

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Andy Miller: I am Andy Miller from Healthcare Quality Strategies which is the New Jersey Quality Improvement Organization. And I'm the Co-leader for the New Jersey Care Transitions Project which is one of the 14 QIO Care Transitions Project that you've been hearing about today. What I'm going to talk about is the implementation about of Dr. Naylor's transitional care model in a community setting. This slide shows a picture of the New Jersey care transitions community. It's the green area. And I just wanted to point out that just to the left of the green area is the city of Philadelphia, not totally coincidentally like what you're talking today. Our main partner in this project has been the Virtua Health System. It's a system that includes four acute care hospitals, two nursing facilities, two home health agencies and a number of outpatient physician practices also. And at the beginning of the care transitions project, CMS invited us, the 14 states together, and we got to hear a presentation by Dr. Naylor and her team which includes a number of really talented and committed people. And we got to hear the unabridged version of the model and how it

works. And we thought, "This is great. And it's just across the river in Philadelphia, about a half hour from our community. We've got to do this."

And so we went back to Virtua and asked would they be interested in working on this. The Virtua home care people which is a part of the system that operates the home health agencies was really excited about it and from the beginning, very committed to implementing the transitional care model.

For them, this was great. It's the nursing model. A number of people in the home care agency and throughout the Virtua system were graduates from the University of Pennsylvania, School of Nursing. So they appreciated where this was coming from. Some of them were aware of the model specifically and Dr. Naylor's work. So we didn't have to do a big job selling this program. Page 164 However, right from the beginning, they said they needed to be, not just they wanted it to be, financially feasible and sustainable after the project ended. And like some of the other QIOs, resources were

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an issue and we said we could help fund one or more of the nurses. And they said, “No. That’s not going to help us. When this project ends, we want to do this in a way that we can continue without outside support.” And so I will come back to that.

Dr. Naylor’s team provided the training and support for the program. Mary, herself, came and gave a number of presentations to Virtua’s leadership. And I think this was really key in, number one, making the people in the home care program feel good that this was something that was supported by the system. But also, the leadership of the system really got a chance to understand the model and how – what a great opportunity it was and how it’s fit also into a number of the other initiatives that the system was putting into place to improve coordination of care throughout their system.

Mary talked about the training modules, the online modules, Virtua hired transitional care nurses. And they went through that training that was reviewed by the Penn team. They made a site visit to Philadelphia. They got to

do a home visit with one of the transitional care nurses and managers went along through this site visit. And the Penn team provided ongoing case conferences for the transitional care nurses and the managers who were involved in the program.

Now, as I said, one of the issues was the home care agency said this has to be a sustainable, financially feasible project for us. And so a number of adaptations had to be made to the model to make it that way in a system that is – or in the community that’s primarily Fee-For-Service Medicare and pre-Affordable Care Act interventions.

So – and Laurie Robinson talked about this. It’s an issue for our home health agency. Alright, how do we provide these services in a way that they’re going to be reimbursable?

So the first was we need to make these visits and these a billable service for the home health agency. So that’s number one. Limits this to only patients

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Page 165 who are eligible for Medicare home health. They had to be homebound and they have to be in need of medically necessary services. So that limits to a certain extent who's eligible.

They said, "We can't afford APNs." They had no problem with the idea of using advanced practice nurses, but said, "We can't afford that based on what we're paid for a home health visit. So we're going to have to use baccalaureate level nurses."

Fortunately, the Penn team had dealt with that before and that was not a major barrier to get past. They also said, "We can't do the first visit in the hospital by the transitional care nurse – the home health nurse because that's not a home care visit. It's not reimbursable. But we have home care nurses. We have our intake coordinators in the hospital and they will do that visit."

They said, "We can't do that visit that's part of the transitional care model along with the patient to the first doctor's visit," which you know that makes so much

sense and they realize that, but they said, "But we can't do it. It's not a reimbursable visit."

And they said – they found that, occasionally, patients even though they were screened in the hospital, either refused services where they said, "You know, I had home care before and I want my old nurse back." "Well, but we can provide you a better service with another one of our nurses." "No. No. I want my own nurse back."

Or, occasionally, somebody would slip through the screening process and not be picked up as being high-risk and in need of this service, so the agency said, "We can enroll patients after discharge from the hospital." So a nurse would go out to the patient's home and determine, "Wait a minute. Here's a good candidate. Here's somebody who would really benefit from transitional care model." And those patients were enrolled.

Because the nurses were not advanced practice nurses, the agency put a lot of effort into training them and getting them to the level where they would be

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comfortable and they would be capable of providing the services through the page 166 model. So they were trained in management of patients with COPD, CHF, with diabetes. And about the resources that are available in the community in which they work for patients with these conditions with other needs.

The program started out and still is a small pilot within the home health agency, but the ultimate goal is to spread it throughout the agency and integrate it into all the care options that the agency provides.

Right now, there are four transitional care nurses who between them work 2.4 FTEs. And they don't spend all of their time in the program. But anecdotally, the program has had a spillover effect within the agency with regard to increasing awareness about care transitions among the other nurses and providers within the agency.

The agency decided after about nine months working with the program that it was really – that it was different enough from the transitional care model and that it was their program, their own program. So they gave it a

separate name and called it Transition to Care Program. And Dr. Naylor was extremely gracious about this. And she put it – you know, I didn't think of it that way, but she did, that really, it was a good thing, that the agency wanted to take ownership of this.

They had put a lot of effort into doing it. They had a lot of pride in how it was working. And they wanted to take it on as their own. They've continued to do this – they've continued – instead of having sort of case conferences now provided by the people from Penn, they run their own case conferences, but they're continuing to follow the model.

Now, this gets back to something Dr. Coleman talked about earlier. Now you're starting to make changes. Dr. Naylor emphasized this is an evidence-based model. This has been shown over 20 years in randomized controlled trials to work and now you're messing around with it. You're taking out pieces, they may be the key pieces. We don't know that and we're not – and we're taking them out not because evidence shows that they

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may not be as important. We're taking them out for financial reasons. So, you know, this is

Page 167 a problem, the potential loss of fidelity with the evidence-based, evidence tested model in any time you do this in implementing within the community.

Now the good news is, I hope you can see that in the back, the outcomes really have been good. The program has really been up and running fully for a little more than a year, so we don't have a lot of data yet. But you can see there's been a significant reduction in the number of hospitalizations. This was not a controlled trial, so we didn't have a controlled group of people who needed the program and didn't get it. So, we compared hospitalizations for patients who were enrolled in the 30 days before they enrolled in the program, versus a 30 days after and then also for 60 days because as Dr. Naylor said, this is designed as an average 60-day program. And as you can see, there was a decrease in hospitalizations both over the 30-day period and the 60-day period.

We also looked at – at the numbers and again, the numbers of patients is small. Those readmission – readmission rates by quarter of the program and we were very happy to see that in the first couple of quarters the nurses were getting used to this. They were getting up to speed. They were learning. As time went on, the readmission rates have dropped. Now, you say, “Well, those readmission rates are not low yet either,” and we can't say what the readmission rates would have been without this program. As Dr. Naylor pointed out, these are patients who were at really high risk of repeated readmissions to the hospital. And so, we hope that the rates will continue to drop, but they are certainly moving in the right direction. And this is just a graph showing those same readmission rates.

Just a few things for people who are thinking of doing this. It says on the slide and I really think it is as good a model as Dr. Naylor says it is. It's worth investing the time and resources necessary to identify and train the transitional care nurses. It was said earlier today how

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important it is to have a coach. In this case, to have a transitional care nurse who really understands the program, who's committed to it, who has the feel for – for working with patients. But it's worth the time finding and training those people.

Page 168 The model does work very well in a community-based setting. And an important part, point is to build in at least a simple evaluation system right from the start. Not just outcomes but is the process being followed and, you know, anybody who's been listening today or if you've worked in any health care system, just because things are supposed to be done a certain way, doesn't mean they happen. Not because people aren't trying. But so did that initial visit happen in the first 24 hours after discharge, did the patient make it to the follow-up visit to the physician for one reason or another and did that impact on the readmission rate for these patients?

I just want to mention the role of the quality improvement organization in this project and to

encourage you to work – to reach out to the quality improvement organizations in your state if you're are thinking of doing any of these projects that have been talked about today. When we, as I said, made the home health agency aware of the transitional care model, there were some people around who were - at least somewhat aware of it. But we brought it to them as this is something that you could do and we could work with you to do in your agency.

The facilitating role, bringing the agency together with Dr. Naylor and her team, assisting with implementation, one of our quality improvement nurses has been a member ongoing of the steering team that oversees the program for the agency. Providing funding support as I said, they didn't want us to pay for nurses, but we were able to provide support for providing the training for the – for the nurses. And analytic support in terms of looking at outcomes, this is a sophisticated health system, a sophisticated home health agency, but didn't necessarily have access to – well, certainly not to the claims data

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outside of the system that the QIO could bring to this and I think we were agreeable to helping them also. Thank you very much.