Transitions of Care
or
How To Tie It All Together

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Palliative Care & Hospice
WellStar Health System
Marietta, GA

October 25th, 2014
transi·tion
noun \tran(t)-ˈsi-shən, tran-ˈzi-, chiefly British tran(t)-ˈsi-zhən\

: a change from one state or condition to another

Full Definition of TRANSITION

1
a: passage from one state, stage, subject, or place to another: change
b: a movement, development, or evolution from one form, stage, or style to another

2
a: a musical modulation
b: a musical passage leading from one section of a piece to another

3
: an abrupt change in energy state or level (as of an atomic nucleus or a molecule) usually accompanied by loss or gain of a single quantum of energy
WellStar Overview

Recognized as the 5th most integrated healthcare system in the country, WellStar employs over 12,500 team members and is one of the largest not for profit health systems in GA serving a population of nearly 1.4 M.

- Service Area: 5 counties
- 5 Hospitals
- 7 Urgent Care Centers
- 2 Health Parks
- 16 OP Imaging Centers
- 950 community affiliated physicians
- 720 providers WellStar Medical Group
  - 1.4 million Medical Group office visits
  - 115+ Office locations
  - 12,600 employees
  - 64,400 discharges
  - 9,600 deliveries
  - 43,000 total surgeries
  - 331,000 ER visits
- Patient service revenues: $1.6B
WellStar Hospital Medicine

• Hospital Medicine Service Line
  – Hospital Medicine, Nursing Homes, and Palliative Medicine & Hospice

• Growth
  – 72 MD FTEs (from 39 in 2012)
  – 26 APP FTEs (from 6 in 2012)
  – 5 Care Transition Coaches (CTC) FTEs

• Large footprint in all five hospitals

• Operational Infrastructure
  – Cabinet
  – Site Directors
  – Associate Directors
  – Epic MD champions
Outline

• Big Picture
• Tactics
  – Care Transition Coach (CTC)
  – Post-Acute Care Network – NH partnerships
  – Acute Care Collaborative Units (ACCU)
  – WellStar Accountable Care Organization (ACO)
Health Care Reform

The Key: Co-Evolution

Delivery System Redesign and Alternative Payment Models must support each other and evolve in parallel.

Payment Methodology

Non-Risk

FFS → Shared Savings → Single Payment (+ Q incentives)

→ Medical Home Pilot → ACO (all payers)

Current Reality
...the current system of care is unsustainable.

New Normal
Paying providers based on value not volume:
fee for health rather than fee for service
Goal: Strengthen the interaction among Patient-Centered Medical Homes–Specialists–Hospitals in order to enhance quality, experience and efficiency of patient care

Aligned Provider Network: Medical Neighborhood

The right care, in the right place, at the right time

Population Health

Experience of Care

Per Capita Costs
• Big Picture
• Tactics
  – Care Transition Coach (CTC)
  – Post-Acute Care Network – NH partnership
  – Acute Care Unit (ACCU)
  – WellStar Accountable Care Organization (ACO)
Problem

• Before CTC
  – No follow-up appointments made
  – No discussion of post-discharge care plan
  – No place for patients to call if things go wrong

• Patients discharged from our Hospitals
  – Frightened
  – Confused
  – Dissatisfied
  – Lost to follow-up
  – Many returned to ED – the only place they know
Program’s Goals

Improve Transitions of Care by:

- Ensuring a smooth transition from the inpatient setting to outpatient
- Reducing length of stay
- Improving patient satisfaction
- Reducing 30-Day Readmissions
- Improving referring physicians’ satisfaction
CTC Staffing Model

CTCs are LPNs at an average salary of $46,266
<table>
<thead>
<tr>
<th>CTC</th>
<th>% Appointments Made</th>
<th>Appointment From D/C Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kennestone CTC 1</td>
<td>65%</td>
<td>7.6 Days</td>
</tr>
<tr>
<td>Kennestone CTC 2</td>
<td>84%</td>
<td>10.5 Days</td>
</tr>
<tr>
<td>Kennestone CTC 3</td>
<td>100%</td>
<td>12.8 Days</td>
</tr>
<tr>
<td>Cobb CTC</td>
<td>50%</td>
<td>6.9 Days</td>
</tr>
<tr>
<td>Douglas CTC</td>
<td>80%</td>
<td>6.8 Days</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75%</td>
<td>9.1 Days</td>
</tr>
</tbody>
</table>
## CTC Workload/Productivity

<table>
<thead>
<tr>
<th>Kennestone CTCs</th>
<th>Team Patient Encounters</th>
<th>30-Day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>159</td>
<td>9%</td>
</tr>
<tr>
<td>March</td>
<td>231</td>
<td>8%</td>
</tr>
<tr>
<td>April**</td>
<td>177</td>
<td>8%</td>
</tr>
<tr>
<td>May</td>
<td>210</td>
<td>7%</td>
</tr>
<tr>
<td>June</td>
<td>173</td>
<td>9%</td>
</tr>
</tbody>
</table>

*All patients that received CTC intervention at Kennestone Hospital*

*Source: Manually collected from Canopy*

**One CTC transitioned from the program**
Summary

Achievements
- Reduced 30-day readmissions
- Improved patient satisfaction
- Improves team member satisfaction
- Improved Transitions

Opportunities
- Differentiate CTC vs Care Coordination duties
- Standardize CTC workflow across the system
• Big Picture
• Tactics
  – Care Transition Coach (CTC)
  – Post-Acute Care Network – NH partnerships
  – Acute Care Collaborative Unit (ACCU)
  – WellStar Accountable Care Organization (ACO)
Overview

• Rapidly changing health services reimbursement model
  – From volume-based → value-based
• Emergence of Population Health
  – Health System’s responsibility extends beyond episodic care
• SNF represents the single largest Post-Acute Care (PAC) expense for Medicare PAC ($62B)
• Tight alignment between Health Systems and multiple provider types is essential
• Post-Acute Care Network (PACN) is the right tool
Post-Acute Care 101

Skilled Nursing Facility
- Primarily cares for orthopedic rehab and chronically ill, multi-morbid patients
- Unlike nursing home, not a long-term care facility

Inpatient Rehab Facility
- Provides occupational and physical rehab services
- Enforcement of 75% rule has shifted patient mix from orthopedic to neurological patients

Home Health Agency
- Offers assistance with daily living activities, limited clinical support primarily to chronically ill patients
- Telemonitoring reduces need for patient travel, allows higher acuity patients to be transferred home

Long-Term Acute Care Hospital
- Serves patients in need of ongoing acute care level services, LOS typically exceeds 25 days
- Ventilator, wound care primary services but patient population highly diverse

Hospice
- In-patient and home-based
- Provides end-of-life care
Use of Hospital Care and Post-Acute Care over Time.

Medicare Acute and Post-Acute Care Payments for 30-Day Episodes That Began with a Hospitalization, 2008.

## Facility Discharge Disposition

**Dec 12 - Nov 13**

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>WellStar Hospitals*</th>
<th>% of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME OR SELF CARE</td>
<td>54505</td>
<td>79.23%</td>
</tr>
<tr>
<td>HOME HEALTH ORG</td>
<td>6938</td>
<td>10.09%</td>
</tr>
<tr>
<td>SKILLED NURSING FACILITY</td>
<td>4724</td>
<td>6.87%</td>
</tr>
<tr>
<td>HOSPICE-MEDICAL FACILITY</td>
<td>886</td>
<td>1.29%</td>
</tr>
<tr>
<td>OTHER FACILITY</td>
<td>780</td>
<td>1.13%</td>
</tr>
<tr>
<td>HOSPICE-HOME</td>
<td>698</td>
<td>1.01%</td>
</tr>
<tr>
<td>NURSING FACILITY</td>
<td>97</td>
<td>0.14%</td>
</tr>
<tr>
<td>ICF</td>
<td>114</td>
<td>0.17%</td>
</tr>
<tr>
<td>COURT/LAW ENFORCEMENT</td>
<td>45</td>
<td>0.07%</td>
</tr>
<tr>
<td>FEDERAL HOSPITAL</td>
<td>1</td>
<td>0.001%</td>
</tr>
<tr>
<td>CANCER CENTER/CHILDREN HOSP</td>
<td>2</td>
<td>0.003%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>68790</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>
What Do We Do?
AG Rhodes – WellStar Partnership

• Go-Live April 2013
• Innovative Care Delivery model
  – Medical Director – WellStar Medical Group physician (Hospitalist, board-certified Geriatrician and Certified Medical Director) + APP based at AG Rhodes Monday-Friday
• Deliverables
  – Improve quality of care at AG Rhodes as measured by CMS-defined reportable metrics
  – Reduce avoidable re-admissions to acute care hospitals
  – Achieve the above through better communication between Nursing Home and WellStar Hospitals leveraging WellStar IT infrastructure and seamless continuum of care provided by the WellStar clinical Team delivering care in both settings
Outcome Measures

A G Rhodes Cobb Scorecard 2012/2013

AG Rhodes – WellStar Partnership Started April 2013

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Day All Cause</td>
<td>36%</td>
<td>24%</td>
<td>31%</td>
<td>20%</td>
<td>30%</td>
<td>24%</td>
<td>14%</td>
<td>6%</td>
<td>10%</td>
<td>0%</td>
<td>6%</td>
<td>18%</td>
<td>6%</td>
</tr>
<tr>
<td>30 Day CMS Penalty d/c rate</td>
<td>4%</td>
<td>1%</td>
<td>23%</td>
<td>1%</td>
<td>15%</td>
<td>6%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>1) Residents without falls</td>
<td>88%</td>
<td>87%</td>
<td>86%</td>
<td>83%</td>
<td>83%</td>
<td>88%</td>
<td>92%</td>
<td>84%</td>
<td>85%</td>
<td>74%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Residents w/o anti-psych</td>
<td>90%</td>
<td>94%</td>
<td>94%</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>91%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3) Residents w/o acquired catheters</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>4) Residents w/o acquired physical restraints</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
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<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>5) Residents w/o unplanned weight loss/gain</td>
<td>96%</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
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<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>6) Residents w/o acquired pressure ulcers</td>
<td>100%</td>
<td>98%</td>
<td>94%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
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Alignment - Key to Success

Patients
- Continuity of Care
- Access to highly qualified team
- Direct admissions
- Satisfaction

Hospital
- Assurance in quality of care at the NH
- Improved throughput (LOS, timely discharges)
- Positive impact on quality metrics (30-d readmissions, patient satisfaction, etc.)
- Direct admissions

Nursing Home
- Tight Quality control
- Readily available APP
- Seamless flow of information from the hospital to NH
- Positive impact on quality metrics (30-d readmissions, anti-psychotics use, etc.)
- Direct admissions

Payers
- Cost containment
- Member satisfaction
• Big Picture
• Tactics
  – Care Transition Coach (CTC)
  – Post-Acute Care Network – NH partnerships
  – Acute Care Collaborative Unit (ACCU)
  – WellStar Accountable Care Organization (ACO)
Definition:
A geographic inpatient area responsible for clinical and cost outcomes

The Accountable Care Unit (ACU) and Structured Interdisciplinary Bedside Rounds (SIBR) were invented at Emory University by Dr. Jason Stein. These slides are adapted from materials created by Dr. Stein.
Design Features of Team-Based Model
Patient-Centered Team-Based Work Flow

Collaborative Bedside Rounds (CBR)
- Patient/Family
- Hospitalist
- Nurse
- Clinical Nurse Leader
- Care Coordination
- Clinical Pharmacist

- Care Transition Coach
- Charge Nurse
- As Staffing/Pt needs allow:
  - Physical Therapy
  - Respiratory Therapist
CBR Ground Rules

- All patients 5 days/week
- All CBR team members must be present
- Start and finish on time
- Rounds end only after patient’s plan-for-the-day has been verbalized and patient/family had an opportunity to ask questions
The Structured Dialogue of CBR

Emphasis on Role Clarity

- Introduce All Team Members
- **Update Status:** (45 sec)
  - Overnight events & Review patients goal of the day (On in room white board)
- Vital Signs & Pain Control
- Fluid and Food Intake
- Urine and Bowel Output
- Mental Status and ADLs
- Physical Findings/Pathophysiology

Report “abnormals”
The Structured Dialogue of CBR

Emphasis on Role Clarity

• **Checklist for Quality and Safety (15 sec)**
  - Foley Catheter
  - Central or Pic Line
  - VTE Prophylaxis
  - Pressure Ulcers/Stage
  - Plan of the Day and Assign Responsibilities

• **Discharge Planning Checklist (30 sec)**
  - Discharge Needs
  - Discharge day and realistic time
  - Follow up Appointment

• **Patient Education (30 sec)**
Acute Care Collaborative Unit Outcomes
### ACCU Outcomes

**Average Length of Stay**

<table>
<thead>
<tr>
<th>ALOS 6S /7W</th>
<th>ALOS 6N /7S</th>
<th>ALOS 7W</th>
<th>TOTAL LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEFORE JAN 2013</td>
<td>AFTER JAN 2013</td>
<td>BEFORE JAN 2013</td>
<td>AFTER JAN 2013</td>
</tr>
<tr>
<td>4.00</td>
<td>3.89</td>
<td>4.21</td>
<td>4.01</td>
</tr>
</tbody>
</table>

$\Delta 2.39\%$

### % Discharges Prior to 2 PM

<table>
<thead>
<tr>
<th>BEFORE JAN 20</th>
<th>AFTER JAN 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.20%</td>
<td>43.44%</td>
</tr>
</tbody>
</table>

*Implemented ACCU Jan 20, 2013*
ACCU Outcomes
2PM Discharges

CURRENT ACU
PRIOR TO ACU
## ACCU Outcomes

### Cost per Case Savings

<table>
<thead>
<tr>
<th>Before January 20(^{th}) 2013</th>
<th>After January 20(^{th}) 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,134</td>
<td>$7,954</td>
</tr>
</tbody>
</table>

- 364 patients/month X 8 months X $180 = $524,160 (Annualized $786,240)
- HM at KRMC annual census 8,000 = potential savings ~$1,440,000/year
Kennestone Hospital ACCUs
Patient Satisfaction Mean Scores

- Overall
- Nursing
- Visitors & Family
- Physicians
- Discharge
- Personal Issues
- Overall Assessment
- Likelihood to Recommend

- Jan-Mar
- April-Jun
- July-Sep
- Oct-Dec

Mean Scores:
- Overall: [Values]
- Nursing: [Values]
- Visitors & Family: [Values]
- Physicians: [Values]
- Discharge: [Values]
- Personal Issues: [Values]
- Overall Assessment: [Values]
- Likelihood to Recommend: [Values]
ACCUs at WellStar Hospitals

- KRMC - Seven ACCUs
  - Gen Med (3)
  - Pulmonary (2)
  - Neuro (1)
  - Cardiovascular Surgery (1)
- Cobb – Five ACCUs
- Douglas – Two ACCUs
- Paulding – Two ACCUs

Total = Sixteen ACCUs
- Bed Capacity = 373
• Big Picture

• Tactics
  – Care Transition Coach (CTC)
  – Post-Acute Care Network – NH partnerships
  – Acute Care Collaborative Unit (ACCU)
  – WellStar Accountable Care Organization (ACO)
Accountable Care Growth

Over 18 million lives are covered under ACOs with 5.3 million of those in MSSP ACOs.

*Estimated Accountable Care Lives; Source: Leavitt Partners Center for Accountable Care Intelligence*
Accountable Care Growth

ACOs now in all 50 states; led by CA(58), FL(55) and TX(44).

Accountable Care Organizations by State; Source: Leavitt Partners Center for Accountable Care Intelligence
Accountable Care Growth

Georgia MSSP ACOs

- Accountable Care Coalition of Greater Augusta
- The Premier HealthCare Network
- Accountable Care Coalition of DeKalb
- WellStar Health Network
- Accountable Care Coalition of Georgia
- Georgia Physicians for Accountable Care
- Accountable Care Coalition of Central Georgia
- Accountable Care Coalition of Greater Athens
- Accountable Care Coalition of South Georgia
- Accountable Care Coalition of Greater Athens
- Morehouse Choice ACO
- Accountable Care Coalition of Western Georgia

- 12 MSSP ACOs in Georgia
- 8 owned by Universal Health
WellStar Health Network (MSSP ACO)

- Start Date – July 2012; 3 Performance Years

<table>
<thead>
<tr>
<th>Period</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>07/01/2012</td>
<td>12/31/2013</td>
</tr>
<tr>
<td>2014</td>
<td>01/01/2014</td>
<td>12/31/2014</td>
</tr>
<tr>
<td>2015</td>
<td>01/01/2015</td>
<td>12/31/2015</td>
</tr>
</tbody>
</table>

- Design of program is to improve quality and bend the cost curve
- Shared savings opportunity; no downside risk
  - System Investment through June 30, 2014 – $2.3 M
- Beneficiaries of 37,567 (60K unique individuals)
- Annual spend of $372+M
- High level savings opportunity of $8M to $37M annually
  - Savings to be split 50/50 with CMS and then 50/50 with hospitals and physicians
WellStar Health Network
Medicare ACO (for each period, rolling 12 months)
Total Expenditures Per Beneficiary Per Year

July 1, 2012 Start Date
37,878 Current Beneficiaries

Implementation of Population Health (3/31/13)

$10,500
$10,000
$9,500
$9,000
$8,500
$8,000

Q3 2012 $9,990
Q4 2012 $9,961
Q1 2013 $9,685
Q2 2013 $9,636*
Q3 2013 $9,428
Q4 2013 $9,333
Q1 2014 $9,129
Q2 2014 $9,024

Original CMS Benchmark $9,896
Interim CMS Benchmark $9,862

2.4%
7.1%

Quality Results **

* First Reporting Period: for 12 months ending June 30, 2013, compared to revised benchmark WellStar achieved a 0.5% savings with a benchmark threshold of 2.3%.

** ACO Quality measure average March 2013 and March 2014.
Population Health Management

• **Charge** – to improve the overall health of our “at risk” populations by building systems and programs to support health and wellness, chronic disease management, acute care management and transitions in care while assuring appropriate utilization of resources and improving the quality of care at every touchpoint.
What is Population Health Management?
A Roadmap, the GPS

- An Extension of the Physician/Patient Relationship
- Complex Care Management
- Disease Management
- Care Coordination for Transitions in Care
- Multidisciplinary Team Care
- Support for PCMH and creation of a Virtual Medical Home
- Evidence based Medicine and Best Practice support
- Wellness and Prevention programs
- Patient Engagement and Self Management support
- Patient Navigation
What Population Health Management is NOT: The Driver

- A replacement for the physician/patient relationship
  - PHM cannot succeed without strong physician/patient relationships and trust
- Utilization Management
  - Interface between payer and provider/facility often viewed as “them”
  - PHM is an interface between the patient and provider intended to strengthen the bond and create “us” as partners in care.
- “Cookbook Medicine”
  - Guidelines, best practices developed by service lines-not PHM
Managing Three Distinct Populations

5% of patients; multiple chronic conditions, catastrophic cases, complex socioeconomic issues

15-50% of patients; 1 or more stable chronic conditions, multiple risk factors for chronic disease

45%-80% of patients; minor conditions, need preventive care, may be undiagnosed

Source: Modified from Health Care Advisory Board interviews and analysis.
The Top 5%

Cumulative Spend for Top 5%

<table>
<thead>
<tr>
<th></th>
<th>2013Q1-Q2</th>
<th>2013Q3-Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verisk Medical Spend</strong></td>
<td>$92,489,213</td>
<td>$75,018,312</td>
</tr>
</tbody>
</table>
Overall CMS ACO’s – Performance Year 1 Results (18 months)

- WellStar’s ACO generated nearly $20 million in Medicare savings and will receive nearly $10 million in gain-sharing payments.
- WellStar improved on 21 of 33 quality measures.
- 53 of 204 ACO’s generated on average $12 million in savings for Medicare and had enough savings to generate shared savings payments of $6 million on average.
WellStar ACO

**Wins**

- Population Health Management
- Better Care Coordination
- Improved Outcomes
- Market Differentiation
- Emphasis on multi-disciplinary team approach (MD + Case Managers + PharmD + …)

**Future Steps**

- Fine-tune the collaboration between ACO → WellStar Clinical Partners
- Leverage ACO umbrella to achieve true Clinical Integration
- Prepare WellStar Health System for the new reality – Quality-Based purchasing of health services
HM Value Proposition: FY14 Progress & Results

- Acute Care Collaborative Units
  - **Reduced** Cost Per Case by $180. Impact of ($985,500)
  - **Increased** Number of Patients Discharged Prior to 2PM by 75%, **creating capacity**

- Care Transition Coach
  - **Reduced** Readmission Rate by 3 Percentage Points with an annualized impact of $2,083,864

- Post-Acute Care Network (SNF/LTAC)
  - **Reduced** Readmissions from Nursing Homes from Nearly 30% to Single Digits, average cost of readmission is $5,788

- Observation Unit/CDU
  - **Reduced** OV Cases by Approx 20% at Cobb & Kennestone. **Cost per case difference of $2,300 in OBV versus IP.**
  - Realized appropriate **increase** in conversion rate to IP status.

- Hospitalist Admission Unit
  - **Increased** throughput efficiency by approximately 20 percentage points and exceeded Kennestone target for D2F metrics, **creating capacity and positively impacting patient satisfaction.**

- Medical Co-Management of surgical patients
  - Implemented PATT program at Kennestone
  - **Increased** Collections by 2 percentage points from 42.8% to 44.2%, an annualized impact of $392,000.

- Comprehensive Palliative Medicine Program
  - Hired system-wide medical director, Dr. Melissa Schepp
  - **Reinstated** programs at Cobb and Kennestone showing annualized savings based on pre-consult and post-consult variable cost savings per day of ($1,233,024)
  - Solidified inpatient and home hospice.
Thank You!
The overall performance of the speaker:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
Overall quality of this session:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
How well were the learning objectives met?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
Did speaker present a balanced view of therapeutic options?

1. Yes
2. No
3. N/A

47% 44% 9%
Were relationships between grantor and speaker announced prior to the presentation?

1. Yes 81%
2. No 19%
How useful will this session be in your practice?

1. Poor
2. Fair
3. Average
4. Good
5. Excellent
As a result of this program, do you intend to change your patient care?

1. Yes
2. No
Thank you!