

Crossing the Continuum:



Integrating Senior Care in Catholic Health Systems

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ABOUT THE PAPER

This report was developed by Howard Gleckman for the Catholic Health Association's "Catholic Health Strategy Summit: Integrating Services for Seniors" event Dec. 13-14, 2010, in St. Louis. Mr. Gleckman interviewed executives from several health care organizations to learn about the challenges they face and how they are improving care for the elderly.

The efforts of three of these organizations are highlighted in case studies at the end of this paper.

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ABSTRACT

How can Catholic health systems provide integrated medical and personal care to elderly patients with multiple chronic diseases? Profound changes in the health status of an aging population, our nation's health laws, payment systems, and the expectations of patients and their families have already begun transforming delivery of care. But the pace is rapidly accelerating. What can Catholic health systems learn from early adapters to an integrated model of care?

“If there is one hallmark, centering idea to achieve better care, better health, and lower cost without harming a single person, it is through integrated care... the awareness of their journey through their lives and through their illness instead of treating them in fragments.”

– *Donald Berwick, Administrator, Centers for Medicare and Medicaid Services*

THE CHALLENGE AND THE OPPORTUNITY

“James Martin”² is, in many ways, the face of health care today.

Mr. Martin is alert and engaged, and he and his wife still live in their comfortable home in a suburb of Washington, DC. But at 84, Mr. Martin suffers from heart disease, kidney failure, high blood pressure, high cholesterol, gout and diabetes. He takes 16 medications every day, and three others as needed.

More than one-third of hospital admissions and half of all bed-days are Medicare patients such as Mr. Martin. Three-quarters of health care spending is for chronic disease, rather than acute episodes. Ninety percent of Americans age 65-plus suffer from at least one chronic disease and half suffer from at least two.³ The costliest five percent of Medicare beneficiaries, most with multiple chronic diseases, accounted for 40 percent of total program costs in 2006. Of the 20 clinical diagnoses that represent the greatest share of medical spending, only two—fractures and pneumonias—are acute.⁴ Just five chronic diseases—heart disease, hypertension, stroke, diabetes and pulmonary disease—account for fully one-third of all health spending.

As the population ages, the challenge of treating seniors with chronic disease will grow rapidly. By 2030, the U.S. Department of Health and Human Services estimates that 60 percent of all Baby Boomers, or 37 million people, will be suffering from two or more chronic diseases.⁵

In this environment, Catholic health systems are being challenged to provide the best possible medical and personal care for James Martin and millions like him. Evidence suggests that fully integrating care both within and among settings is a key to clinical success. Hospitals, nursing homes, assisted living facilities and home health agencies will all play a role in providing the essential care that sits in the sometimes-awkward intersection of acute, chronic and personal care. Yet they must achieve their mission in cost-effective ways that make good business sense.

THE CHALLENGE

The challenges are many. Today's medical system remains built on an acute care foundation even as chronic care needs become more prevalent. It remains hospital-centric, although care increasingly will be provided outside of the four walls of these institutions. This evolution will require ever-closer partnerships among providers, even as these relationships remain uncomfortable at best. Health systems must get ahead of a legacy fee-for-service payment system that still impedes, rather than encourages, new models of care. The weak links in the current system are well-known:

- * Lack of appropriate primary care.
- * High in-patient risks, including infection and delirium.
- * Weak transitions, including discharge planning.
- * Poor post-discharge compliance, especially medication management.
- * Uncoordinated medical, personal, spiritual, and social care in all settings.

While these flaws exist for all patient populations, they are magnified for chronically-ill seniors.

Catholic health systems—indeed all medical providers—are at a crossroads. Demographics, new consumer demands, severe and growing government budget constraints, restrictions on credit and a major economic slump, and rapid technological change are placing immense pressure on hospitals, nursing homes, assisted living facilities, and other providers of both medical and long-term care services. And perhaps most challenging of all, Catholic health systems must adjust to these changing markets in an environment of massive regulatory uncertainty, created in large part by the Patient Protection and Affordable Care Act of 2010 (ACA).

There is no doubt that this environment creates huge risks for providers. However, it also opens the door to new opportunities—a chance to break free from the secure, but limiting, shackles of an increasingly obsolete payment system. Some health systems will thrive in this new world and better serve their mission of providing the best possible care to patients and residents. Others will fail both themselves and those they serve. Those who succeed must adopt a culture of constant innovation that is very different from the way most health systems operate today.

The nation's deficit crisis is the predicate for a debate over health reform that by no means ended with passage of the ACA. The Congressional Budget Office (CBO) estimates that, by mid-century, federal spending on health (primarily Medicare and Medicaid) will exceed more than 20 percent of the Gross Domestic Product—and absorb all projected tax revenues.⁶ The inevitable outcome: major tax increases, substantial reductions in government health spending, or both. States, facing severe long-term budget shortfalls of their own, must make the same calculation regarding their share of

Medicaid. The ACA did not create these fiscal issues. And it will not solve them. It was, rather, a relatively modest attempt to address the impact of rapidly rising medical costs on government budgets.

The ACA is expected to cover 32 million currently uninsured. This reform should significantly reduce uncompensated care now provided by hospitals even as it increases demands on primary care physicians. Yet the ACA will also cut projected payments to many providers. The CBO estimates the law will result in about \$500 billion in Medicare cost savings over the next decade, principally due to reductions in expected payments to hospitals, nursing homes, home health agencies, physicians and Medicare Advantage plans.

Providers will also face long-term Medicaid pressures. Beginning in 2014, the ACA will add 16 million persons to the Medicaid rolls who will be eligible for acute care services. And while the law promises to pay an average 96 percent of the cost of this expansion from 2014 to 2019 (a share that declines over time), this commitment may prove problematic given ongoing federal budget pressures. Even if the added federal share is delivered as promised, overall state costs are still expected to increase.⁷ To the degree those costs rise, the law will increase financial pressures on those nursing facilities and home health agencies that must compete with acute care for scarce Medicaid dollars.

Overall, both long-term government budget pressures and the ACA may fundamentally change the current delivery system. As the chief operating officer of one community hospital reports, “I finally get it. All we have to do is provide better care to more people for less money.”⁸

THE ACA AND INTEGRATED CARE

Integration of care for chronically-ill seniors is just one example of the crosscurrents health systems will face in coming years. Navigating this turbulence will require nothing less than breaking down long-standing—but artificial—barriers between medical care on one hand, and personal, social and spiritual care on the other.

The new health law includes both penalties and rewards, many aimed at the twin goals of lowering costs and coordinating care.⁹ The carrots include funding for a wide range of demonstrations explicitly designed to better coordinate care for chronically-ill patients as well as increased payments for providers that exceed certain performance benchmarks.

Among the biggest sticks: Starting in 2012, Medicare will begin reducing payments to hospitals with high readmission rates. It is hard to overestimate the importance of this change. Not only does it have the potential to dramatically affect financial results for hospitals that already struggle with narrow margins,¹⁰ it is already driving managers to qualitatively rethink the cost-benefit calculations of programs aimed at reducing readmissions.

In the current payment environment, readmissions benefit some hospitals and hurt others. Those that can fill beds with high-margin patients already have incentives to reduce admissions of chronically-ill, low-margin seniors. However, for those with empty beds, programs aimed at reducing these “round-trips” not only cost money upfront, they reduce revenues. Hospitals will be forced to revise those calculations once Medicare begins cutting payments for excessive readmissions.

Under the ACA, hospitals will have as much as six percent of their base Medicare payments at risk by 2017.¹¹ As a result, the law will reward those facilities that improve quality and efficiency while reducing payments for those that do not. For instance, while the ACA imposes penalties on hospitals with high risk-adjusted readmission rates, it also provides \$500 million over 5 years to help hospitals manage patient care for 30 days after discharge.

And these financial incentives will not only affect hospitals, but other providers as well. For instance, the Centers for Disease Control estimates that in 2004, 123,000 nursing home residents made an emergency department (ED) visit within a 90-day period, and that 40 percent of those visits were preventable.¹² The Kaiser Family Foundation reports that half of long-term care residents of skilled nursing facilities made at least one ED visit in 2006, and one quarter had two or more. Thirty-eight percent of these residents were admitted to a hospital during the period.¹³ Inevitably, skilled nursing

“Navigating this turbulence will require nothing less than breaking down long-standing--but artificial--barriers between medical care on one hand, and personal, social, and spiritual care on the other.”

facilities will find themselves under pressure to address the causes of these visits, including falls, pneumonias and urinary tract and skin infections.

Finally, the law will require greater consumer-oriented transparency for both hospitals and nursing homes, a step likely to reward high performers and punish those unable to adjust to the new environment.

To add to this uncertainty, it is impossible to predict exactly how these many changes in delivery and payment will operate until regulations are written—a process that is likely to take at least three to five years, and perhaps, much longer. For instance, until the federal Department of Health and Human Services writes regulations, no one can be quite sure exactly how integrated care models—such as accountable care organizations or bundled payments—will operate. In addition, while bundled payments are a step away from fee-for-service and its perverse financial incentives, they remain essentially an acute care concept. Thus, making bundling work in a chronic care setting will create huge challenges. One key question: Who will decide how payments will be divided and what will be the consequences of those allocations?

During this transition, health systems must survive in the current payment environment even as they adapt to future designs. “We are driving the car and repairing it at the same time,” says James Higgins, CEO of Bon Secours New York Health System.

A key issue for hospitals, of course, is the current payment structure. Insurance-based risk models such as Medicare Advantage Plans, Special Needs Plans, and staff-model health systems create their own incentives for integrating care since they are financially rewarded for reducing costs. However, because these systems are insurance products, their relationships with doctors, hospitals, nursing homes, and other providers can range from tense to hostile. But while even these systems often fall far short of well-integrated care, they operate in a far more flexible world than traditional fee-for-service provider-based models.

These problems are equally severe for skilled nursing facilities, which must operate under their own payment and regulatory constraints. Most assisted living facilities and many home health agencies, by contrast, operate largely on a private pay model. This provides them with some additional flexibility.

Another important predicate for this discussion is the often difficult relationship between hospitals and senior services within the same health system. Senior services managers often feel they are not full partners in these systems. For example, staff in skilled nursing facilities, assisted living facilities, and home health operations often complain their units are referred to as “non-acute services.” As one top manager put it, “We are defined by what we are not.”¹⁴

Yet, in many systems, SNF and home health margins exceed those of hospitals. In addition, because they are able to provide sub-acute, chronic and long-term care at less cost than a hospital, they offer opportunities for synergies that are often unused.

THE OPPORTUNITY

Yet, for all that, we are entering a period of great opportunity. The ACA holds the promise of innovation and creativity in delivery of both medical and long-term care. It recognizes that chronic care is the fundamental challenge of the health delivery system in 21st century America, and it acknowledges the need to restructure the Medicare and Medicaid payment systems to reflect these changing realities. And it takes steps—albeit small ones—in the direction of provider flexibility. At the same time, technology is making possible new systems of care that were unimaginable even a decade ago.

The fee-for-service box that in many ways curbed innovation is crumbling. Accountable care organizations, bundled payments, medical homes and other explicit coordinated care demonstrations will all create opportunities for better integrating care.

The result may be a system where buildings—hospitals, nursing homes and large assisted living facilities—give way to hybrid designs where care, sometimes provided at quite intense levels, moves to the community. Health systems may still provide that care, but not always in their familiar edifices.

Until now, Medicare and Medicaid have functioned as “golden handcuffs” that, in many ways, insulated the health care industry from these pressures. After all, their current payment systems assure a steady revenue stream (though perhaps not always a sufficient one), and providers have learned to live within their limitations. But this legacy payment model seems to defy the rules of economics and thus discourages creativity and innovation.

For all of the challenges of the ACA, this new flexibility may prove to be the key to the transformation of health care that payers want and consumers such as James Martin so desperately need.

MODELS FOR REFORM

Despite the constraints of Medicare and Medicaid regulation, innovative thinkers are finding ways to better deliver integrated care. Some focus on one piece of the puzzle, such as improving transitions among settings. Other models attempt to address two or more of these issues. And at the very edge of innovation, at least one collaborative is exploring ways to build a fully-integrated system that provides care to chronically ill seniors across a single service line. These various experiments are aimed at achieving one or more of the following goals:

- * Keeping patients healthy and avoiding unnecessary admissions.
- * Improving care transitions.
- * Providing hospital-level care in lower-cost settings.
- * Reducing readmissions.

Overall, both long-term government budget pressures and the ACA may fundamentally change the current delivery system. As the chief operating officer of one community hospital reports, “I finally get it. All we have to do is provide better care to more people for less money.”

MODEL FOR REFORM:

Community Outreach

These models focus on patient education, preventive care, monitoring and alternative treatment venues for relatively minor complaints. They take traditional community benefit far beyond their minimum legal requirements and, rather, use these initiatives to reach deeply into local populations. This can not only result in better health outcomes, but has the potential to become a powerful marketing tool for health systems.

Collaboration between health systems and religious congregations is one powerful mechanism to achieve those ends, and an obvious tool for Catholic health systems. Richard Bennett, MD, and W. Daniel Hale, Ph.D., describe the paradigm: “To reach and maintain contact with people...health care organizations...need to work closely with institutions that are deeply rooted in the community and are trusted by people in the community. ...Religious congregations ... clearly fit this description.”¹⁵

Parish Partnerships:

The Benedictine Health System is building partnerships with local parishes aimed at coordinating both paid care and volunteer services for the elderly. In an initial project, called Assisting Better Lives for Elders (ABLE), Benedictine is partnering with the parish of St. John the Baptist in New Brighton (Minn.). The project will combine health clinics, care management, information and referral services, and volunteer programs, all aimed at helping aging parishioners remain at home.

The effort’s long-term goal is to build partnerships among Catholic senior care providers and parishes throughout the archdiocese. The Benedictine Health System Foundation, which is helping to fund the St. John model with an innovation grant, is also supporting a similar project in North Dakota.

Congregational Health Network:

Among the most creative is the Memphis (Tenn.)-based Congregational Health Network, (CHN) a partnership of Methodist LeBonheur Health Care and more than 250 local churches of all denominations, many in high-poverty neighborhoods. CHN uses full-time hospital navigators who work with clergy and lay health liaisons in each church to identify and treat at-risk patients. While this network is available to people of all ages, its focus on chronic disease is makes it a valuable model for senior care (see case study).

Senior Villages:

Hundreds of these local non-profits are growing organically around the country. The concept: seniors in a community form a cooperative that provides services to help one another age in place. Some are dues-paying membership organizations with professional staff; others are less formal, volunteer-only groups. Most provide volunteer assistance for rides and friendly visits. Some offer concierge-type access to paid eldercare and other services.

While most focus on social services, a few are beginning to partner with local health providers to provide access to medical care. For example Boston's Beacon Hill Village¹⁶—one of the oldest and well-developed of these co-ops—has built a relationship with Massachusetts General Hospital. While it includes the usual health fairs and flu vaccine clinics, the relationship also provides access to Mass General's geriatric practice (which is closed to other new patients). Perhaps most importantly, village staffers work closely with hospital staff to help develop post-discharge care plans. Village staffers also help arrange the post-discharge infrastructure that makes it possible for its members to return home, including visiting nurses or aides, physical therapy, meal deliveries and transportation services.

In suburban Philadelphia, Pa., the Crozer Keystone Health System¹⁷ has taken this model a step further. In cooperation with Delaware County residents, it created its own village. For an annual fee of \$50, village members get access to a range of social and medical services, including a patient navigator who serves as a single point of contact with the health system and its physicians.

MODEL FOR REFORM:

Providing hospital-like care in lower-cost settings

Recent technological improvements make it possible to recreate a hospital room in a nursing facility or even in a private home. Payment reforms will encourage care in the lowest-cost setting.

Bon Secours New York:

The Bon Secours New York system has developed a sophisticated cardio-pulmonary sub-acute care unit at its Schervier skilled nursing facility. In partnership with local hospitals, including Montefiore Medical Center, this unit can now provide a high level of care for heart and lung patients that, until recently, could only be provided in a hospital (see case study).

Hospital at Home:

As the name implies, Hospital at Home¹⁸ (HaH) takes this concept one more step from a traditional medical center setting. In effect, HaH fully substitutes care at home for inpatient care by turning a patient's bedroom into a hospital room.

It works this way: carefully-targeted patients (normally those 65-plus with congestive heart failure, chronic obstructive pulmonary disease, cellulitis, or pneumonia) are screened when they arrive at a hospital emergency department. Those who require hospitalization are asked if they'd prefer to be admitted or sent home under the HaH program. Eighty percent choose the home option. A patient is sent directly home from the ED, where she receives continuous nursing care, physician visits, diagnostic testing, monitoring, therapies such as oxygen, and pharmacy support. At discharge, care reverts to the patient's primary care physician.

It is important to emphasize that this is hospital care, though provided at home. It is, in effect, a virtual hospitalization, provided by the facility, but not in the facility.

This substitutive care model appears to have both clinical and cost benefits. Patient satisfaction is high while length of stay is roughly equivalent. Patients in the program have had fewer complications such as delirium or bowel and urinary problems, and fewer overall emergency situations.¹⁹

Like other innovations, HaH struggles against the perverse incentives of the U.S. payment system. Medicare has not granted a waiver for the program.

However, successful models are operating overseas, in countries such as Australia and Italy. The Veterans Administration uses the model in Portland, Ore.; New Orleans; and other cities. Presbyterian Healthcare Services, a large integrated system in New Mexico, has recently implemented a version.

According to Bruce Leff, MD, the Johns Hopkins University physician who designed Hospital at Home, careful screening is key to the program's success. Not only are patients screened for certain diseases, but also for appropriate home settings and acuity levels. The program design explicitly recognizes that some patients must be admitted to traditional hospital care because they are too sick to receive care at home or because their homes are not appropriate for the program. At the same time, providers must avoid offering hospital-level treatment to a patient who could simply be discharged to normal care at home.

Leff believes such a design may also work well for skilled nursing facilities. For instance, skilled nursing facilities (along with assisted living facilities) could serve as the virtual hospital (as with the Schervier model).

At the same time, nursing facilities could mimic HaH by creating virtual rehabilitation programs in the community.

MODEL FOR REFORM:

Fully Integrated Chronic Care Management

There is, by design, significant overlap in successful models. Ideally, they would fit together in a single seamless package. Joanne Lynn, MD, for instance, has argued that a standard set of medical, personal and social services can be designed to follow each of us throughout our lives. In this model, which she calls “Bridges to Health,” these teams would evolve with our care needs, and take on an increasingly important role as we age and accumulate chronic diseases.²⁰

At first glance, such a concept may seem fantastical. However, experimental provider-based models already attempt to accomplish the goal Dr. Lynn and others describe.

Much has been written about the risks of hand-offs. These transitions (both within a single institution and between care settings) are especially risky for chronically-ill seniors. Poor communications among providers, inaccurate record-keeping and patients’ inability to comply with discharge instructions all lead to unnecessary complications, readmissions and sometimes death. Half of adults experience a medical error after discharge and nearly one-quarter suffer an adverse event, usually involving medications.²¹

Discharge planning is a broken link in the chain of care. With no financial support from payers and often under great pressure to complete a discharge within a few hours, overworked staff have little time to tailor care plans to the needs of individual patients. Self-care instructions are often unclear and providers have had little incentive to follow-up to assure patients are able to comply. Too often, patients who fail to follow instructions are written-off as “non-compliant.”

“Discharge planning is a broken link in the chain of care.”

The Chronic Care Model:

In an effort to address these failures, at least three successful models have been built on the framework first designed by Edward Wagner, MD, at the MacColl Institute for Health Care Innovation in 1998.²² His Chronic Care Model explicitly focuses on improving care across the continuum for the chronically-ill.

Variations have been developed by Mary Naylor, Ph.D., at the University of Pennsylvania, Eric Coleman, MD, at the University of Colorado, and Chad Boulton, MD, at Johns Hopkins University. Each varies somewhat in design and primary goal—for example, Naylor’s Transitional Care Model²³ is aimed at improving care of those being discharged from the hospital, Coleman’s Care Transitions Program²⁴ focuses on movement across all care settings while Boulton’s Guided Care Model²⁵ aims to identify at-risk patients sufficiently early to prevent initial admissions.

Guided Care:

In this model, high-risk patients are assigned a registered nurse. Working closely with a primary care physician (PCP), he/she becomes the patient's point of contact with the health system. Its goal is to use the nurse-PCP team to fully manage care of chronically-ill patients across settings. Randomized trials of the model at the Baltimore-Washington region of Kaiser Permanente as well as the Veterans Administration show the program can result in lower costs and higher satisfaction among both patients and participating physicians (see case study).

Palliative care:

Integrated care is a key element of well-designed palliative care programs. Teams of nurses, pharmacists, social workers, clergy and both specialists and primary care physicians provide a full range of holistic care to those with complex diseases. The recently published results of a formal randomized trial found that lung cancer patients enrolled early in a fully-integrated palliative care program had a median survival rate one-third longer than those receiving standard cancer care only, even though the palliative care patients chose less aggressive medical treatment.²⁶

PACE:

Programs of All-inclusive Care of the Elderly (PACE)²⁷ has been operating for decades. Based on the On Lok program created in the 1970s in San Francisco for Chinese-American elders, PACE provides integrated medical and social care for those living at home but requiring a nursing-home level of care. It often combines adult day care with medical care and home-based social services, all aimed at allowing seniors to age in their communities as long as possible. Despite substantial evidence that this model both improves outcomes and saves money, PACE has only about 20,000 participants nationwide. In part, this may be because its unusual funding mechanism relies on resources from both Medicare and Medicaid—an arrangement that can often be awkward at best. However, the ACA includes incentives aimed at expanding use of this model.

Improving communications across settings:

The Hebrew Home in Boston is working jointly with several area hospitals to reduce readmissions through improved communications among medical staff and between health professionals and patients.

The program focuses on patients who are at high risk of readmission, including those with heart failure, dementia, and chronic pulmonary disease. In this design, the discharging hospital shares its electronic medical record with the Hebrew Home's sub-acute and post-acute units in an effort to reduce errors and help build an appropriate care plan. The program includes an early palliative care

consult, participation of family members in developing a care plan and an assessment of caregiver needs.

A key element of the program is an interdisciplinary conference called TIPS (Team Improvement for Patient Safety) that is held to discuss errors or sub-optimal care that may result in readmission. These sessions include nurses and aides as well as physicians, and are aimed at identifying system flaws rather than individual mistakes.

Building on the foundation:

Finally, at least one group of medical innovators has proposed building a seamless, fully-integrated care program for chronically ill seniors from existing “off-the-shelf” care models, two of which are described in this paper.²⁸

In a 2009 *Health Affairs* article, Albert Siu, chairman of the Department of Geriatrics at Mount Sinai School of Medicine, along with Dr. Leff and co-authors, proposed linking HaH, palliative care and other in-hospital programs, and post-hospitalization transition programs (such as Guided Care) into a single, fully-integrated design.²⁹ They estimate that 10 percent to 20 percent of acute care discharges could benefit from such a portfolio, and costs could be reduced for that subgroup by 15 percent. In addition, capacity could be increased by 2.8-5.5 percent. Combined cost savings and additional capacity could increase annual net income for a hypothetical 300 bed hospital running at 85 percent capacity by \$2.8-\$6.6 million (after program expenses).

One could imagine accomplishing the same goal by combining other models. For instance, programs such as the Montefiore/Bon Secours cardio-pulmonary unit and the Memphis Congregational Health Network could fit ideally into such an integrated design.

Role of Electronic Medical Records:

Many of these models rely on electronic medical records (EMR) to help providers across settings seamlessly share information. However, while necessary to integrate care, they are hardly sufficient. Systems may risk failure if they assume that installing an EMR is a substitute for more fully integrating care.

The Business Case:

The question raised by providers about many of these designs is obvious: to be blunt, “What’s in it for me?” When lengths of stay, overall costs and readmissions are reduced, the financial beneficiary is the payer, and often not the hospital or nursing facility—at least in the traditional fee-for-service model. To the degree these experiments improve patient outcomes they surely help Catholic health systems fulfill their mission. But in a fee-for-service system, why should providers implement such a model—at some cost—if the savings inure to Medicare and private insurers?

As noted above, high-performing hospitals may already benefit from reducing their population of low-margin, chronically-ill patients. At the same time, skilled nursing facilities must find new revenue sources in an increasingly difficult long-term care environment. As Schervier and Montefiore learned, the synergies are apparent.

In the medium term, the answer may reside in the risk-based model that is at the core of delivery experiments such as accountable care organizations, medical homes and bundled payments. In these designs, providers may themselves become the beneficiaries of cost savings. These changes will develop rapidly—in many cases as soon as 2012.

CONCLUSION

Implementing these reforms is by no means simple. It requires major changes in the mindset of physicians and administrators. Successful programs are often built on fully-integrated teams of physicians, nurses and non-medical personnel—people who have struggled to work together in traditional medical environments.

For instance, while a growing body of research suggests that palliative care programs can improve outcomes at lower cost, they are more likely to do so when patients are enrolled early and where care teams are well assimilated.

Similarly, of 15 programs in a recent Medicare care coordination program, only three were deemed effective. Well-functioning designs appeared to share six characteristics: They were well targeted, had substantial in-person contact with patients, timely access to information about changes in a patient's health status, close interaction between care coordinators and physicians, provided the right mix of patient education and services, and were properly staffed.³⁰

In both the Medicare demonstrations and palliative care programs, buy-in by primary care physicians is critical. For instance, patients in one otherwise-successful palliative care program reported no significant reduction in pain. Researchers concluded this was because primary care doctors prescribed recommended opiates in only 8 percent of the cases where these meds were recommended by the care team.³¹

Well-functioning designs appeared to share six characteristics:

- Well targeted
- Substantial in-person contact with patients
- Timely access to information about changes in a patient's health status
- Close interaction between care coordinators and physicians
- Right mix of patient education and services
- Properly staffed

Even PACE, for all of its clinical success, has proven to be difficult to replicate for reasons that are still not well understood.

Notwithstanding these challenges, there is little doubt that well-integrated care for those with chronic disease will be a cornerstone of our evolving health and long-term care systems.

Payers, looking to reduce costs, will demand it. But most importantly, Catholic health systems will best be able to fulfill their sacred mission of caring for the sick by adopting models that seamlessly integrate care for the most vulnerable of their patients.

REFERENCES

- AARP, 2009 “Chronic Care: A Call to Action for Health Reform” Washington, D.C. AARP
- American Hospital Assn., 2009 “Trendwatch Chartbook: 2009”
- Richard G. Bennett and W. Daniel Hale, “Building Healthy Communities Through Medical-Religious Partnerships” Second edition, 2009 Johns Hopkins University Press
- Chad Boulton, Lya Karm, and Carol Groves, 2008 “Improving Chronic Care: The Guided Care Model” *The Permanente Journal* Winter 2008 Vol. 12 No.1
- Randall Brown, 2009 “The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness” Mathematic Policy Research Inc. and The National Coalition of Care Coordination (March, 2009)
- Christine Caffrey, 2010 Centers for Disease Control “Potentially Preventable Emergency Department Visits by Nursing Homes Residents: United States 2004” NCHS *Data Brief* No. 33 (April 2010)
- Congressional Budget Office, 2010 “The Long-Term Budget Outlook (June 2010)
- Karen Davis et al, 2010 “Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions in the Patient Protection and Affordable Care Act of 2010” The Commonwealth Fund
- Kevin D. Frick et al, 2009 “Substitutive Hospital at Home for Older Persons: Effects on Costs” *The American Journal of Managed Care* 2009 15(1): 49-56
- Howard Gleckman, “Caring for Our Parents” St. Martin’s Press, 2009
- John Holahan and Irene Headen, 2010 “Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL” Kaiser Family Foundation
- Gretchen Jacobson, Tricia Neuman and Anthony Damico, 2010 “Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities” October 2010, The Kaiser Family Foundation
- Sunil Kriplani et al, 2007 “Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key issues for Hospitalists” *Journal of Hospital Medicine* Vol. 2 No. 5 Sept/Oct 2007 314-323
- Medicare Payment Advisory Commission, 2010, “Health Care Spending and the Medicare Program: A Data Book June 2010” Washington, D.C., MedPac
- Milliman, Inc., August 16, 2010 letter to Vivianne Chaumont, Director Division of Medicaid & Long-Term Care Department of Health and Human Services, State of Nebraska. Available at:

<http://www.governor.nebraska.gov/news/2010/08/pdf/Nebraska%20Medicaid%20PPACA%20Fiscal%20Impact.pdf>

Michael W. Rabow, Suzanne Dibble, Steven Z. Pantilat, and Stephen J. McPhee, 2004, "The Comprehensive Care Team: A Controlled Trial of Outpatient Palliative Medicine Consultation" *The Archives of Internal Medicine* Vol. 164 January 12, 2004, 83-91 American Medical Assn.

Nicoletta Aimonino Ricauda et al, 2008 "Substitutive Hospital at Home Versus Inpatient Care for Elderly Patients with Exacerbations of Chronic Obstructive Pulmonary Disease: A Prospective Randomized, Controlled Trial" *Journal of The American Geriatrics Society* March 2008, Vol. 56 No. 1 493-500

Albert L. Siu, Lynn H. Spragins, Sharon k Inouye, R. Sean Morrison and Bruce Leff, 2009 "The Ironic Business Case for Chronic Care In the Acute Care Setting." *Health Affairs*, Vol. 28 No. 1 113-125

Martha L Sylvia et al, 2008, "Guided Care: Cost and Utilization Outcomes in a Pilot Study" *Disease Management* Vol. 11 No. 1 2008, 29-36

Jenifer S. Temel et al, 2010 "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *The New England Journal of Medicine* 368; 8 733-42 August 10, 2010

NOTES

¹Donald Berwick, speech to the Kaiser Family Foundation Policy Briefing on Improving Care and Reducing Costs for Medicare Beneficiaries in Nursing Homes, October 12, 2010. <http://www.kff.org/medicare/High-Medicare-Spending-for-Beneficiaries-in-Long-Term-Care.cfm>

²To protect patient privacy, this and other patient names have been changed, unless noted. However, all other details, including diagnoses, are true.

³AARP, 2009 “Chronic Care: A Call to Action for Health Reform”

⁴Medicare Payment Advisory Commission, 2010, “Health Care Spending and the Medicare Program: A Data Book June 2010” Washington, D.C., MedPac

⁵Estimate of Health and Human Services Secretary Kathleen Sebelius, accessed <http://www.hhs.gov/news/press/2010pres/03/20100330a.html> September 20, 2010

⁶Congressional Budget Office, 2010 “The Long-Term Budget Outlook (June 2010) <http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf>

⁷Analysts disagree over the rate of increase in state costs. For instance, Holahan and Headen (2010) estimate the state Medicaid costs will rise by between 1.4 percent to 2.9 percent. Milliman (2010) projects greater state cost increases.

⁸Anonymous hospital executive. Interview with author, Sept 15, 2010

⁹Karen Davis et al, 2010 <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Analysis-of-the-Payment-and-System-Reform-Provisions.aspx>

¹⁰American Hospital Assn., 2009, “Trendwatch Chartbook: 2009” The average community operating margin averaged about 3.5 percent from 2002-2007, before the economy severely slowed. [http://www.aha.org/aha/trendwatch/chartbook/2009/chapter4.ppt#258,4,Chart 4.2: Aggregate Total Hospital Margins, \(1\) Operating Margins, \(2\) and Patient Margins, \(3\) 1991 – 2007](http://www.aha.org/aha/trendwatch/chartbook/2009/chapter4.ppt#258,4,Chart 4.2: Aggregate Total Hospital Margins, (1) Operating Margins, (2) and Patient Margins, (3) 1991 – 2007)

¹¹Association of American Medical Colleges undated PowerPoint. Beginning in 2012, 1-2 percent is at risk through value-based purchasing requirements and an additional 1-2 percent is at risk through readmission penalties. Beginning in 2015, an additional 1 percent reduction in DRG payments may be imposed for hospital acquired conditions such as infections.

¹²Christine Caffrey, 2010 <http://www.cdc.gov/nchs/data/databriefs/db33.pdf>

¹³Gretchen Jacobson, Neuman and Damico 2010

¹⁴Interview with author

¹⁵Richard G. Bennett and W. Daniel Hale, 2009 pg. 2

¹⁶Information about Beacon Hill Village is available at <http://www.beaconhillvillage.org/>

¹⁷Information about the Crozer Keystone Village is available at <http://ckvillage.crozer.org/>

¹⁸Information about Hospital at Home is available at <http://www.hospitalathome.org/dgm/>

¹⁹Ricauda, Nicoletta Aimonino, 2008; Frick, Kevin et al, 2009

²⁰Howard Gleckman, 2009

²¹Kriplani, Sunil et al, 2007

<http://www.caretransitions.org/documents/Promoting%20effective%20transitions%20of%20care%20-%20JHM.pdf>

²²Information about the Wagner model is available at <http://www.improvingchroniccare.org/>

²³Information about Transitional Care Model is available at <http://www.transitionalcare.info/>

²⁴Information about the Care Transitions Program is available at <http://www.caretransitions.org/index.asp>

²⁵Information about Guided Care is available at <http://www.guidedcare.org/>

²⁶Temel, Jenifer S. et al, 2010

²⁷Information about PACE is available at <http://www.npaonline.org/website/article.asp?id=4>

²⁸Siu, Albert L., Lynn H. Spragins, Sharon K Inouye, R. Sean Morrison and Bruce Leff, 2009

²⁹ibid

³⁰Brown, Randall (2009)

³¹Rabow, Michael W., Suzanne Dibble, Steven Z. Pantilat, and Stephen J. McPhee, 2004

CASE STUDY

Linking Health and Faith in Memphis: The Community Health Network

How can a health system successfully serve a population that struggles with high levels of poverty and chronic disease? How does it reach those who often have no insurance, no primary care doctor and a deep distrust of the medical system? And how does it do so in a way that both improves health quality and makes economic sense?

Rev. Gary Gunderson and his team at Methodist Le Bonheur Health Care in Memphis (Tenn.) are convinced that the answer lies in a delivery system that links their hospital system with an interfaith network of hundreds of local churches. The program, called the Congregational Health Network (CHN), is a model of how hospitals can use existing faith-based institutions to touch a community that is largely disconnected from quality health care. Just as important, it is a design that helps break down the traditional barriers between medical, personal and spiritual care. Gunderson calls the network “an experiment in the future.” CHN, he says, “suggests that a hospital can make something happen outside of its walls.”

Both Methodist Le Bonheur and the residents of Memphis and the surrounding Mississippi Delta face enormous challenges. Methodist operates 1,000 beds in seven hospitals. Many are in inner-city Memphis—a city with high rates of chronic illness, including cardiovascular disease and diabetes. It has been described as “the limb amputee capital of the Southeast.”¹ And Methodist’s own financial challenges are compounded by long-stay Medicare patients—many of whom have nowhere else to go. Nearly 40 percent of its discharges are Medicare patients, and in 2009 the average charge for these discharges was \$40,914, while the average reimbursement was \$9,534.²

Once the hospital made a decision to remain in the city, it had only one option, believes Gunderson, and that was to collaborate with the local faith community.

Thanks to an initiative led by CHN director Rev. Bobby Baker, the network has grown to more than 250 churches representing a wide range of denominations. Participating clergy agree to actively participate in and promote the program, and serve as role models by practicing a healthy lifestyle. In return, they receive access to wellness events and a 60 percent discount off of Methodist health system charges for their personal medical care.

Most participating congregations are African-American Protestant, although CHN has begun to build relationships with Hispanic churches and Muslim mosques as well. It aims to sign up 400 participating faith communities by 2012. To date, CHN estimates that more than 40,000 individuals are currently connected to the network.

CHN melds the existing social infrastructure of local churches with clinical services provided by the hospital. The keys to the design are navigators—hospital staffers who are assigned to CHN participants—and community liaisons—church members who provide the day-to-day links between congregants and the health system.

Congregants of member churches may voluntarily enroll by filling out a simple, one page registration. On the day they are admitted to a system hospital, they are visited by a navigator. If they agree to participate in the program they are placed in an electronic medical record database. The navigator provides inpatient assistance and advocacy, and works with social workers, nurses, chaplains and volunteers to improve the patient’s hospital experience. She also contacts the liaison, who can help arrange visits by fellow congregants, as well as post-discharge after-care.

The design also allows for liaisons to inform the navigator if patients are having difficulty complying with post-discharge instructions. In the current implementation, navigators say this happens rarely. It is not clear whether this is due to improved patient education and post-discharge support, or an indication that liaisons require additional training and experience to cope with compliance issues.

Finally, CHN provides for participating congregants, a range of education and training programs including hospital visitation, aftercare, care for the dying, and mental health. These programs, most of which last as long as seven weeks, have been extremely popular and many are oversubscribed. More than 100 past participants in the visitation program are now regularly volunteering at Methodist hospitals.

While CHN provides care for all congregants, its early focus has been on seniors with chronic disease. A typical inpatient is a 65-year-old African-American woman on Medicare. Nearly half reported circulatory system disorders.

Early evidence suggests strong benefits for both hospitals and patients. Within a study group followed for 27 months, the program resulted in fewer admissions, fewer readmissions, shorter lengths of stay, lower total costs and lower per patient charges. Average charge per admission for CHN patients declined from \$40,277 prior to the program to \$37,409 after participation.³

Until now, CHN has focused on non-clinical services. However, given the need for routine medical care within this population, it might make sense for CHN to eventually partner with health clinics or even a Guided Care-type program that could provide high-risk patients with additional services.

Another possibility: Create a parish-nurse type program. For instance, Miracle Temple in south Memphis has at least nine nurses who are church members, says assistant pastor Fannie Kelley. “It would be an excellent idea if the hospital could use them to provide medical assistance for people in the congregation,” she says.

¹ Teresa Cutts, 2009, “The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network”

² Teresa Cutts, 2010, “Faith-Based Delivery Network Reduces Utilization and Charges for Elderly Hospitalized Patients.”

³ Ibid

CASE STUDY

The Cardio-Pulmonary Sub-Acute Program at Schervier Nursing Care Center

After Moira Murven had triple coronary artery bypass surgery at New York's Montefiore Medical Center, she knew she had several weeks of recovery ahead of her. After all, the 66-year-old had just had major surgery: she had a large incision in her chest and a vein removed from her leg, and she needed to bounce back from the debilitating effects of the heart disease that required the bypass in the first place.

Like Ms. Murven, more than half a million Americans get bypass surgery each year. Following her procedure, a patient such as she would normally expect to spend about a week in the hospital. She'd get some physical therapy during that time, but mostly she'd simply be monitored for post-surgical complications and given some routine medications. But she'd also run the risk of infection, and, like many elderly patients, could also fall victim to confusion or delirium as a result of her prolonged hospitalization.

Given her age and overall medical condition, she would also need a few weeks of rehabilitation after her discharge from the hospital.

But thanks to an innovative sub-acute care program at Bon Secours New York Schervier Nursing Care Center, Ms. Murven was out of the hospital in just a couple of days. She received both post-surgical care and rehab at Schervier, which made this smooth transition possible by creating a unit dedicated to cardio-pulmonary care.

On a chilly October day, Ms. Murven was reading a romance novel and recovering in a comfortable suite with two private rooms and a shared bathroom. A former licensed practical nurse herself, she was pleased with her care and said she didn't miss seeing her cardiologist on daily rounds. She even liked the food. Her only complaint: she wished lunch and dinner were not scheduled so close together.

The 39-bed unit at Schervier specializes in heart disease, including both pre- and post-surgical care as well as pneumonias and chronic pulmonary disease. Specially-trained registered nurses and aides, along with attending physicians from Schervier's hospital partners, provide a hospital level of care. While Medicare will not pay for daily rounding-type visits by these specialists, the hospital-based physicians are available for routine consultation and in the event of a major change in a patient's condition.

Schervier opened the unit at minimal cost. It spent only about \$200,000 for in-wall oxygen and specialized hospital beds. Rehabilitation services are subcontracted to the Burke Rehabilitation Center, which sends its staff to the nursing home. Training for nurses and aides was provided by Good Samaritan Hospital, another member of the Bon Secours system. “I offered to trade,” says Schervier’s medical director Joseph Scarpa, MD. “I agreed to teach them how to prevent pressure ulcers and they taught our nurses how to do cardio assessments.”

While Schervier has not compiled formal cost and outcomes data, the program appears to be a win for patients, the nursing facility, its partner hospitals and Medicare—the major payer.

Typically, Medicare pays \$30,000-\$35,000 for an uncomplicated bypass in New York. If there are complications, or a patient has other pre-existing conditions, Medicare may pay as much as \$50,000.¹ The hospital stay alone can cost \$1,500-\$2,000 per day. By contrast, Medicare pays Schervier about \$550.

The hospital partners benefit as well. Even at \$50,000, hospitals can lose money on elderly cardio-pulmonary patients—especially those with complex medical problems who often cannot be discharged quickly enough to meet the Medicare Diagnosis Related Group (DRG) guidelines that drive hospital payments. A key reason: There often is no care setting able to take them. So these patients may remain for weeks with nowhere to go—and the hospital loses money each day.

A hospital such as Montefiore also benefits because its busy cardiac care program would prefer to open up Ms. Murven’s bed to a new patient. A final key advantage: A well-managed, integrated sub-acute and rehab program may reduce readmissions through both good care and patient education. Administrators are well aware that Medicare will soon begin reducing its payments to hospitals with excess “frequent flyers.”

At the same time, the program has been a financial life-saver for Schervier. Before creating the cardio unit, this 364-bed nursing facility had only about 35 rehab beds. Nearly every one of its long-term care residents was on Medicaid, which reimburses at only \$200 per day, far less than it costs Schervier to care for them.

Schervier management is very happy with the sub-acute program and is anxious to expand it, not only to take more cardio patients, but also to include other chronic disease such as diabetes.

In the future, the relationships among the participating facilities may become more formalized. Today, the arrangement among Schervier, Burke and their hospital partners, including Columbia University Medical Center, is something of a proto-accountable care organization, a model the 2010 health law will encourage. In such a design, groups of providers agree to share both revenues and risk to care jointly for targeted high-risk patients.

In some ways, Schervier is returning to its past. Built into the brick wall over the main entrance is the original 1950s-era name of the facility: Frances Schervier Hospital. Schervier has no plans to

become a full-blown medical center, but it may find an expanded role providing those sub-acute services that, until now, have been largely limited to traditional hospitals.

¹ Centers for Medicare and Medicaid Services “Inpatient Hospital DRGs of High-Utilization: 2006 Data. Accessed on the Web 10-8-10 at http://www.cms.gov/HealthCareConInit/02_Hospital.asp

CASE STUDY

Kaiser Permanente and Guided Care

All things considered, “James Martin” is doing remarkably well. At 84, he is alert and engaged and still living in his comfortable suburban home with his wife “Norma.” But he suffers from a long list of chronic illnesses, including diabetes and heart and kidney disease. And even though Mr. Martin prides himself on his ability to follow instructions, he struggles to keep up with 16 daily medications, plus three others he must take as needed.

His biggest problem is his evening insulin. Instead of taking it around dinner time as he should, Mr. Martin sometimes waits until he goes to bed—a potentially dangerous delay that could lead to hospitalization or worse.

But the Martins have help, thanks to an unusual collaboration between his health system—Kaiser Permanente—and an experimental program called Guided Care, designed by a team led by Chad Boulton, MD, of the Johns Hopkins Bloomberg School of Public Health.

The key to Guided Care is a registered nurse who serves as the key point of contact for participants. But she is not an independent case manager. Instead, the nurse, who may see up to 60 patients, is fully integrated into a primary care practice. Working in close consultation, the patient, the patient’s family, the physician and the RN build a formal plan that guides both medical and personal care. The plan is adjusted as needs change, and a plain language version, called an Action Plan, serves as a patient’s self-care blueprint.

The Martins’ nurse is Cecilia Daub, who has worked with Kaiser’s Guided Care program since it began four years ago and has been with the Martins for the past three years.

Guided Care targets chronically-ill seniors at highest risk of hospitalization. Originally begun as a pilot in 2003, it was run as a randomized controlled trial from 2006-2009. The design adopts several elements of chronic care—including disease management, case management, patient self-management, transitional care and caregiver support. The nurse helps the patient make connections to social services and personal care as well as medical care.

The process begins with a careful screening. The Guided Care nurse performs a two-hour assessment at the patient’s home, which begins the process of building the care plan. The nurse monitors her patients at least monthly by phone or, if needed, with in-person visits. Patients are instructed to contact the nurse if their condition changes, and are also trained in self-management. In the event a patient is hospitalized, the Guided Care nurse works closely with patients and their caregivers to smooth a transition back to the community.

While Dr. Boulton and colleagues are still analyzing data from the trial, early evidence from Kaiser suggests it may reduce both nursing home days and ED visits. While the cost of a nurse (including expenses) in the grant-funded trial averaged about \$90,000 annually, early evidence suggests it may result in net cost savings to participating providers when self-funded. Kaiser is in the process of determining whether to incorporate the program into its normal operations.

One Monday afternoon, Cecilia is sitting with the Martins at their dining room table. At Cecilia's request, James has brought out his many pill bottles—a half-dozen in a small box, the rest in a plastic grocery bag.

Using a technique called motivational interviewing, Cecilia asks James to describe how he takes each pill. He wants to read from the labels, but she asks him to tell her in his own words what he does with each medication.

In two cases, they discover an inconsistency between Cecilia's printout and what Mr. Martin thinks he should be doing. And then there is the matter of his delayed insulin.

Cecilia tells him not to worry about having an occasional drink or a bite of ice cream. "You get to have some fun and pleasure," she says. But, she adds, "You can't forget your insulin."

She is not using motivational interviewing now. She is giving James a blunt warning: "Don't worry about high blood sugar," she says, "the lows are way more dangerous."

She also encourages Norma to remind him, and urges James to listen to his wife. "If he forgets," Cecilia tells Norma, "you can tell him."

Then Cecilia brings up a sensitive subject. Despite his precarious health, James has no living will, and it isn't clear if he has designated anyone as his medical proxy. She gives him a copy of an advanced directive and gently, but firmly, says, "This is about your preferences. It is not an emergency now, but suppose you are in a coma. Put it in writing."

Because this conversation is taking place in the Martins' own dining room, and because they know Cecilia so well, it doesn't seem at all awkward or rushed. Cecilia spends well over an hour with the Martins, far more time than a physician could.

"I have no interest in being a PA (physician's assistant) or a doctor," Cecilia tells me later. "I don't do diagnosis, and don't want to." But she is the eyes, ears and sometimes even the voice of a medical system that too-often seems disconnected from its patients.

Cecilia is fully integrated into the practices of four Kaiser primary care doctors. All changes in meds and other therapies are routinely noted on an electronic medical record. But while her own office is just a few feet from the four physicians, she also communicates with them through e-mail and brief personal contacts. Just before the Martins come in for a consultation, Cecilia walks down the hall with James' primary care physician and, with just a few words, updates him on James' condition.

“I love Guided Care,” says Cecilia, “This is not piecemeal health care. I follow patients for the long haul. I know them. It positions me to spot red flags and avoid hospitalizations.”

Robert Trimble, MD, one of the Kaiser doctors who works with Cecilia, is also a fan. “It helps integrate care for people with chronic disease,” Trimble says. When asked whether it improves patient compliance, he laughs and nods his head, saying, “It’s amazing how well they do.”

And what does Mr. Martin think about Guided Care? “You just tell them Kaiser does what it is supposed to do,” he says. “They do a damn good job.”



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