Achieving Care Coordination:

Insight, Investigation, Introspection Required

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National Database of Nursing Quality Indicators (NDNQI)
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Mr. Jenkins & Family

- 76 years old; retired investment broker; active lifestyle
- Lives with wife of 50 years in suburban Philadelphia; wife showing signs of cognitive changes
- Three children living w/families in other states

Mr. Jenkins' Health History

- History of 8 chronic conditions
- Under the care of 7 specialist physicians; PCP retired
- Taking 14 prescribed medications daily; coping with dietary restrictions
- Health problems increasingly interfering with lifestyle
- 3 hospitalizations within past 8 months
- Most recent hospitalization for "another acute episode of heart failure"

"The hand-off"

- Three day hospital stay
- Three major changes in medications
- Verbal + handwritten discharge instructions
- No referral for home health care follow-up
- Told to schedule follow-up M.D. visit within 7 days

Perspectives at Hospital Discharge

Patient and Family	Health System
▪ Health needs *unmet* ▪ Needs *additional help* at home ▪ Health issues *stressing* family	▪ Health needs met ▪ Family able to meet needs ▪ Strong, available support system

At home, Mr. Jenkins…

- Can't read discharge instructions
- Has questions about medications but does not know whom to call
- Is weak, dizzy, and unable to eat
- Unable to get M.D. appt. for 10 days
- Before he is able to see his M.D., Mr. Jenkins is readmitted for a 4th time with acute heart failure "*due to lack of adherence to prescribed therapies*"

Care Coordination (CC)

"***Care coordination***…function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time…high quality patient experiences and improved healthcare outcomes." (NQF, 2006)

Transitional Care (TC)

"***Transitional care***…range of time limited services and environments that are [complimentary to primary care and] designed to ensure health care continuity and avoid preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers and across settings." (Coleman & Boult, 2003; Naylor, 2003)

Vision

- A healthcare system that guides patients and families through their healthcare experience… a system that…
  - Aligns with patients' and family caregiver's needs/preferences/values
  - Increases safety
  - Improves functional status
  - Enhances quality of life
  - Decreases hospital readmissions
  - Reduces total health care costs

What do we know about opportunities to improve CC and TC

- Search of published evidence
- Examination of legislative activities (i.e., Accountable Care Act, HITECH)
- Review of National Priorities Partnerships' transformational drivers
- Synthesis to formulate a roadmap to accelerate improvements in CC and TC

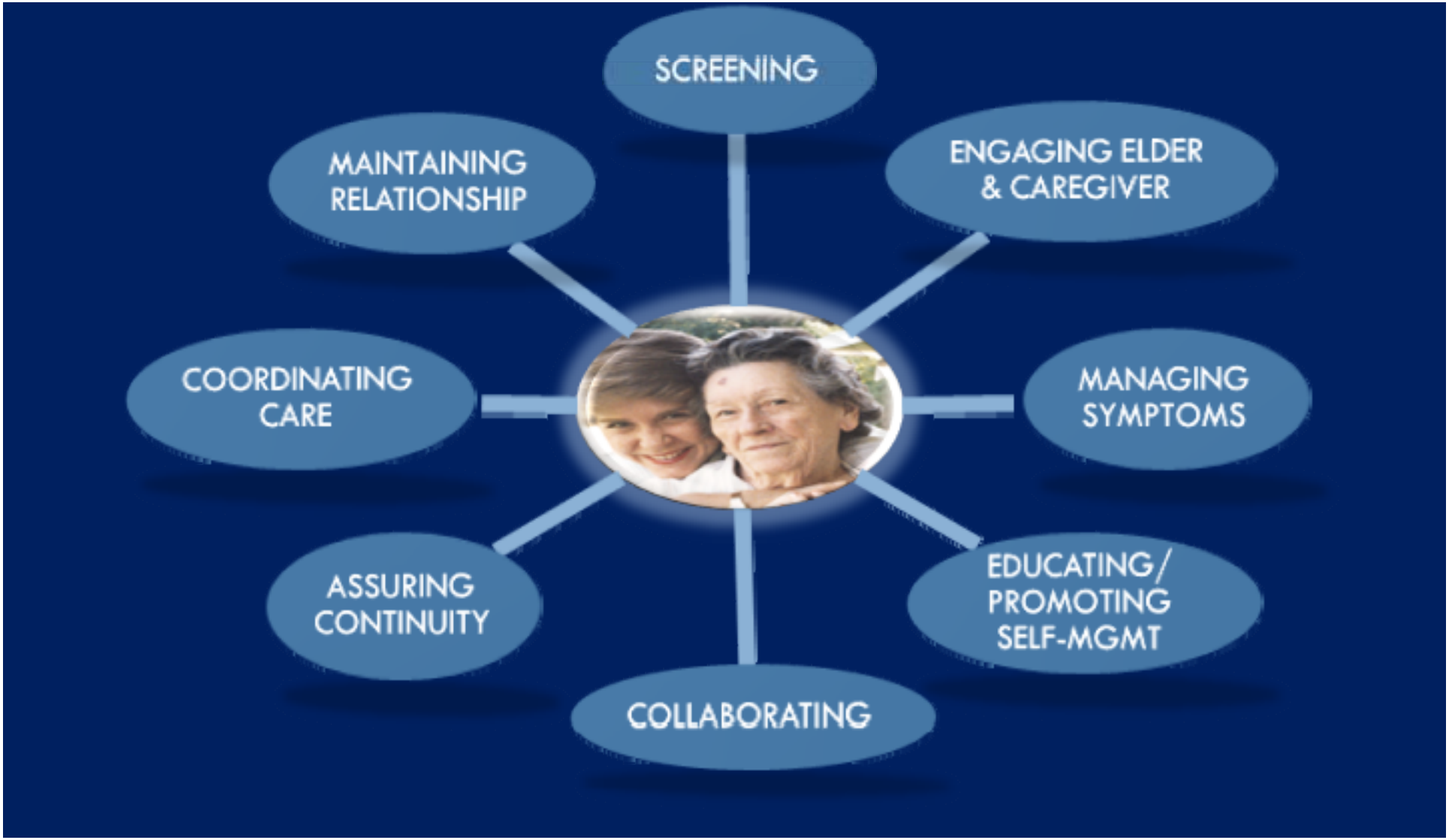
State of Care Coordination

- To date, limited overall progress in improving CC
- Requires tailored strategies that fit patient's and family caregiver's preferences + goals
- Typically target chronically ill older adults but evidence of CC among children also available
- Mixed evidence of CC's impact on outcomes

State of Transitional Care

- More consistent evidence demonstrating the effectiveness of transitional care
- Evidence suggests core elements
- Reliance on inter-professional teams with clinicians as “hubs”
- Legislative opportunities create opportunities

Quality Cost
Transitional Care Model (TCM)



Unique Features

Care is delivered and coordinated

…by same advanced practice nurse

…in hospitals, SNFs, and homes

…seven days per week

…using evidence-based protocol

…with focus on *long term* outcomes

Core Components

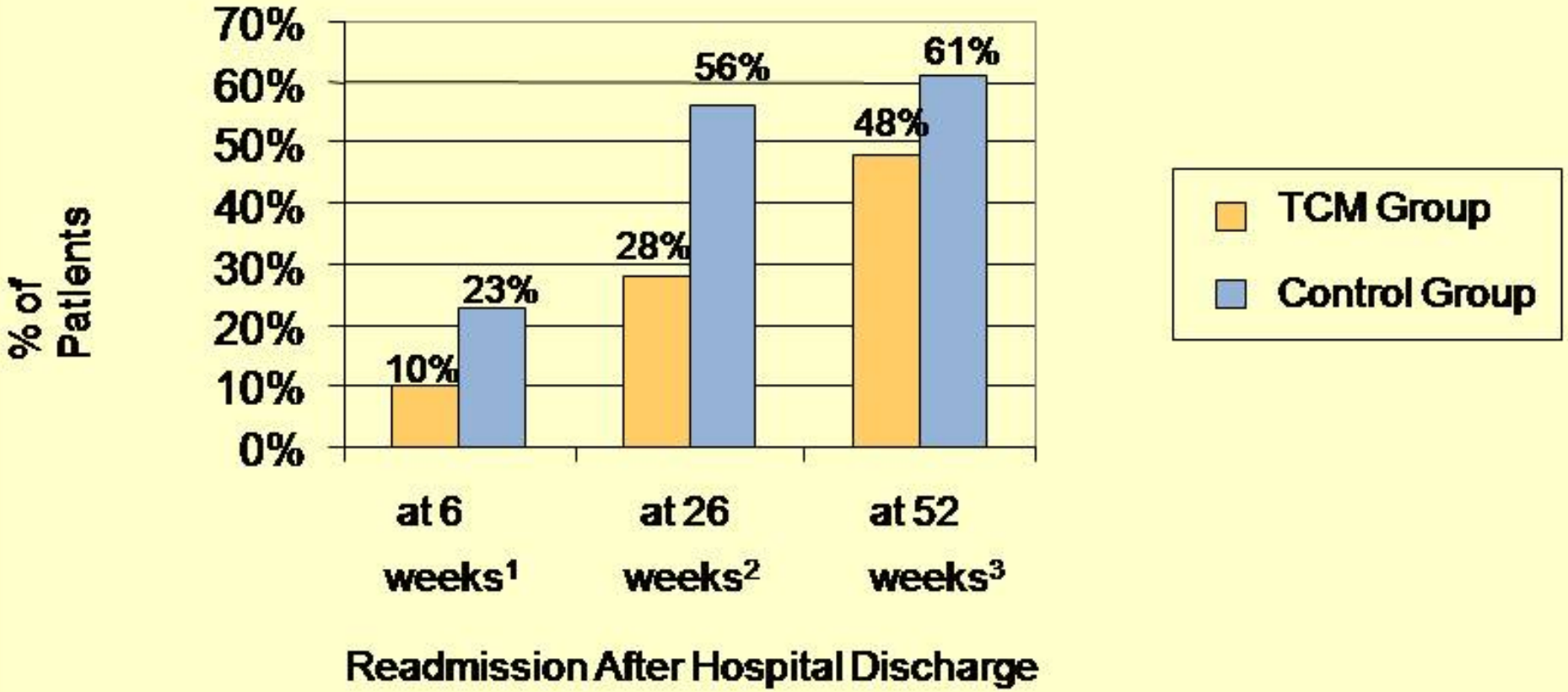
- Holistic, person/family centered approach
- Nurse-led, team model
- Protocol guided, streamlined care
- Single "point person" across episode of care (relational/management continuity)
- Information/communication systems that span settings
- Focus on increasing value over long term

Across RCTs, TCM has…

- Increased time to first readmission or death
- Improved physical function and quality of life*
- Increased patient satisfaction
- Decreased total all-cause readmissions
- Decreased total health care costs

*Most recently completed RCT only

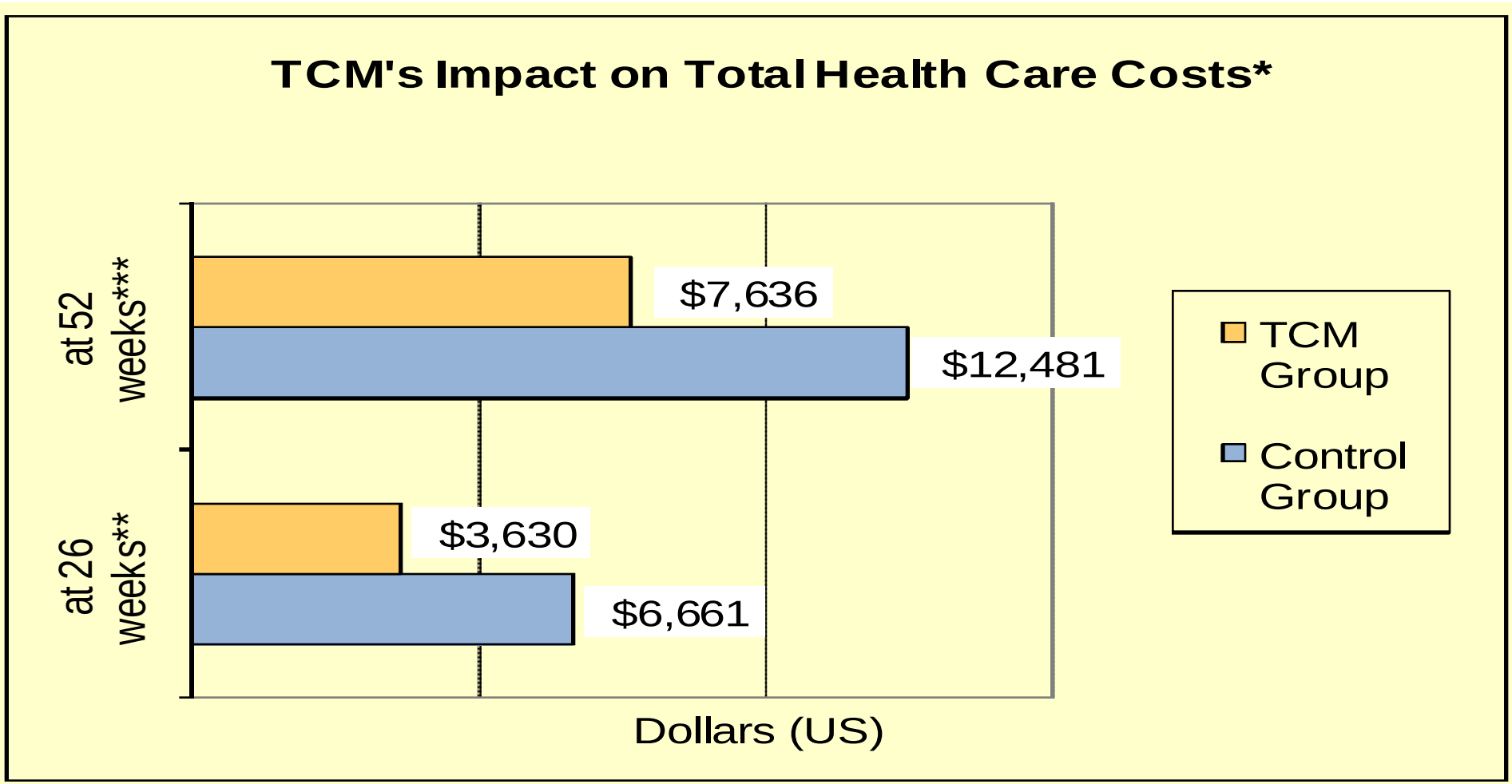
TCM's Impact on Readmission Rates After Index Hospitalization



[1] Naylor MD, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, & Pauly MV. Comprehensive discharge planning for the hospitalized elderly. *Ann Intern Med*. 1994;120:999-1006.

[2] Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, & Schwartz JS. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA*. 1999;281:613-620.

[3] Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, & Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc*. 2004;52:675-684.



* Total costs were calculated using average Medicare reimbursements for hospital readmissions, ED visits, physician visits, and care provided by visiting nurses and other healthcare personnel. Costs for TCM care is included in the intervention group total.

** Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, & Schwartz JS. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. *JAMA*. 1999;281:613-620.

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Barriers to Widespread Adoption

- Organization of care
- Regulatory barriers
- Lack of quality and financial incentives
- Culture

Translating TCM into Practice

Penn research team formed partnerships with Aetna Corporation and Kaiser Permanente to test "real world" applications of research-based model of care among at risk elders.

Funded by The Commonwealth Fund and the following foundations: Jacob and Valeria Langeloth, The John A. Hartford, Gordon & Betty Moore, and California HealthCare; guided by National Advisory Committee (NAC)

National Advisory Committee

VHA

Penn Home Care & Hospice Services

Project Goals (Aetna)

- Test TCM in defined market
- Document facilitators and barriers
- Provide for ongoing NAC input
- Present findings to Aetna decision makers
- Widely disseminate findings

Tools of Translation

- Patient screening and recruitment
- Orientation of nurses (web-based modules)
- Documentation and quality monitoring (clinical information system)
- Quality improvement (case conferences grounded in root cause analysis)
- Evaluation

$$\text{Value} = \frac{\text{[Improved] Quality/Satisfaction}}{\text{[Relative to] Health Resource Utilization (Costs)}}$$

Environment: Extant comprehensive system of geriatric telephonic care management

Question: Does the Transitional Care Model offer greater value in this environment?

Findings

- Improvements in all quality measures
- Increased patient and physician satisfaction
- Reductions in rehospitalizations through 3 months
- Cost savings of $2170 per member through one year

All significant at $p < 0.05$

Higher Quality

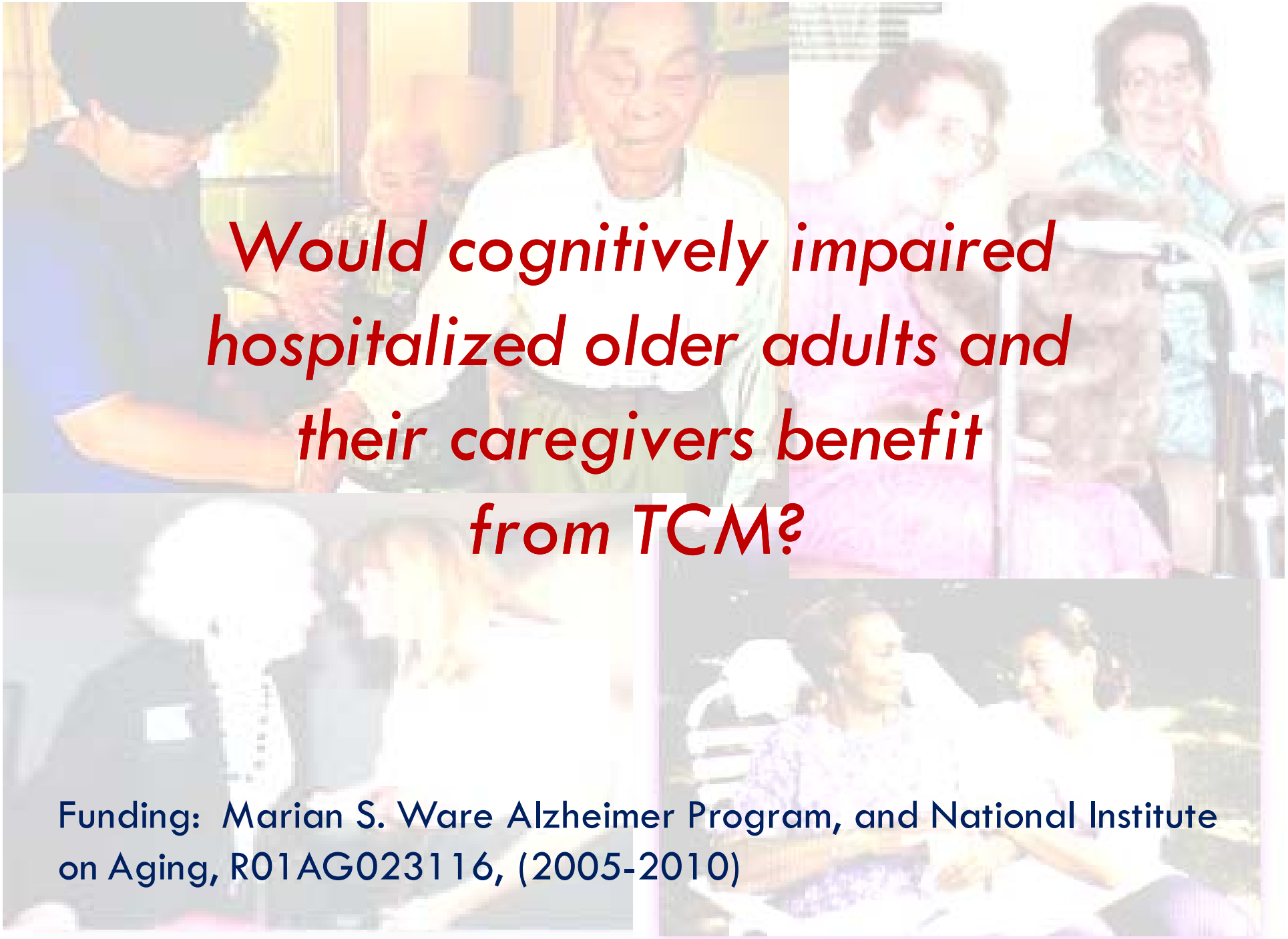
+ Satisfaction

+

Reductions in Acute Readmissions (Costs)

=

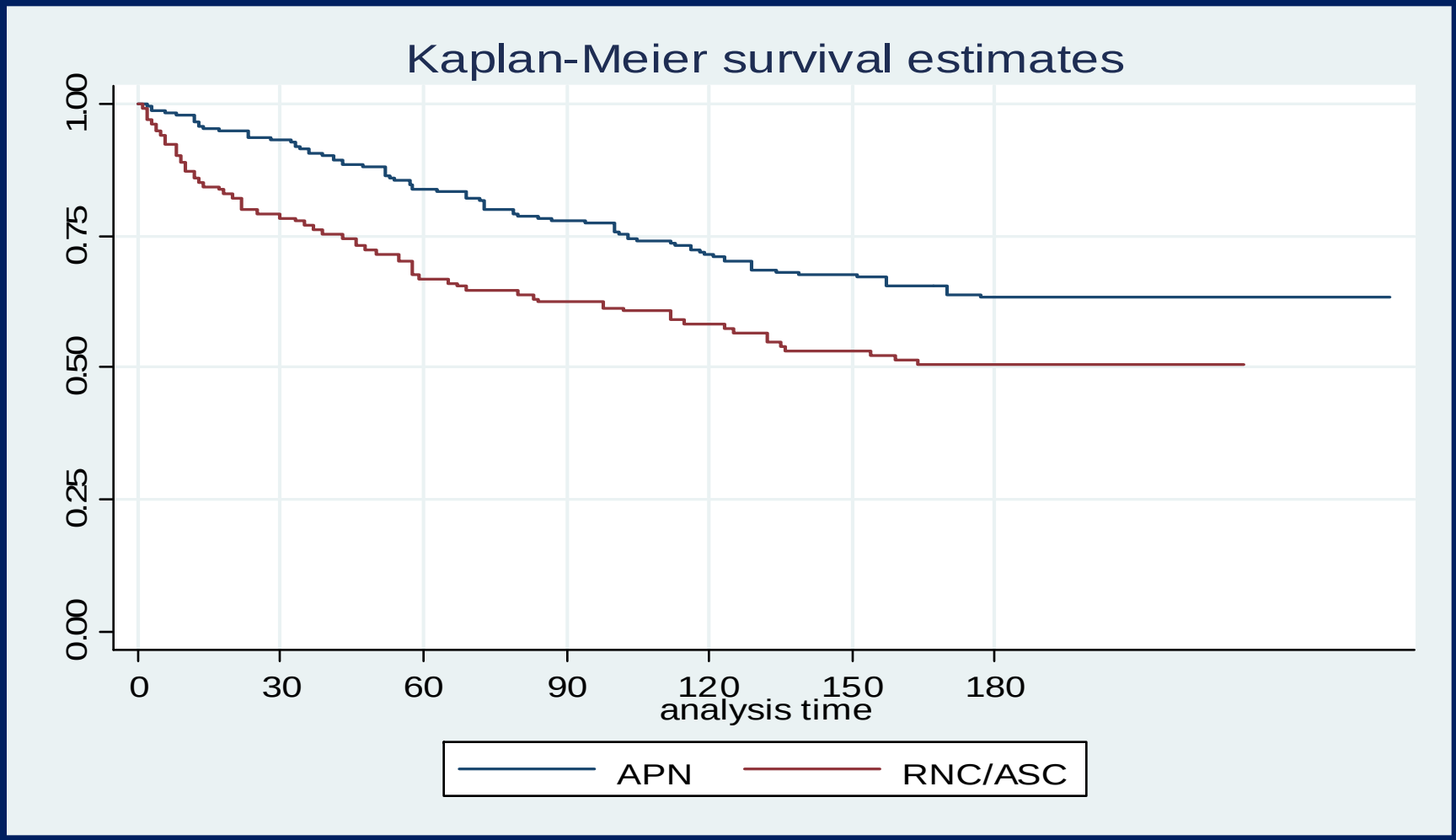
TCM as High Value Proposition for Aetna



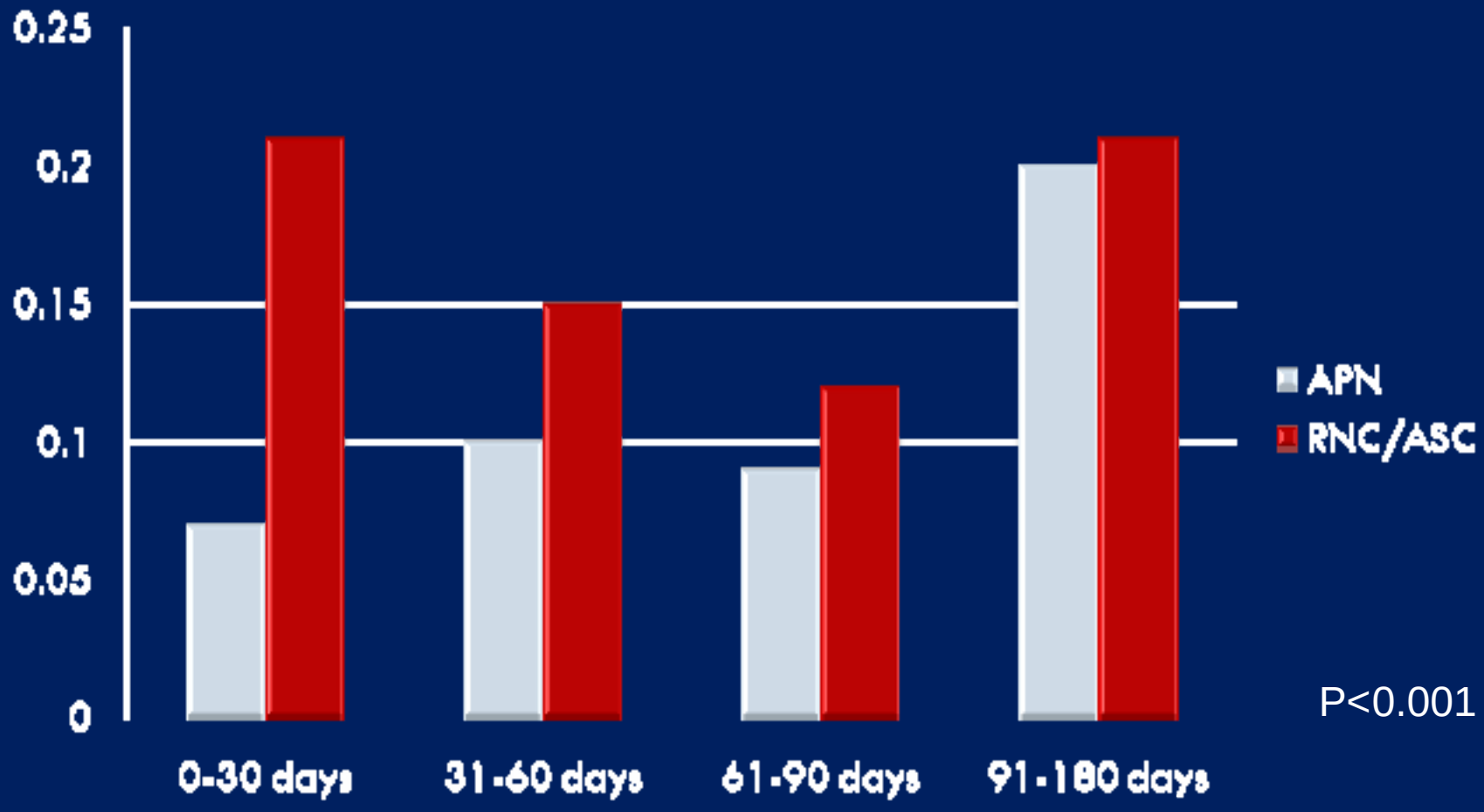
Would cognitively impaired hospitalized older adults and their caregivers benefit from TCM?

Funding: Marian S. Ware Alzheimer Program, and National Institute on Aging, R01AG023116, (2005-2010)

Preliminary Findings: Time to First Readmission or Death

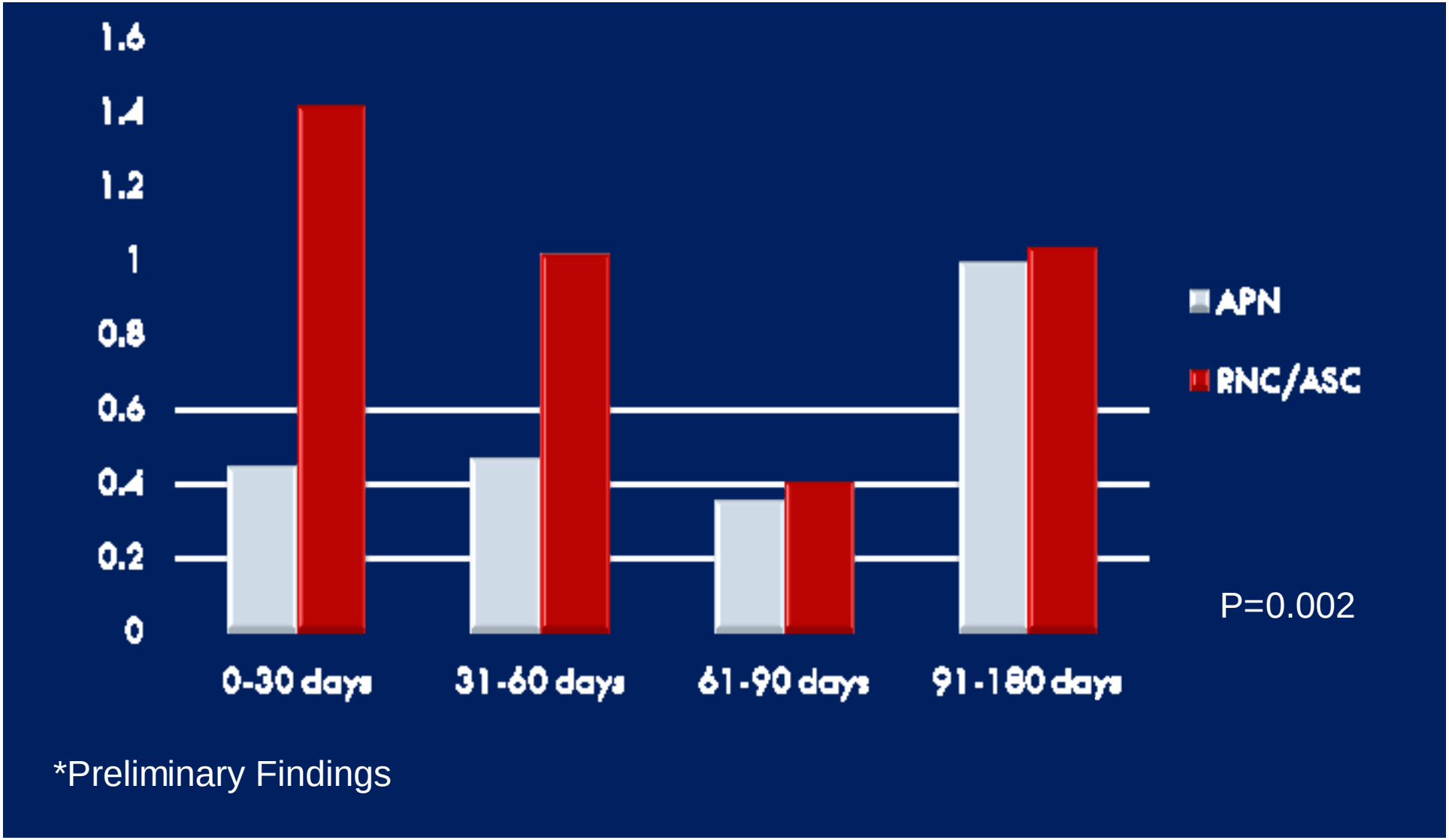


Mean Number of All-Cause Rehospitalizations Through Six Months



*Preliminary Findings

Mean Number of Total Hospital Days Through Six Months



*Preliminary Findings

What do we know about effects of transitions in health among elderly long-term care recipients over time?

Funding: Rand-Hartford Center for Interdisciplinary Geriatric Health Care Research (2005-2008); National Institute on Aging, National Institute of Nursing Research, R01AG025524, (2006-2011)

Key Lessons

- Solving complex problems requires multidimensional solutions
- Evidence is necessary but not sufficient
- Change is needed in structures, care processes, and health professionals' roles and relationships to each other and people they serve
- Overcoming inertia requires substantial force

Need For…

- Strong champions
- Provider awareness of what works and does not work
- Clearly defined, aligned and actionable goals
- Organizational commitment
- Upfront, ongoing investment in and shared accountability for higher value

Progress to Date

- *Aetna* – expansion proposed as part of Aetna's Strategic Plan
- *Kaiser* – data collection/analyses ongoing
- *University of Pennsylvania Health System* – adopted TCM (Aetna and Blue Cross reimbursing)
- *QIOs* – working with NJ and NY
- *Other health care providers*

Promoting Adoption

- *Sample strategies*: national and international collaborations and consultations, website, media efforts
- *Selected outcomes*: endowed center; featured in *Wall Street Journal*, *Washington Post*, PBS, NPR; AAN Edge Runner, AHRQ Health Care Innovations, RWJF Innovative Care Models, NQF Best Practice, Coalition for Evidence-Based Policy's *Top Tier Evidence Initiative*

Influencing Health Policy

- *Sample strategies*: Policy briefs, Congressional testimony, Hill and MedPAC briefings
- *Selected outcomes*:
  - Medicare Transitional Care Act (S.1295, and H.R. 2773)
  - Provisions re: transitional care in current health care bill

Transformational Drivers:
A Starting Place

- Nationally endorsed performance measures for CC and TC
- Nationally endorsed preferred practices for CC and TC
- Public reporting platforms
- Federally-sponsored performance-based payment programs

Recommendation 1:
Enhance Performance Measures

- Achieve consensus on what constitutes a potentially avoidable readmission
- Identify and endorse additional measures that reflect high value CC and TC
- Achieve consensus on and endorse composite measures that reflect the adequacy of CC and its five domains

Recommendation 2: *Promote Accountability for Care Coordination and Transitional Care*

- Publicly report comparative performance results for measures that reflect CC and TC outcomes

Recommendation 3:
Redesign Payment Policies

- Better align eligibility criteria under Medicare, Medicaid, and the Children's Health Insurance program (CHIP)
- Link payment to performance related to CC and TC

Recommendation 4:
Expand System Capacity

- Accelerate the scaling of effective CC and TC interventions, and testing of these and novel approaches among especially vulnerable groups…
    - children and their family caregivers
    - people receiving long-term services and supports and their family caregivers
- Develop specific tools to ease implementation of preferred practices

Recommendation 4:
Expand System Capacity (cont'd)

- Support implementation and expansion of CC and TC-related meaningful use objectives/measures

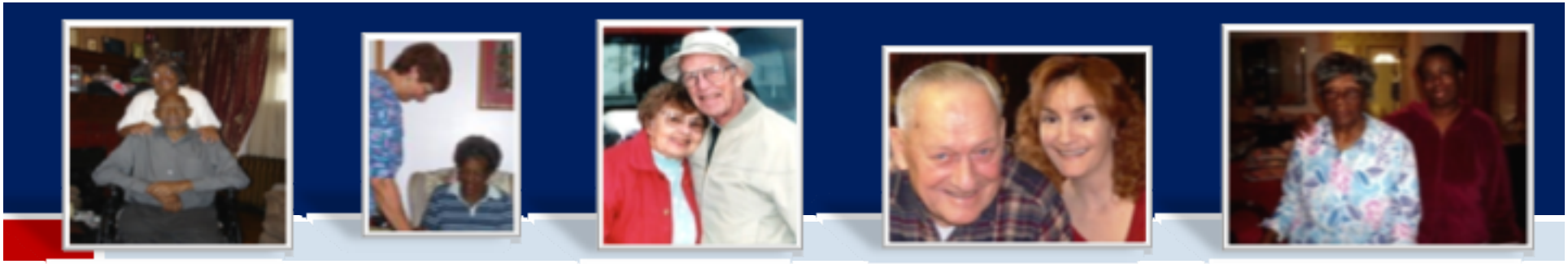
- Enhance the content and delivery of health professions education to reinforce the provision of care that is well coordinated

Implementation Recommendations

- National goals and measure sets that focus on care coordination transitions
- Large scale pilots of effective CC and TC
- Stretch performance targets with generous rewards
- Distribution of rewards across providers/health care professionals involved
- Enhanced preparation of current/emerging work force

THE FUTURE: *High Quality CC and TC for Mr. and Mrs. Jenkins & Family*

- Enhanced alignment with patients' and family caregiver's needs/preferences
- Increased safety
- Improved functional status
- Enhanced quality of life
- Decreased hospital readmissions
- Reduced total health care costs



Thank You

www.transitionalcare.info