to our presenters, please press star then the number one on your telephone keypad. We'll pause for a moment to compile the responses.

We did receive a request for you to repeat the email address for the slides.

Barbara Cebuhar: OK, great. It's Barb again, and it's [www.cms.gov/opendoorforums/05\\_ODF\\_specialodf.asp](http://www.cms.gov/opendoorforums/05_ODF_specialodf.asp). We are happy to get those out to people. If you want to send a note to [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov), we can send the slides as well.

So, (Steve), are there people in the queue?

Operator: Yes. Your first response comes from the line of Charles Parker with Continua Health Alliance. Your line is open.

Charles Parker: Yes. We'd like to say thank you very much for offering this project, and we look forward to working with the government and CMS, specifically on this project.

One of the questions that we had and some of the information we'd like to ask about is, how are organizations to be allowed to access this? And working as an industry alliance, how are we be able to provide support to this type of ongoing project, which is a very important work that the government has taken forth? And we do commend the CMS for this work and look forward to working with you.

Barbara Cebuhar: Thank you, Mr. Parker.

(Steve), our next respondent please.

Operator: Next response comes from the line of Dr. Charmaine Lawson with Advanced Clinical Company. Your line is open.

Charmaine Lawson: Hello. Thank you for this opportunity. I'm a nurse practitioner and I have a nurse practitioner house call practice in New Orleans. And for the first question, how do physicians and nurse practitioners with practices solely providing care in the home obtain referrals?

Well, we get a lot of our referrals from our collaborating physicians and from some hospitals. I believe one of the questions was, do you have any type of, I guess, network with the hospitals and/or rehab facilities? And we do in the

area. They call us and say, "We have a patient that we're discharging. Do you have someone available to see the patient?"

We also get referrals from home care agencies, sometimes from churches. Some of the church groups will call and say, "We have a patient. We have a senior while in church. Do you have someone who can go out see them?" We get referrals through United Way. Just several agencies will call us. We're always surprised with where we are getting referrals from.

We do use an electronic medical record. We do have mobile diagnostics that we can actually send referrals to, to go out, and do x-rays and labs and that sort of thing. And we also have a pharmacist that works with us as well. So we have been up and running since 2003, and we're happy to help out in any way we can, and thank you so much for the opportunity.

Barbara Cebuhar: Thank you, Dr. Lawson. Our next respondent, please?

Operator: Your next response comes from the line of Elaine Alfano. Your line is open.

Elaine Alfano: Hi, I'm Elaine Alfano. I'm the Deputy Director of the Bazelon Center -- the Policy Section of the Bazelon Center for Mental Health Law. And I just wanted to urge you to encourage -- to encourage people with -- or participants with serious mental illness be included as part of this demo, and I know that that is part of the reason for this.

But I think it's particularly important to understand that they have -- that often they have a condition, either depression or agoraphobia or other conditions like extreme anxiety where the fear of going out may simply be too daunting. And they have both serious, you know, chronic mental illnesses and they have also serious chronic health conditions.

Some people with mental illness die very -- as many as 25 years or other people when they -- there's quite a bit of room, they often -- because they don't get primary care. Even when they have Medicare and Medicaid, they don't often get it. This is an opportunity to serve them and prevent some hospitalizations -- unnecessary hospitalizations and use of hospitals that could

be avoided. So I would urge you to think about that as you move. I really appreciate the opportunity to give that comment, and thank you very much.

Barbara Cebuhar: Thank you, Elaine. Our next respondent, please, (Steve)?

Operator: Next response comes from the line of Debra Carradine with UAMS. Your line is open.

Debra Carradine: Yes. My name is Debra Carradine, and I'm a physician who makes house calls along with an APN. And we have been practicing for about 11 years. I have made over about 15,000 patient visits and we have a patient population of about 220 on our rolls.

We get our referrals from our clinic, from other physicians in the community. We also get it from DME companies, pharmacies, our patients, hospitals, nursing homes who are discharging patients to home, and pharmacy. So we really would appreciate an opportunity to participate in the project. Thank you.

Barbara Cebuhar: Thank you, Dr. Carradine. Our next respondent?

Operator: Next response comes from the line of Jill Studley with Baylor Elder Health. Your line is open.

Jill Studley: Yes, hi. My name is Dr. Jill Studley, and I'm the Medical Director of the Baylor Elder House Calls Program. We've been seeing patients at home for the past 13 years and currently have about 900 patients on service, and we work with a team of seven full-time nurse practitioners and three physicians to provide primary care in the patient's home.

We currently receive our referrals from all the sources mentioned before. We have a very tight relationship with the Baylor Healthcare System Hospital System and so get a lot of referrals directly from the hospital, even from the emergency rooms to try to decrease unnecessary admissions to the hospital. We then follow the patients for primary care.

We do have a very strong relationship with a hospitalist who takes care of the patients for us in the hospital. We work with an electronic health record so they have direct access to our patients' medical records on a timely basis and work closely with them when they're in the hospital to decrease length of stay and have them set-up with us within 24 hours to 48 hours of discharge from the hospital.

We do have -- in Texas where we're at, we have a large network of home health agencies and work with a number of them, so again have pretty quick access to them to get out -- nursing staff out to the homes and physical staff out to the home.

And then, as far as tracking our performance, we look at emergency room visits, hospitalizations, length of stay once they do get into the hospital. And then we have had a large push towards our advanced directive planning and how many of our patients we have allowed to die at home. As everybody knows in this population, most people list that and we work hard to help that become reality. And we have good outcomes and good data to support that our numbers are good in that area. Thank you.

Barbara Cebuhar: Thank you, Dr. Studley. The next question.

Operator: Next response comes from the line of (Michael Chick) with NASUAD. Your line is open.

(Michael Chick): My -- I'm with the National Association of States United for Disabilities and Aging. My question is there were parameters around participation for persons enrolled in Medicare Advantage plans. Will there be parameters related to persons using health homes or accountable care organizations?

Barbara Cebuhar: I don't think we can answer questions, (Michael). But if you would go ahead and submit that as part of your comments, that would be really helpful?  
Thank you.

(Michael Chick): Certainly. Thank you.

Barbara Cebuhar: Our next respondent, please?

Operator: Next respondent comes from the line of Marcy Ammons with Mobile Doctors. Your line is open.

Marcy Ammons: Yes, hi. My name is Marcy Ammons, and I'm the Director of Contracting for Mobile Doctors. We have four locations in four separate states. We do receive our referrals from all of the sources that have already been listed. We also receive referrals from primary care physicians, case managers and the health insurance care plan for which we are currently enrolled. We work very closely with them to help them minimize the utilization of the emergency room as a primary care location and help the patient stay well at home, and so that they could meet the targets that they are required all to meet. We'll be interested in participating in this program.

We're very curious as to the information regarding the spending target and who is going to be determining that and how we will be able to work with input on that type of situation. And we just thank you for the opportunity.

Barbara Cebuhar: Thank you, Marcy. Do we have any other respondents in the queue, (Steve)?

Operator: Yes, there are three more.

Barbara Cebuhar: All right.

Operator: Next respondent comes from the line of Chris Herman with National Association of Social Workers. Your line is now open.

Chris Herman: Thank you and thank you for the opportunity to comment. I wanted to respond to the question about how to get referrals that social workers can be an excellent source of referrals because we work with older adults and people with disabilities and multiple community-based settings so -- you know, whether in AAAs or other parts of the aging network, disability services, community-based organizations, EAPs, elder cares. So those are just a couple of ideas because oftentimes we're right out in the field and witnessing, you know, unnecessary hospitalizations and working with clients to help them avoid the very problems that Independence at Home is trying to address.

And along those lines, at least from the presentation, there doesn't seem to be a specificity about other health and social services staff defined in the law. But any social worker would certainly encourage inclusion of professional social workers, you know, whose academic and supervised internship background is unique among social services personnel and hope that you will take that into account as we have a proven record in healthcare settings and in community-based care. Thank you.

Barbara Cebuhar: Thanks, Chris. We only have time for two more. So if you would mind, (Steve), I'm sorry that we're not going to get a chance to talk to the third.

Operator: OK. And your next respondent comes from the line of Margaret Hadley with Holy Cross Home. Your line is open.

Margaret Hadley: Yes. I'll talk very quickly. Just in terms of our program, we've been providing primary medical care to frail elderly patients in the Silver Spring, Maryland area. We have two nurse practitioners and a medical director. We've been doing this for 10 years.

And just to add to the list of referrals, we get many referrals now by word of mouth from family members of patients and neighbors, as well as from many of the other sources that have already been elucidated. So I just wanted to add that too. There's a lot of community interest in this program.

Barbara Cebuhar: Thank you, Margaret. And our tenth caller, please?

Operator: Comes from the line of Christine Broderick with the National Partnership for Women and Family. Your line is open.

Christine Broderick: Hi, this is Christine Broderick. I'm representing the National Partnership for Women and Families and the Campaign for Better Care. The campaign is a multi-year effort to improve care especially for older adults and people with chronic conditions. These were the heaviest users of healthcare services with highest cost and obviously, that's the (poorest) outcomes.

The statutes supposedly states that physicians and nurse practitioners are not encouraged to limit services, nor should beneficiaries be required to relinquish

any benefits in order to participate in a program. Given the especially vulnerable nature of these beneficiaries, we're asking CMS to establish very clear and frequent monitoring processes to assess beneficiaries' access to care throughout the demonstration, including claims review and beneficiary surveys. And to further protect beneficiaries, we believe the Secretary should also inform beneficiaries of the financial incentives, practices will have to reduce costs.

Further, the statute allows practices to be led by an individual physician, nurse practitioner or group of physicians that works together with a team of other healthcare providers, and the provider must furnish services to at least 200 beneficiaries.

To ensure that these vulnerable beneficiaries have access to care on a 24-hour a day, 7-day a week basis especially when the practice is led by a single physician or a single nurse practitioner. We believe the Secretary should establish standards and requirements for the size, clinical expertise, access to providers and availability of the health team. And we also believe that the secretary should specify that beneficiaries may, when necessary, seek care outside of the Independence at Home medical practice.

And finally, we're going to urge you to make sure that there is an external appeals process that's available to beneficiaries and that beneficiaries and caregivers are notified of their appeals, right, on an annual basis and in plain and understandable language.

Thanks so much for allowing me to make a comment.

Barbara Cebuhar: Thanks, Christine.

Our next question is, do the practices have relationships with hospitals and emergency rooms? And if admitted to the hospital, who follows the patient and who is the physician of record?

If, (Steve), you could give people instructions about getting into the queue again, I'd appreciate it.

Operator: As a reminder, in order to respond to our presenters, please press star then the number one on your telephone keypad. If you'd like to withdraw your response, please press the pound key. We'll pause for a moment to compile the responses.

And your first response comes from the line of Jack Resnick with Dr. Resnick. Your line is open.

Jack Resnick: Hi. My name is Jack Resnick. I'm an internist in New York City and have been doing house calls over the last 15 years. And I've been solo practice. I'm attending at one of the hospitals -- New York City Medical Hospital and follow my own patients into the hospital. I think that that model is extremely important because these vulnerable people are most vulnerable in the hospitals and the hand-off system at most hospitals to hospitalists and health staff is, you know, weak at best. So I think it'd be an important part of this demonstration to make sure that the providers who follow these patients in their homes follow them in the hospitals as well. Thank you.

Barbara Cebuhar: Thank you, Dr. Resnick. Our next respondent, please?

Operator: Next response comes from the line of Margaret Betts from Betts Medical Group. Your line is open.

Margaret Betts: Thank you so much for that and thanks for including me on the call. I'm Dr. Betts. I practice a multispecialty practice in the City of Detroit in Southeast Michigan. I do hospitalize my patients with the help of a hospitalist in light of the fact that I do home visits and nursing home. I am in contact with the hospitalist if they need to go back home or if they need to go to a rehab facility, which I follow there and then follow them into their home.

Barbara Cebuhar: Thank you very much, Dr. Betts. Our next respondent?

Operator: Next response comes from the line of Debra Carradine from UAMS. Your line is open.

Debra Carradine: Yes. Again, this is Debra. I'm a geriatrician here in Little Rock, Arkansas. Part of the university system, we have a department where we have several

geriatricians who do clinic hospital and nursing home. Because I am full-time in the home, seeing patients, when a patient need to be hospitalized, we do refer to our hospital and one of the geriatricians in the group takes care of the patient when they're in the hospital.

We do have electronic medical records so they have access to my visits from the home visits, as well as I have access to the visits when the patient leaves the hospital.

Barbara Cebuhar: Thank you, Dr. Carradine. Next respondent, please?

Operator: Next response comes from the line of Cathy Kenley from the American Academy of Home Care Physicians. Your line is now open.

Cathy Kenley: Thank you. I am a physician assistant practicing in Macon, Georgia and have been managing our house calls program since 1994. We have a very large group of physicians and physician assistants who provide services in nursing home, clinic, hospital, etc. So when one of the house call patients is admitted, they are cared for by a member of our team.

The house call clinician who is associated with that patient at home also attempts to visit the patient in the hospital if at all possible, and the teams know to coordinate with each other. Thank you for the opportunity to comment.

Barbara Cebuhar: Thank you. Our next response, please?

Operator: There are no further respondents.

Barbara Cebuhar: Great. Our next question for folks to consider is, do primary care, admitting physicians, hospitalists refer patients to home care physician practices? Do primary care, admitting physicians, or hospitalists refer patients to home care physician practices?

(Steve), if you could tell them again, I'd appreciate it.

Operator: As a reminder, in order to respond to our presenters, please star then the number one on your telephone keypad. And your first response comes from the line of Margaret Betts from Betts Medical Group. Your line is open.

Margaret Betts: Hi. Again, thank you. As a specialty system group of nine different specialties, yes, they do and including the emergency room. When patients come to the emergency room and are too -- not sick enough to be admitted, they will call us and ask us to see the patient. And hospitalists have the primary responsibility for only taking care of patients in the hospital. So with the relationship we have with some of the hospitalists in Southeast Michigan, they will then give -- send the patient back to us and we will take care of them. Someone from our office will take care of them accordingly. Thank you for the opportunity.

Operator: Your next response comes from the line of Scott Lara from Welcome Homecare. Your line is open.

Scott Lara: Again, thank you for this opportunity. We're finding that a lot of doctors in the hospitals or hospitalists refer home health services to visiting physicians in our community but those visiting physicians may be medical directors of a home health agency. So that's something that needs to be looked at in the demonstration project.

And as I mentioned in my comments, Welcome Homecare would like to be a part of the demonstration as we feel we can shed some light on taking care of patients in the home as we feel that visiting doctors and nurse practitioners certainly can do a lot of things. But in the home health arena, we do physical therapy, speech therapy and just a host of other necessary items. Thank you and have a good day.

Barbara Cebuhar: Thank you. Our next response, please?

Operator: Next response comes from the line Debra Carradine. Your line is now open.

Debra Carradine: Thank you. Yes, we do get referrals from the primary physicians and hospitalists, and also the emergency room physicians because we are the only group that do home visits in our state. So when they find that a patient cannot

make it into the office without a great deal of effort, we are the first people to call. Thank you.

Barbara Cebuhar: Our next response, (Steve)?

Operator: And there are no further respondents.

Barbara Cebuhar: Great. All right. Our next question is, what level of integration do home care physician practices have with electronic health records, remote monitoring and mobile diagnostic technology? What level of integration do home care physician practices have with electronic health records, remote monitoring and mobile diagnostic technology?

(Steve), if you could remind people how to queue up?

Operator: As a reminder, in order to respond to our presenters, please press star then the number one on your telephone keypad. And your first response comes from the line of Jack Resnick. Your line is open.

Jack Resnick: Hi. Thanks again, Jack Resnick. I'm again an internist in New York. My practice uses an electronic health record and we use it on house calls through Verizon cards. We contact a variety of other resources remotely. We contact our hospitals remotely. We contact our radiologic services remotely. We're able to get radiologic services in the home at least the plain films. We do bedside diagnostic laboratory work.

And we're hoping -- we're working actually with Verizon to try to get to a live audio/video integration with our patients because I think this is an extremely important piece of the puzzle. Thank you.

Barbara Cebuhar: Next response?

Operator: Next response comes from the line of Jill Studley with Baylor Elder Health. Your line is open.

Jill Studley: Yes, hi. Thank you. As I mentioned before, we do have a fully integrated electronic health record, which is across the multiple office settings and can be seen by the inpatient team.

As far as mobile diagnostic, we use separate companies. We refer out for radiology, ultrasound, and cardiovascular services, including echocardiography which they go out directly to their home and then give us the readings and results to our team. Thank you.

Barbara Cebuhar: Thank you. Our next response?

Operator: Next response comes from the line of Margaret Betts. Your line is open.

Margaret Betts: Yes, thanks again for the opportunity. I'm Dr. Betts. I'm servicing patients from Southeast Michigan, primarily the Detroit area. We do have electronic medical records and use not only our own in-house mobile diagnostics but others.

We -- I am -- this office is connected to our -- we call the Citrix or the mainframe of the hospitals so that we can access who's admitted, doing labs with the x-ray, etc. And we are in a process of developing some in-home mobile monitoring with the patient if they fall, or if they need some emergency care, they will push a button and be able to access someone at a call center. Thank you for the opportunity.

Operator: Your last response comes from the line of Deborah Randall with the Law Office of Deborah Randall. Your line is open.

Deborah Randall: Good afternoon. Nice to be able to make a comment on this. I think the answer is it depends on whether the physician practices have, in the past, been affiliated with either a model that has been under a contract or under a grant, or whether the state or the local (inaudible) programs had embarked on paying for these kinds of remote services for physicians to be integrating those into their practices.

I also just wanted to comment that some of the practices that see patients exclusively in the home are palliative care physicians and they are often associated with hospice programs. So I hope that you will do what you can at CMS to take a look at some of those important programs when you put the Independence at Home projects in place.

Barbara Cebuhar: (Steve), any more respondents for this question?

Operator: There are no further respondents.

Barbara Cebuhar: OK, great. Our fifth question is, what are home care physician groups measuring to track their own performance? What are home care physician groups measuring to track their own performance?

Operator: As a reminder, in order to respond to our presenters, please press star then the number one on your telephone keypad.

And your first response comes from the line of Theresa Soriano from Mount Sinai. Your line is open.

Theresa Soriano: Hi. This is Dr. Theresa Soriano. I direct the Mount Sinai Visiting Doctors Program in New York City. We are an academic home-based primary care program composed of a multi-disciplinary team. Most of our referrals actually also come from our inpatient system both the hospital services as well as outpatient hospital clinics and practices.

We do have an EMR and we do employ electronic health records, as well as mobile technologies in choosing EKG machine, bladder scanners, in-home lab, drug, and x-rays, which we outsource through the New York City companies that are available.

In terms of what we use to track our own performance, we really focus more on advanced directive discussion of vaccination rates, that being influenza and pneumococcal vaccines, and we do track place of just home versus hospital or other facilities, hospitalization rates, nursing home placement rates, and patient and caregiver satisfaction.

I guess, as a practice in our 15 years of experience, we found that the metrics that are the most meaningful for this type of care really don't focus on disease control measures as much as quality of life and individualized care plan measures, such as speaking with families about it against directive, which, in the end, helps to guide their care in a much more efficient way than how much

we're controlling their diabetes or whether they've had specific tests done, which is I think more applicable in different outpatient care settings.

Barbara Cebuhar: That's very helpful. Thank you, Dr. Soriano. Our next response, please?

Operator: Next response comes from the line of Margaret Betts. Your line is open.

Margaret Betts: Yeah, thanks again. As a primary care physician and internist, we strive -- well, we monitor patients or (the quality measures) is the ability to stabilize the medical condition by improved health viability, decreased medications, decreasing the services outside the home, increasing the relationship between the families so we all have a better understanding of how to interact with a sick loved one, and keeping the patient at home as long as possible, so preventing nursing home, assisted-living facilities, etc.

We -- when most of the patients that I see don't like hospitals, don't want to go to hospitals, and so therefore are willing to cooperate as much as possible to maintain their health in their home.

Barbara Cebuhar: Thank you, Dr. Betts. Our next response?

Operator: Next response comes from the line of Christine Broderick with the National Partnership for Women and Family. Your line is now open.

Christine Broderick: Hi again. This is Christine Broderick with the National Partnership for Women and Families and the Campaign for Better Care. I just wanted to make a comment from the consumer perspective about some of the quality measures. I appreciated hearing about some of the other patient-centered measures that others have just spoken to.

To ensure the demonstration project's success both for patients and for the Medicare program, the Campaign for Better Care has identified some core elements of patient-centered care that we believe should be built into the framework of the project. If feasible, the Secretary should require reporting at both the group and individual provider level and practices should be evaluated based on whether the practice has built into its design, appropriate patient-centered components, including access after hours, routine, and urgent care,

support for shared decision-making, medication review, functional status and pain assessment, complex case management, facilitation of safe transitions from one care setting to another, and links to appropriate community supports.

Measures of that practices' performance should assess patient and family caregiver experience, care coordination, clinical outcomes and functional status and all data should be stratified by race, ethnicity, language and gender while protecting the confidentiality of an individual's personal health information -- excuse me.

Finally, I wanted to emphasize that we believe that Independence at Home -- that the Independence at Home program should be linked with and coordinated with other new payment and delivery system strategies in order to really become an integral part of the broader continuum of comprehensive, coordinated, patient-centered care that we believe will truly transform our healthcare system to improve quality and reduce cost.

Thanks again for the opportunity to provide a comment.

Barbara Cebuhar: Next response?

Operator: Next response comes from the line of Scott Lara from Welcome Homecare. Your line is open.

Scott Lara: Thank you. The question, what are home care physician groups measuring to track their own performance? I could just say -- as I said in my written comments, the number one thing I don't like to do is reinvent the wheel. And if you look at the Home Health Compare website that CMS already has, that's an excellent way for consumers and for CMS to see how home health agencies are doing on a number of different levels.

And I appreciate -- well, one of the other commenter said regarding, you know, not so much, you know, medications and so forth, their quality of life and that's a very difficult thing to measure but I'm very much in favor of that.

I did want to just finish up by saying I'm deeply concerned about the rewards that are going to be given to the agencies participating in this demonstration is

based on how much money we can save. I think it's critically important to ensure that the patients and their quality of life, that's the true measure of success, not the number of dollars we save. Thank you.

Barbara Cebuhar: Thank you. Next response?

Operator: Next response comes from the line of Beth Hennessey from Baptist Health. Your line is open.

Beth Hennessey: Thank you. This is Beth Hennessey and also thank you for the opportunity to comment. I'm a home care provider. I'd like to kind of expand on the last comment and also say that as we're looking at appropriate metrics, there are a tremendous number of metrics within a home care environment already collected and publicly reported. And I think if we look at data stratification and the two comments before about incorporating this in other models, I think it is equally important to determine in these outcomes if there was a home care agency involved in this patient's care as well. Thank you.

Barbara Cebuhar: Thank you.

Operator: There are no further respondents.

Barbara Cebuhar: All right. Our next question is, what quality metrics are meaningful for this very vulnerable population? What quality metrics are meaningful for this very vulnerable population?

Operator: As a reminder, in order to respond to our presenters, please press star then the number one on your telephone keypad. We'll pause a moment to compile the responses.

And your first response comes from the line of Roger Lucero with Medical Physicians. Your line is open.

Roger Lucero: Thank you. I don't know what all you've talked about now. I just got online. But one of the questions asked was what people are measuring to track their own performances.

We've been tracking whether or not we've been giving the vaccines -- pneumonia vaccines, fall risk and number of falls, if they went to physical therapy. I'll say we had more than one fall in the past year and also whether they have advanced directives and just curious as to what other people feel is important as well.

Barbara Cebuhar: We've heard about the same thing, Dr. Lucero, but we welcome everyone's comments to the email line if they have something different. So can I...

Roger Lucero: OK.

Barbara Cebuhar: Next respondent please. Thank you for your time.

Operator: Next respondent is Jack Resnick. Your line is open.

Jack Resnick: I want to second what Dr. Soriano said earlier. I think it's really important that for this vulnerable population, classical process-related measurements, you know, do they get an ACE inhibitor, do they get their A1c levels are not the right way to go. I think there are really two broad areas to measure -- one, the most important is ADL. Are people who are in these programs doing as well or better than a controlled population in their ADLs -- are ADL slipping or getting worse?

And second, an aggressive attempt to monitor patient satisfaction both of the patients themselves and -- both formal or informal caregivers, I think would be the second major component of a process that really tries to look at the quality of the care that's being delivered. Thanks.

Barbara Cebuhar: Thank you, Dr. Resnick. Next response?

Operator: Next response comes from the line of Scott Lara, Welcome Homecare. Your line is open.

Scott Lara: I really can't comment more than the previous caller and I totally agree with what he just said. Thank you.

Barbara Cebuhar: Great. Thank you.

Operator: Next response comes from the line of Jeff House from the Visiting Nurse Association. Your line is open.

Jeff House: Thank you and good afternoon. One of the -- many of the things that I think we should be measuring when it comes to efficiencies of these vulnerable people are symptom control, pain control, compliance with medications, hospitalization rates and the amount of care needed in the home as they become fragile and they start to decline.

Barbara Cebuhar: Thank you.

Operator: Next response comes from the line of Margaret Betts. Your line is open.

Margaret Betts: I'm sorry. I pushed 0-1. I had to take another call. I thought you had another question but I've already made my comments in terms of quality of care earlier.

Operator: Next response comes from the line of Thomas Parker from the American Academy of Home Care Physicians. Your line is open.

Thomas Parker: Oh, thank you. Yes. I would second the comments made by the previous presenters. But in addition, I think the quality measures should really be disease-specific for those chronic diseases for which the patients entering the IAH program are actually eligible and are enrolled. For instance, congestive heart failure has its own set of metrics that do have a lot to do with symptoms and also with functional performance. COPD would have a somewhat different performance measure. Sometimes, it could be done by spirometry, by days of relative good health. So there's a number of measures that I can say we don't have to reinvent the wheel.

But really when we talk about quality, the IOM measures of safety, efficacy, efficiency and satisfaction are the three primary quality -- or four primary quality measures, I think, all of us should be looking at. Thank you very much.

Barbara Cebuhar: Thank you, Mr. Parker. Next response?

Operator: Next response comes from the line of Margaret Hadley, Holy Cross Homes.  
Your line is open.

(Margaret Adley): Hi. You know, I would just like to underscore, I think for this population, the importance of measuring referrals to home health and hospice agencies against directive discussions, medication, reconciliation and, of course, patient and family satisfaction.

Barbara Cebuhar: Thank you. Next response?

Operator: Your last response comes from the line of Beth Hennessey with Baptist Health. Your line is open.

Beth Hennessey: Thank you. And I want to reiterate the focus of quality of life measures. I think those are critical as well as not just patient satisfaction but patient engagement aligns with the comments about truly being patient-centered and having their role, combining both those evidence-based measures for the disease along with quality of life and patient engagement. Thank you.

Barbara Cebuhar: We have moved very quickly through the questions that we had. I don't know if there are other concerns of issues that you would like to bring up for CMS today. If we could open the lines to any other issues that you think would help us design and develop this demo, that would be very helpful.

(Steve)?

Operator: As a reminder, if you would like your line to be open, please press star then the number one on your telephone keypad.

And your first comment comes from the line of Scott Lara, Welcome Homecare. Your line is now open.

Scott Lara: Thank you very much. One major concern I have and in a way, I kind of had the last one I read this not on special open door forum sheet but there was another sheet that I had read regarding, you know, what Congress have said about it. And you mentioned that at the beginning about -- and I'm paraphrasing this being pretty much all-inclusive, you know, continuous care,

24/7 -- I mean, that was just -- the amount of care that Congress is asking for this group here on this phone call to be able to provide is going to be astronomical. And it is just kind of interesting to me when we're seeing all these cuts in home health care, the five or six percent cut here of January 1st with the PECOS requirement, with the face-to-face requirement, and we're cutting home healthcare left and right.

What Congress is asking us to do here is to go after this very special, very chronically ill population and try to, you know, keep it as cost-effective as humanly possible. And I would think that most people on this call would agree with me that this is going to be very expensive to take care of this people -- COPD, chronically ill, recent hospitalizations.

And the other interesting thing I wanted to point out was and this is Congress for you, and I'm a lobbyist at my day job. They excluded the Medicare Advantage program in this demonstration, and it's no surprise to me that they've done that because, in my opinion, the Medicare Advantage program is going after the healthiest of the healthy, the folks that are going out on their own cruises, playing racquetball and jet skiing. But for the home health industry, we are dedicated to the needs of the sickest of the sick, the poorest of the poor, the frailest of the frail who have no voice. And so it's going to be interesting to move to this demonstration and see what the results are.

But as I mentioned earlier, we, here, at Welcome Homecare in Jacksonville are committed to helping CMS with this demonstration and to see what we can do to be able to provide adequate care at a cost-effective price. Thank you.

Barbara Cebuhar: Thank you. Next response?

Operator: Next response comes from the line of Jordan Green with the National Alliance for Caregiving. Your line is open.

Jordan Green: Hi. Thank you for this call today. I think it's been very informative. I do just want to state that while you are getting this input from physicians in their respective service and the like that you also seek input from the family caregivers and patients themselves based on their experience with using home

health agencies in this type of thing in the past and just be sure that we are definitely on the right track with what the actual consumers are looking for as well. So thank you very much.

Barbara Cebuhar: Thank you.

Operator: Next response comes from the line of Deborah Randall. Your line is open.

Deborah Randall: Thank you. I just wanted to urge the CMS to take the broadest possible approach in the field of nurse practitioners and also with regard to Telehealth to help encourage a broad use of nurse practitioners and to use maximally and creative ways of Telehealth rather than a narrowing of approach when you do your ranks. OK? Thanks.

Barbara Cebuhar: Thank you.

Operator: Next response comes from the line of Bob Wardwell. Your line is open. Bob Wardwell, your line is now open.

Bob Wardwell: Yeah, this is Bob Wardwell speaking. Yeah. I guess, this goes in line with what Ms. Randall already said to some degree and not that I -- I really hope that CMS takes the opportunity to make this as broad the demonstration require experiment as possible to try to get into different localities across the country to try to get to large and small type practices, get at the ones that are, you know, I guess, independent practice as well as the ones that are linked more closely with home health agencies, try to get a real diversity.

In terms of the 10,000 people and help that 10,000 people at any one time because I've seen a lot of demonstrations kind of fail because of attrition from the demonstration, so I hope you'll take that interpretation of the 10,000 at any one time in this. And also, if you can, take the opportunity to keep as long a track on this as possible across the years because I think some of the positive effects that these kind of programs don't happen in a year, they happen over multiple years. Thanks very much.

Barbara Cebuhar: Thank you.

Operator: Next response comes from the line of (Judith Boyco) with the (Visiting) Nursing Association. Your line is open.

(Judith Boyco): I guess, I just want to say that I hope CMS keeps in mind that home health agencies have been, in many respects, doing this for a long time and would welcome the opportunity to work with physicians and nurse practitioners who are currently serving patients at home. I hope that CMS looks at this demonstration as a potential partnership because I think those of us in home care feel as though we are positioned given the variety of services and professionals that we have in our agencies to provide this kind of care to patients.

And I also want to agree wholeheartedly with the gentleman that stated, if this demonstration takes place the way it's being presented, it will be very expensive. And those of us in home care has faced cuts, are facing cuts -- try very, very hard to provide this kind of excellent care to the frailest of our patients. And I think that CMS needs to keep that in mind as well.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of (Vicky Morgan) with Riverside Home Health. Your line is open.

(Vicky Morgan): Good afternoon and thank you for the opportunity to be able to participate in this call. I am a home health agency and I would very much like the -- well, I guess, the chance to be able to work with CMS in this program, I'm very interested in it.

I do agree with the comment from the physician from Welcome Home. I think that pretty much is my perspective today. And the lady that preceded me, I agree with her wholeheartedly that we need to have the chance to be a part of this to be able to solve the problems. Thank you.

Barbara Cebuhar: Thank you.

Operator: Next response comes from the line of Anita Major, Riverside Hospital. Your line is open.

George Taffet: Hi, this is George Taffet. I'm the chief geriatrics at the Baylor College of Medicine. I'm sitting here with Dr. Anita Major. We just had a couple of points that hadn't been mentioned we think people should take into consideration.

First one is about adult protective services as a source -- a very expensive source of referrals. We think that at least in many of the urban -- well, I guess, probably a rural problem as well, but these folks consume a ton of resources and require a special hand. Maybe that could be taken into consideration.

The second thing is the low-hanging fruit of ambulance visits. As a source of cost and yet a potential outcome measure, just the avoidance of ambulance visits may make what people are saying as an impossible task, the expensive care of these older people, it's one that's fairly simple.

And then the third point is -- and this may be the most controversial of all is I really think that the science here has some questions in it. For instance, the quality measure of giving influenza vaccination to these patients actually isn't all that good. We know that many, many of them won't respond to it. And perhaps the most appropriate quality measure should be giving influenza vaccines to all the people in the household other than the patient because they may be the ones who are likely to protect the patient from getting the flu and die. I think I'll stop there.

Barbara Cebuhar: Thank you for your help.

Operator: Next response comes from the line of Jack Resnick. Your line is open.

Jack Resnick: Thank you again. Again, I'm a solo physician in New York. And this is a point that was alluded to earlier. You know, the opportunity to make this a really broad national event that really affects how healthcare is practiced is there. And it's really important to make sure that the structure of the demonstration makes it possible for individual and small groups of providers to participate in.

If we restrict this demonstration to large organizations that are basically health systems and insurance companies, home health agency, you know, their institutional interest were not -- are not properly aligned with the patient that we're seeking to take care of. They have their own (institution) survival. That's hard in really providing as much care at home as possible what is not in line with those -- the part of the healthcare system that's most aligned with these objectives are independent physicians, nurse practitioners and small groups.

So if you want to design a demo that will be attracted and work well for them, I think the most important thing to do is to recognize what you hear several people say. It will be expensive to implement this. And it will be extremely important that savings be distributed early, waiting for a year or two or three or even for six months. We'll make the capital investment beyond the need of most physicians and small groups.

I know this is a difficult task that I'm asking but you really need to figure out how to make some of the savings distribution happen as early as the first quarter. Thank you.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of Margaret Betts. Your line is open.

Margaret Betts: Thank you for this opportunity. Yes, I agree with Dr. Resnick but we need to work together to have the best outcomes possible. What I -- and to make this demonstration process very successful is utilize some of the governmental agency already in place like the Area Agency on Aging. They have a lot of outreach because we need a dual monitoring system.

If you're going to monitor physicians and their ability to improve the health, you need to monitor the patients in terms of their understanding of what is happening and then have strict handling of abuse. In Southeast Michigan, there's a kind of abuse of patients with all different types of home health care providers, forcing their way into their homes. So it may be a little bit easier to be very successful if you're already putting -- already identified some of those

governmental agencies already in place to help with the implementation of this project.

Barbara Cebuhar: Thank you, Dr. Betts.

Margaret Betts: You're welcome.

Operator: Your next response comes from the line of Cathy Kenley from the American Academy of Home Care Physicians. Your line is now open.

Cathy Kemle: Thank you very much. Actually, at this point, I just need to say I agree wholeheartedly with most of what the last three or four speakers have said. I think it's very important that we have to give our input as central to the program. I agree with using a wide variety of models and diversity at local patients and providers. And I would just like to thank CMS for moving forward so expeditiously with this.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of Debra Carradine. Your line is open.

Debra Carradine: Yes. I would just like to suggest that you all consider home hospital care for those patients who do not want to be hospitalized where you would pay for IV therapy and antibiotics to be provided at home, and the physician or nurse practitioner or home health agency going in and managing that patient. Thank you.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of Leonardo Cuello from the National Health Law Program. Your line is open.

Leonardo Cuello: Hi. Good afternoon and thank you for hosting this call. My name is Leonardo Cuello. I'm with the National Health Law Program, and we are also a partner on the Campaign for Better Care, working to improve care for chronically ill older adults.

I wanted to just make a few points. The first one that I -- to reiterate on the points made earlier, I think, we really urge you to make this as a voluntary format as possible. We think there's so much value in these types of services. People need home care so badly. We think that if you do a good job setting it up, people will be opting in and so we encourage a voluntary scheme.

Second, I can't emphasize enough how important, I think, notice will be in this process to make -- making sure that people have clear notice that really explains what their options are, that notice be unbiased so that they're getting the notice from a source that doesn't stand to gain in any of the shared savings, for example, and that there are resources for people to follow up. We know that the individuals and their caregivers are in tough situations and they're going to have questions and they're going to need some way to understand this.

Third, that these resources be made available in a culturally appropriate way and with linguistic access for people who don't speak English as a primary language.

And then fourth and finally, I just wanted to say that I urge you to also really think about how this can be neutral in terms of networks. And what I mean by that is, you know, if we have a shared savings type of group that is treating someone, that person may already have five different providers, 10 different providers, 15 different providers. They are saying, "We know how complex these individuals are." And they have, in many cases, a diverse network of doctors already treating them, and so there would be a lot of concern that that network -- they would lose access to that network they already have going by sort of going into this new program. And that I would say is one of the reasons why getting their upfront consent and voluntariness is so critical, so I urge you to consider all these things. And thank you so much for the time.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of Constance Row from the American Academy of Home Care Physicians. Your line is open.

Constance Row: Yes. We just want to thank you at CMS so much for holding this Special Open Door session. This follows many other efforts that you've made to gather data and information, and we so appreciate that it does demonstrate your commitment to trying to move forward with this demonstration, which I think we all agree. It needs to bring better care to the frail elderly as a priority objective for many reasons.

The point that I would like to make is something that is may be obvious on the call. There are so many people who are out there. They are experienced. And in general though -- and this is a point I'd like to make. There is so much consensus around the answers to these questions and so much else because there's so much experience across the country with doing this. We're going to -- we have compiled more answers from people who could not be on this call to send in and we will.

The good news if there is good news about this is that there is a group of people out there who has been doing this for a long time. They have established practices. They have established programs and relationships and with encouragement and support from CMS, I think, are going to be potential solid applicants for this program, and we're just committed to working with you to make this as successful as possible.

Barbara Cebuhar: Thank you, Constance.

Operator: Your next response comes from the line of Gwenesia Collins from Tri-Unity Pharmacy. Your line is open.

Gwenesia Collins: Good afternoon. My name is Dr. Gwenesia Collins, and I'm a managing member of Tri-Unity Infusion Services and -- Tri-Unity Infusion and Pharmacy Services. And we actually have a collaborative agreement with Betts Medical Group here in the metro area. And what we do is we not only provide home infusion or home antibiotics and kicking in therapy for patients. We also do oral medication, nutritional consults. We do medication reviews for appropriateness and compliance.

I just wanted to say that I would urge CMS or hope that they would -- make sure that they include pharmacy services in the IAH for continuity of care. Thank you.

Barbara Cebuhar: Thank you.

Operator: Your next response comes from the line of Thomas Parker with the American Academy of Home Care Physicians. Your line is open.

Thomas Parker: Yeah, thank you very much again. I would just echo what Constance have said about the fact that we really do have a lot of folks that have been doing this and doing this very, very well and waiting until 2012. It seems like a long stretch for many of us. But also point out that some of our most thriving home care practices really started at least as mom-and-pop type operations. You know, these may not have the same level of integration. Some of them are just sponsored programs, but they have two key elements which have been shown repeatedly to be success factors in this type of operation. Those are passion and high-level of clinical skills. So we definitely don't want to discourage these folks that have really been holding the line and doing this work for so long.

I will say that there's a challenge to integration that we see with these types of small practices that perhaps CMS has not taken into account. And some of these have to do with the Stark provisions that limit us so many times -- limit physicians and other providers. We are often excluded from participating in meaningful pharmacy and lab interaction, often technical and diagnostic studies are ineligible for payment in the home environment.

Physicians, for instance, cannot receive relatively modest carry fees for carrying a laboratory specimen to the lab. So things of this nature really should be addressed in this overall payment reimbursement. And I'll just finish by saying that home care medicine truly is the ultimate in access for all patients. But I think that adding in a number of folks that have significant mental illnesses, this has really caused a number of previous demonstration projects as you know them to fail.

If we add in a lot of people with addition, we add people, you know, street people, for instance. And I administer to these people and for them, but I think that these are folks who either have conditions or behaviors that is not amenable to the patient-centered care model, and I would not want to interfere with the high success that we know we can achieve by making it overly broad at the inception. Thank you again.

Operator: Your next response comes from the line of Margaret Hadley with Holy Cross Home. Your line is now open.

Margaret Hadley: I just would like CMS to think about how you would measure or demonstrate shared savings for patients who already are participating in these programs. Since many of them, their cost to CMS already are lower than it might be otherwise expected.

Barbara Cebuhar: Thank you.

Operator: There are no further responses at this time.

Barbara Cebuhar: Well, everyone, we are very grateful for your time. I know that we are ending just a little bit early here. But just a reminder if something occurred to you or you didn't get a chance to offer your comments. Could you please forward your information to [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov) by the end of the year.

We really do appreciate your time and your interest. It's been instrumental to us as we continue to design this new demonstration. I wanted folks to know that there will be an Encore presentation of this call. All you need to do is have them call 800-642-1687 and ask for the conference ID number 30308336. The recording will be available two hours after this call upon until midnight on December 15, 2010.

So unless I hear anything else from anybody else, we are grateful for your feedback. Please don't forget, comments are welcome and encouraged at [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov) by the end of the year.

(Steve), I think we are through with the call unless anybody else is in the queue.

Operator: There is one final response. It comes from the line of (James Summerfelt) with the Visiting Nurse Association. Your line is open.

(James Summerfelt): Thank you. Linda, I guess, on top of everything else that's been said, the shared savings -- I guess, I'm a little confused as far as how you know what doesn't occur which would fall into the heading of avoided emergency room visits or avoided unnecessary hospitalizations or even shorter hospitalizations because the providers that have been speaking here for the last hour and a half are doing a great job in helping to reduce those acute care and emergency room costs that were saving Medicare and Medicaid a tremendous amounts of money. So I just got to get -- have CMS think about that a little bit as far as how to quantify that.

Thank you for the opportunity to speak.

Operator: And there is one more response from the line of Margaret Betts. Your line is open.

Margaret Betts: Yeah, this is Dr. Betts. I had some ideas. There's a lot of -- my patients are in a donut hole and also sometimes cannot afford their copay. So in an effort to design a program that is inviting for the patient and will leave them, not only some of the stress of paying their bills, maybe CMS could consider a way that they can eliminate the donut hole or decrease it, as well as have some opportunities to defray the copays and maybe the yield (inaudible).

Barbara Cebuhar: Thank you for your help, Dr. Betts.

Do we have anybody else in the queue, (Steve)?

Operator: There are no further responses.

Barbara Cebuhar: We are very grateful to everyone for their help today. This has been very useful. Please don't forget to send your comments to us before the end of the year at [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov).

I think that we will go ahead and close the call now. Thank you again for your time and energy.

Operator: Ladies and gentlemen, this concludes today's Independence at Home Demonstration Open Door Forum. You may now disconnect.

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