

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

Mary Naylor: Well, I can't tell you how thrilled I am to be here. For those of us that have been working in this field for a long time since we were 10, this is quite a day. This is an extraordinary day. So when I received the invitation and I was – I had a little bit of a conflict this morning. I said there's just no way I'm going to miss this opportunity to be a part of a beginning of a movement around care transitions for beneficiaries, doing what Don Berwick talks about and that is figuring out how it is that we will deliver better care, better health and reduced cost at the same time. And so I've had the great fortune for the last 20 years to be part of a team, based at the University of Pennsylvania, that's been focused on this issue and to see 3026 of the Affordable Care Act and all of the provisions that are really in that Act that provide a road map to achieving what our Medicare beneficiaries and all that we serve deserve is really extraordinary. So I can't tell you how excited I am to be here. I'm going to talk with you about the transitional care model and I know you've been here all day. And I can actually ask you what transitional care is, but because we all have a bit of nuances on these definitions, I wanted to make sure that you understood how it is that our team has been thinking about this work. And by the way, we didn't start out this way. It has evolved over time. We've been thinking about transitional care and transitional care environments as those opportunities to target high-risk populations who really need more than we're currently providing, to assist them

as they navigate an increasingly fragmented health care system, to really promote positive outcomes, assure continuity of care and prevent all of the things that we now know are preventable and you've heard a great deal about them over time.

We view transitional care as complementary to really excellent, advanced primary care. And so it's not one or the other, but rather a part of a system that really assists high-risk Medicare beneficiaries achieve their goals.

I had the great fortune a couple of years ago to work on a national quality forum group that began to think about how is that we can reframe the way we think about health care delivery and began to think about communities and populations at risk and how it is among those at risk people targeting those that are navigating increasingly our care system.

And so we talked about people moving from acute care through sub acute to the primary care network. But we recognized immediately that not everyone navigating that is the same, that there are individuals who have an acute heart attack who are going to be fine if we give them the right information, the right support like good handoffs in terms of transfer of information, et cetera.

But increasingly, we are serving a population of people who have multiple complex chronic conditions often complicated by all of the social and other issues you've heard about today—cognitive impairment, lack of willing and able social networks to be available to support them during really vulnerable times, depression as

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coexisting conditions. And we also have a growing population of people who are using the acute care system who are really need to be in better palliative or end-of-life services.

And so we began working 1990 on the quality cost transitional care model. And right from the outset said we want to be able to demonstrate higher value, improve care and at the same time figure out how we can increase efficiency of the value of the investment that we're making. And we knew right from the beginning, that meant targeting people at highest risks for poor outcomes, the top 20 to 25 percent of the Medicare beneficiaries consuming the 75 to 80 percent of our expenditures.

We also knew long before it was named or framed that the only way to get from where we were to where we could be was by engaging the people, by engaging patients, by engaging the family caregivers, by engaging the community resources that are essential to long term success.

We began to understand pretty quickly that not everybody is on a great care management plan so that we couldn't start by saying we're going to move towards self-management, but rather had to figure out how to work with all the providers and all the players and again, especially directed by what people's goals were, what family caregivers' goals were on coming up with a streamlined, rational plan of care. We know from science that many of the people we serve are on way too many medications, often not the right plans of therapy, et cetera.

Once we get a great plan of care in place and everybody onboard with it, then we can begin to promote the kind of self-management, the early identification that someone's running into trouble, the prevention of the risk factors that contribute to poor outcomes. The rest of the model is guided by everything that we learned in nursing, in social work, in pharmacy and every other health discipline. It's going to take a village. It's about teamwork. People care a great deal about continuity, about coordinated care that's not just connecting the dots, but integrating care in a way that creates efficiencies and it is all built on a foundation of trust.

The unique features of this care model as it evolved is that that care is both delivered and coordinated by masters prepared nurses. The same nurse who begins to work with the patients at hospital admission continues to work with the patient throughout the hospitalization. If the patient is discharged for a period of time into a skilled nursing facility or rehab facility, they're there within 24 hours helping to make sure that everybody is onboard in terms of the plan of care and they follow the patients into the home substituting for traditional visiting nurse services. So there are not many players going into the home, there's this provider.

Seven day per week availability and you've heard about the importance of that, all guided by evidence – that which we know happens in the hospital to create the risk for poor outcomes or happens within 24 hours after discharge.

We know, for example, from following people 7 to 10 days, post

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discharge, they are at a low ebb functionally, physically, emotionally. It becomes a really important outreach time. So this evidence-based protocol guides the work of the team. And our focus is on long term outcomes.

What is it that we're going to be able to do today to interrupt a chronic illness trajectory, to interrupt the multiple hospitalizations that are resulting in people becoming increasingly deconditioned, increasingly vulnerable to risk going forward?

So this is something you can't see, but let me just stop there. Mr. Smith is admitted during a given hospitalization and immediately offered this service. An advance practitioner, if Mr. Smith agrees, comes in and does an assessment of what the priority issues are, that if unabated, if not interrupted will result in poor outcomes for Mr. Smith.

The nurse will begin to work with all the players involved—pharmacists, social work, whatever the priority issues are, will engage the team members in helping to solve the problem, does outreach not just to the physician who's admitting, but all the physicians including the primary care practitioners because they know a great deal about what's going on and essentially uses the hospital time to really get somebody who has been not well, manage better position for better outcomes after discharge to prevent some of the seeds of readmission that sometimes happen during hospital admissions.

Is in the home within 24 hours, goes to the first visit with the patient

and family to the primary care provider not just to position the patient and family to how to maximize on a 20 or 25-minute time, but also to establish the collaborative relationship with the primary care practitioners so that two weeks later, three weeks later the nurse is in the home and the patient is running into trouble, they can collaborate with each other. There's a trust established and there is a better opportunity to avoid unnecessary acute utilization.

And the nurse will continue to work with the patients and family caregivers until they are no longer at risk for poor outcomes. In our work, that's been shown to be an average of about two months, but ranges from one to three months.

So what are the core components? This is a holistic approach. It recognizes that there are many person and family and system factors that contribute to poor outcomes and we need to be thinking about how it is that we're going to focus on the individualized needs but within the context of knowledge that it's going to take more than just looking at medical management.

It is a family-centered approach because we recognize the central and critical role that families play in assuring. And families, in this case, broadly defined—it could be a neighbor, blood relative, et cetera, whoever is going to and willing to get involved in the care in order to contribute to positive outcomes.

I should also mention, it's a community-based approach because these nurses are capitalizing on community resources to assure positive outcomes. It's nurse-led, but it's team-based. It capitalizes

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on the skills and expertise of every team member. It is protocol-guided. A principle is streamlining the plan of care for many people whose regimens are way too complex, a single point person throughout the acute episode with information systems and a focus on increasing value in the long term.

So across multiple clinical trials, NIH funded, we've demonstrated consistently the capacity of this approach to care to delay first time readmission or time to first readmission, to improve health, physical function and quality of life, to increase the satisfaction with the care experience, to decrease total all cause readmissions and in doing so, decrease total all cost. And we look at all costs except out of pocket and cost for medications.

So this gives you a sense of what the first three randomized clinical trials demonstrated in terms of reductions. We started where many people do. Could we have an impact on discharge planning and immediate post discharge follow-up? And we showed we could, but it was short term. We then said, "Could we affect change by adding a home care component, targeting high-risk individuals?" And we showed that we could reduce readmissions through six months by more than 50 percent.

But we then had the opportunity to look and say, "Did we do it well for all of the diagnostic groups?" And we found that we did not do as well with patients with heart failure who are in many ways emblematic of the complexity of challenges people face today, multiple chronic conditions, multiple other risks and on a downward

trajectory path. And that became a focal point of our latest reported clinical trial where we showed reductions in all cause readmissions, all cause readmissions through 12 months.

This shows you the impact demonstrated in terms of savings in these clinical trials with the latest reported trial demonstrating a mean savings per Medicare beneficiary after accounting for the cost of the intervention of \$5,000. And again, this is all costs. We've looked at home health, skilled nursing, acute care visits to physicians, emergency.

So you would think with these publications in the right places, right journals, great reviews that you all would be saying, "Let's do this." And we learned that it takes more than just publishing papers in order to accomplish meaningful change. We had to begin the work of working in partnership and collaboration first with the managed care organization, then with health systems, all funded very generously by a number of foundations listed here and some represented in this audience to help say what's it going to take to move evidence into the real world of clinical practice.

We were very fortunate to have a fabulous project officer also sitting here who said, "Have around your table, everyone, representatives from all of the groups that you ultimately want to influence, the people who measure care, the people who pay for care, other insurers, the people who deliver care, et cetera." And so we were very fortunate to have an outstanding advisory group including an individual represented at the table.

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I'm going to tell you briefly about our work with Aetna since that's a completed project. We were testing the transitional care model in a defined market. We had an independent consultant say, "What are the facilitators and barriers to having something like this happen in real life?" We provided the basis for ongoing advisory committee input. Our commitment was to present our findings to Aetna decision makers and obviously, to widely disseminate them.

In the process, we learned a great deal. It's very different to run a clinical trial than it is to make things happen in the real world. We had to build tools of translation. And so we had to take what we knew and create patient screening and recruitment tools. We had to position nurses who are not traditionally prepared to deliver this kind of approach with web-based modules. We had to build a documentation and quality monitoring system. We had to figure out what is the quality improvement system that will be needed in organizations using root cause analysis which was the way that we've done all our work in the clinical trials; how could we make that happen on an ongoing basis and obviously we had to rigorously evaluate all of this.

So the findings with Aetna, despite the fact that we ran into very significant adaptations of the transitional care model, including, at that time, a legal ruling that we couldn't implement the hospital component which has since been changed. We demonstrated improvements in all of the quality measures.

And at this point, the quality measures are not Penn's team's quality

measures, they're what Aetna and Penn together determined were really important quality measures—symptoms status, functional status, quality of life, et cetera. We demonstrated improvements in patient and physician satisfaction, reductions in rehospitalizations through three months and cost savings that extended through a year. So a very important question emerges along the way. Up to this point in time, all of our work has been with high-risk, cognitively intact older adults. And we received a call from the Alzheimer's Association saying, "You have chosen an easy population." We're like, "Are you kidding? Are you kidding? This is extraordinarily high-risk." They said, "No. You need to really focus on people who are coming into our emergency rooms and hospitals who have cognitive impairment as a coexisting problem."

And I cannot tell you what the first grant for which we did not have to write a proposal yielded. But it yielded a passion in us to deliver on the promise of having a large scale study. And we're very fortunate last week to report at GSA some of the findings from the study for the first time.

We're very excited that we were able to demonstrate. And in this case, we were not comparing the transitional care model to standard care. By now, we have convinced all the reviewers that standard care is not what we need.

Now, we had to compare it against a low dose intervention where we simply told everybody involved in the team that people had cognitive impairment and we told them exactly the nature and what we found.

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A second intervention, we prepared nurses via web-based modules to better both assess and manage patients with cognitive impairment. And in the third, we tested the transitional care model which enabled us to follow these patients throughout an acute episode.

So the preliminary findings, and these are final in terms of these findings, we demonstrated as the result of this that the transitional care model compared to these other lower intensity interventions, increased time to first readmission or death, decreased all cause rehospitalizations through six months and decreased the total number of hospital days through six months.

Our next biggest venture is to really tackle what some of you have already been talking about, which is how do we connect the acute care sector more efficiently and effectively with the long term care sector.

And when we went to approach this in our traditional way, we realized that we did not have a very good understanding of what it is that we were working toward. There are very few data out there to help us to understand what is a good outcome for the long term care population. We have lots of studies that tell us what points in time might be, but not a sense of what the care experience is like for this population, their care trajectories, and how it is that their care difference varies over time.

So we have enrolled about 500 English and Spanish speaking individuals and we are literally tracking the transitions from the point

they enter long term care until they die. And part of this experience is to really help to get us to understand from their voice, the voice of the older adults, what are the changes in health and quality of life that they're experiencing; how does that vary over time; how does that vary based on whether or not they start receiving long term care services in their home, assisted living facilities in nursing homes and so on.

But we're also able to track the impact of vulnerable transitions on their health and quality of life. And so this will be very important to us as we begin to approach application of the model with this group.

So in summary, the transitional care model focuses on the needs of high-risk, cognitively intact and cognitively impaired beneficiaries across multiple settings, designed specifically to increase value over the long haul. It has been successfully translated into practice. And it was recently recognized by the Center for Evidence-based Policy as an innovation that meets the top tiered evidence standard.

This is a nonpartisan group, funded by the MacArthur, McConnell Foundations. And that is a group that basically says innovations, if scaled, could have a major impact on society. So such recognition is really extraordinarily humbling and we feel very privileged to be among this group.

But mainly, what drives us, what keeps us excited every day are stories like the one that was published in the Washington Post about a Mr. Lynn who for the few years before we were involved in his life, was homebound. And that means, only time that he got out of his

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home was when he was taken by the emergency – by the ambulance to the emergency room for yet another hospitalization, and his wife of 50 years who was watching her beloved husband go through this experience.

And the picture in the Washington Post was a picture of Mr. Lynn in his garage where he had this fabulous wood working shop. And his goal was to get back into the garage and do the things that gave him quality of life, meaning in life, et cetera. His wife's goal was to get Mr. Lynn out of the house.

We met both of those goals and it was – it is that opportunity to deliver better care, to achieve better health and to do it more efficiently and achieve the cost savings that will become – that are important today and will become increasingly important on January 1st when the first baby bloomer hits 65 and so on.

So we are really privileged to be a part of this movement and to try to help communities that are interested in joining it, to know what works, what doesn't work, to begin with that which we know and begin to adapt according to your own needs.

So thank you for this extraordinary opportunity.