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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Care Transitions:
Evidence-based best practices for Case Managers

Mary D. Naylor, PhD, FAAN, RN
Marian S. Ware Professor in Gerontology
Director, NewCourtland Center for Transitions & Health
University of Pennsylvania School of Nursing

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Agenda

- Welcome and Introductions
- Learning Objectives
- **Patrice Sminkey**, CEO, the Commission
- **Mary D. Naylor, PhD, FAAN, RN,** Marian S. Ware Professor in Gerontology; Director, NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing
- Question and Answer Session

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Audience Notes

- There is no call-in number for today's events. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the links section to the left of your screen. Refresh your screen if slides don't appear to be advancing.
- Please use the "chat" feature on the lower left-hand part of your screen to ask questions throughout the presentations. Questions will be addressed as time permits after both speakers have presented.
- A recording of today's session will be posted within one week to the Commission's website, http://www.ccmcertification.org
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

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Learning Objectives Overview

After the webinar, participants will be able to:

- Identify individual/family and system factors associated with poor post-discharge outcomes among hospitalized older adults.
- Illustrate the context for transitional care in everyday practice across health care settings.
- Identify key findings from testing of the Transitional Care Model and describe the core components of the model.
- Describe the impact of the evidence supporting the Transitional Care Model on clinical practice and health care policy recommendation.

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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- **Webinars**
- **Certification Workshops**
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IssueBrief

VOLUME 5, ISSUE 3

Measuring Care Coordination:
Validated tools for an evolving environment

No one questions that care coordination is essential to safe, efficient and effective patient-centered care. What professional case managers have known and practiced for decades is now widely viewed as an essential function of case management.

Care coordination is explicitly identified in the Commission's description of case management: "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs."[1] The emergence of models such as the patient-centered medical home, the patient-centered medical neighborhood and accountable care organizations highlight the value of care coordination as an essential element for success.

Now comes the challenge of quantifying and evaluating care coordination. We've all heard the truism "you can't improve what you can't measure." But first, you have to agree on *what* to measure. For all the attention paid to care coordination and the consensus that it's essential

[1] CCMC, Definition and Philosophy of Case Management

For all the attention paid to care coordination and the consensus that it's essential to improving quality and lowering costs, the health care community has struggled with just how and what to measure.

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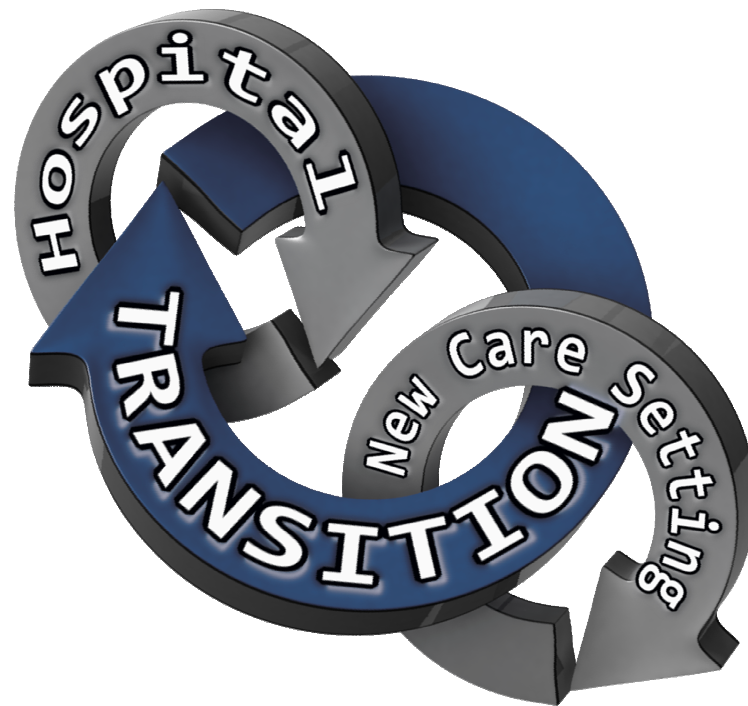
Bridging the gap in care transitions



:

2,610 hospitals assessed penalties Oct. 2014 to Sept. 2015

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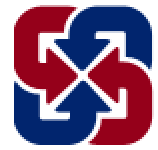


TRANSITIONAL CARE MODEL

Care Transitions: Evidence-based best practices for Case Managers

Mary D. Naylor, Ph.D., RN
Marian S. Ware Professor in Gerontology
Director, NewCourtland Center for Transitions and Health
University of Pennsylvania School of Nursing

Webinar

December 2, 2014

Transitional Care

Range of time limited services and environments that are 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 health care team members and across settings such as hospitals to homes.

(Adapted from, *J Am Geriatr Soc*, 2003, 51(4): 556-557.)

The Case for Transitional Care

- High rates of medical errors
- Serious unmet needs
- Poor care experiences
- High rates of preventable rehospitalizations
- Tremendous human and cost burden

Published Evidence

- 21 RCTs of diverse “hospital to home” innovations targeting primarily chronically ill adults
- 9/21, + impact on at least one measure of rehospitalization plus other health outcomes
- Effective interventions
  - Multidimensional and span settings
  - Use inter-professional teams with primarily nurses, as “hubs”

(Naylor, et al., 2011. THE CARE SPAN--The Importance of Transitional Care in Achieving Health Reform. *Health Affairs*, *30(4)*:746-754.)

Different Goals of Evidence-Based Interventions

- Address gaps in care and promote effective “hand-offs”
- Address “root causes” of poor outcomes with focus on longer-term value

Transitional Care Model

Unique Features (Hospital to Home)

Care is delivered and coordinated…

…by same advanced practice nurse (APN) supported by team

…in hospitals, SNFs, and homes

…seven days per week

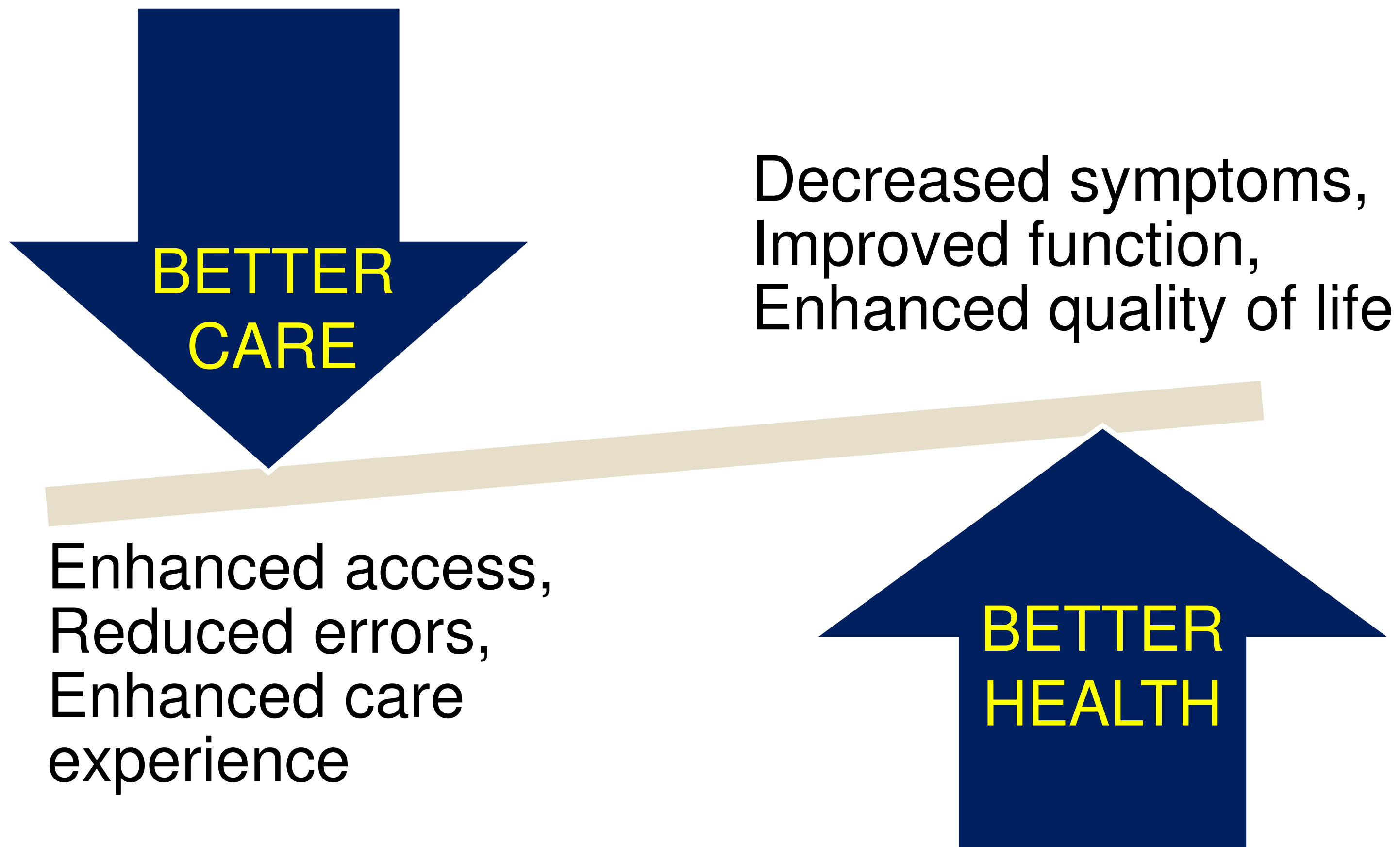
…using evidence-based protocol

…supported by decision support tools

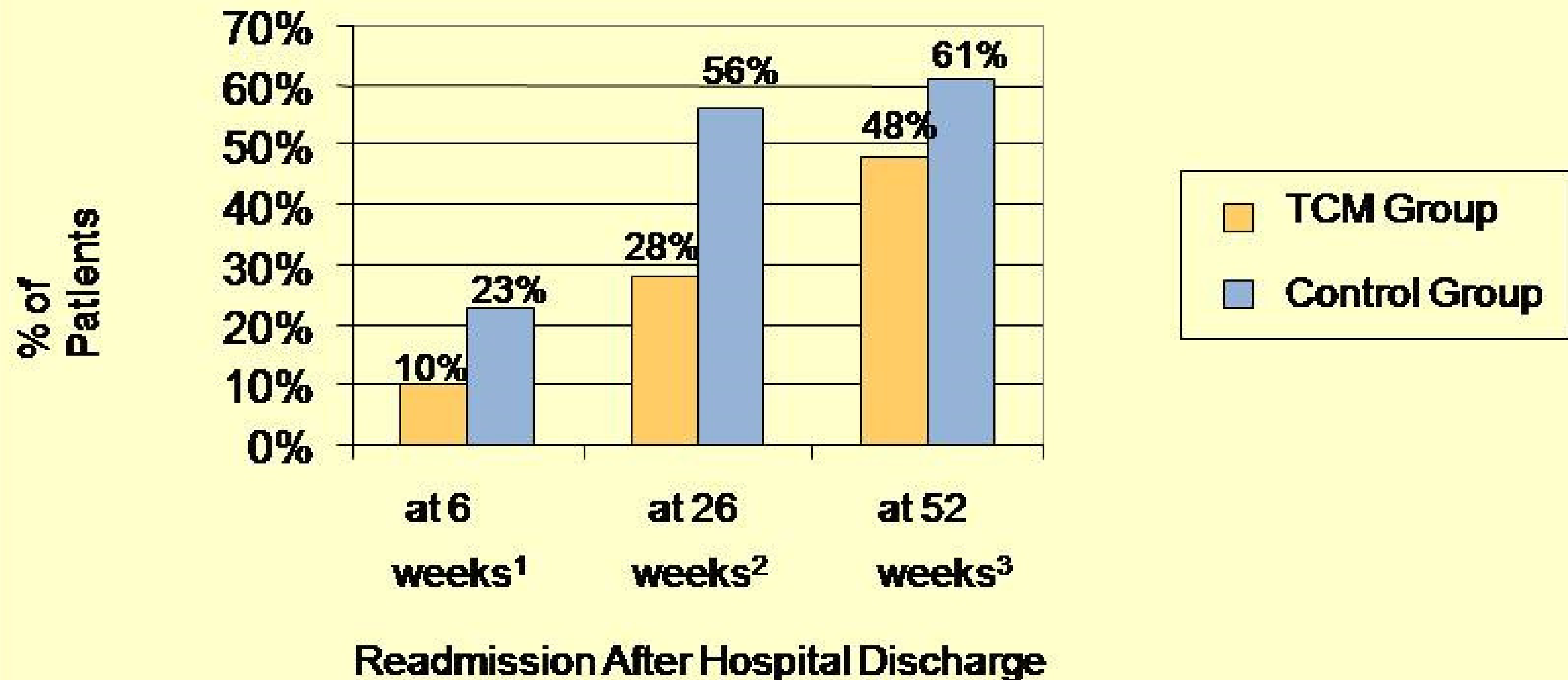
Core Components

- Holistic, person/family centered approach
- Nurse-coordinated, team model
- Protocol guided, streamlined care
- Single "point person" across episode of care
- Information/decision support systems that span settings
- Focus on increasing value over long term

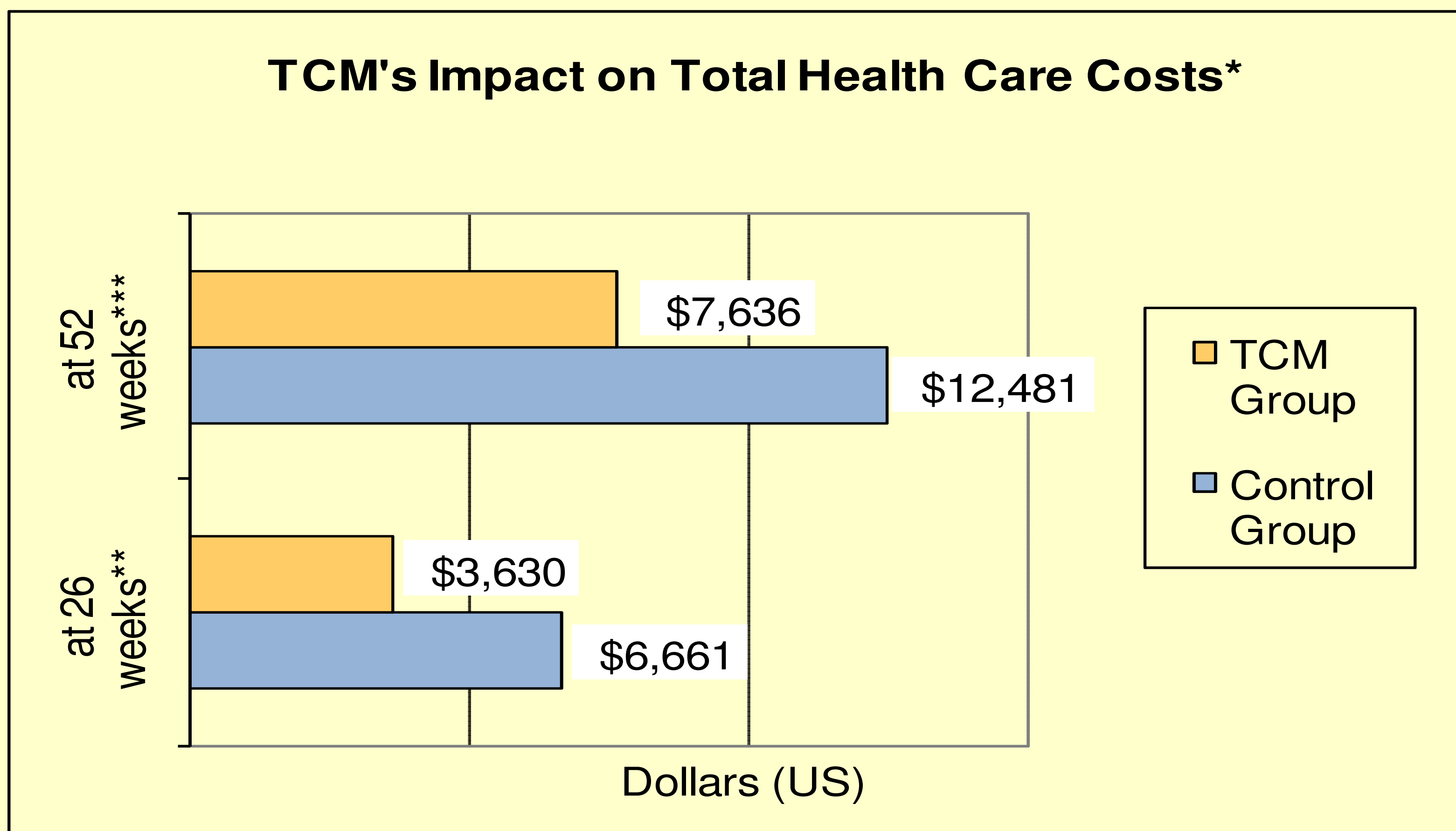
Hospital to Home Findings*



(* Based on 3 NIH funded RCTs: *Ann Intern Med*, 1994,120:999-1006; *JAMA,* 1999, 281:613-620; *J Am Geriatr Soc*, 2004, 52:675-684)



(Based on 3 NIH funded RCTs: [1]*Ann Intern Med*, 1994,120:999-1006; [2]*JAMA,* 1999, 281:613-620; [3]*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.

*** 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.

Translating Evidence Into Practice

Penn research team formed partnerships with Aetna Corporation and large health systems to test “real world” applications of research-based model of care among high 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)

Tools of Translation

- Patient screening and recruitment
- Preparation of TCM nurses, teams and sites (e.g., online seminars, on-site consultations)
- Documentation and quality monitoring (clinical information system)
- Quality improvement (case conferences grounded in root cause analysis)
- Evaluation

Foundations of Transitional Care Seminar

Unit 1	• An Introduction to the Transitional Care Model
Unit 2	• Fundamentals and Implementation
Unit 3	• Core Principles
Unit 4	• Achieving Quality and Promoting Success

Foundations of Transitional Care Seminar

- Orient nurses and other health team members
- Identify evidence-based tools and strategies
- Understand the core components of the TCM
- Develop operational plan to guide implementation
- Establish benchmarks for quality control
- Articulate value of TCM to organization

Foundations of Transitional Care Seminar

- Ongoing access and support from experienced, clinical transitional care experts
- Community Learning Network
- Online registration process
  https://upenn.irisregistration.com/Site/transitionalcare2014

Findings (Aetna)

- Improvements in all quality measures
- Increased patient and physician satisfaction
- Reductions in rehospitalizations through 3 months
- Cost savings through one year
- All significant at $p<0.05$

(Naylor et al., 2011. *Journal of Evaluation in Clinical Practice.* doi: 10.1111/j.1365-2753.2011.01659.x.)

Funding:

Marian S. Ware Alzheimer Program,

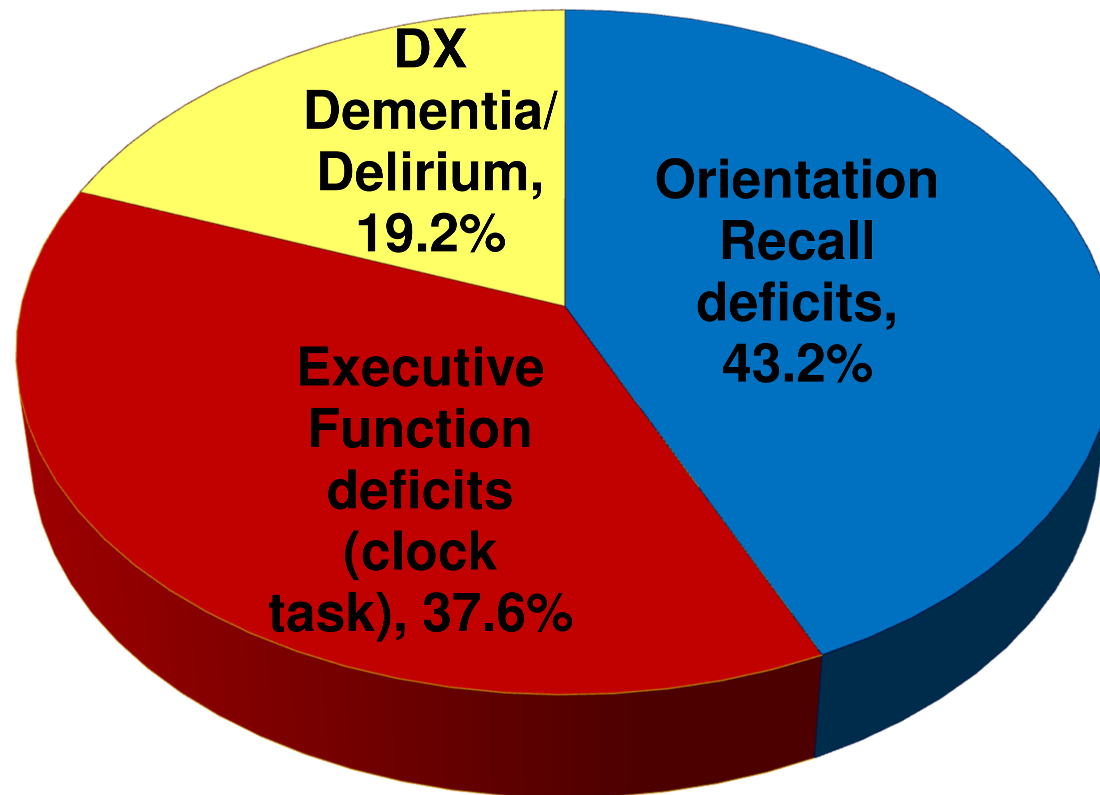
and

National Institute on Aging, R01AG023116, (2005-2011)

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

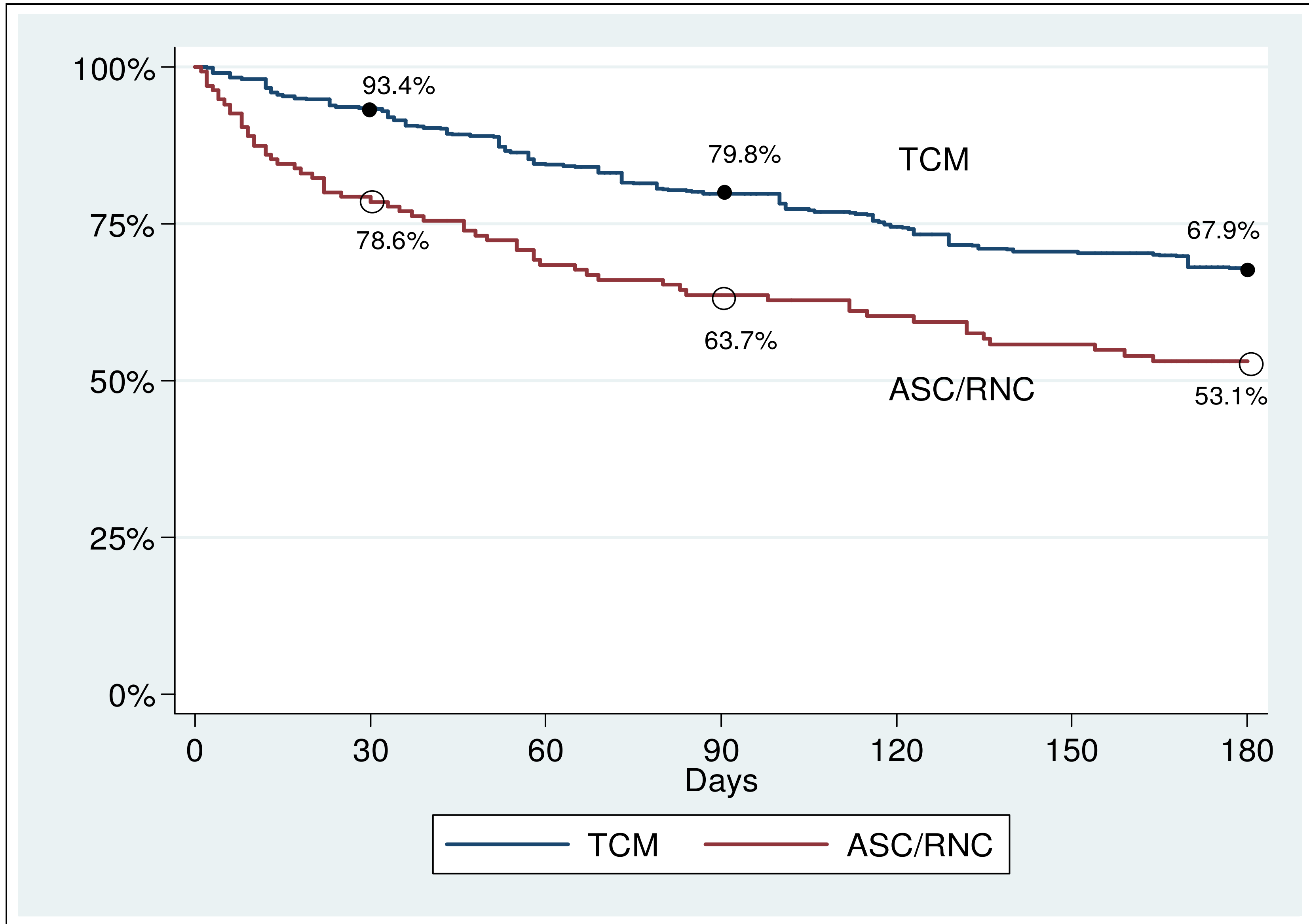
(Naylor et al., 2014, *J Comp Eff Res*, 3:245-257; McCauley et al., 2014. *Am J Nurs*, 114(10):44-52.)

Cognitive Deficits at Baseline



24.9% also had delirium (+ Confusion Assessment Method)

Time to First Readmission



Implementation of TCM Service Line within Health Systems (e.g., UPHS)

- Placed within health system's home care and hospice division
- Reimbursed by local payers (IBC and Aetna) using case rate with defined performance expectations
- Implemented using a learning health system framework

Funding:

Gordon and Betty Moore Foundation, Rita and Alex Hillman Foundation and the Jonas Center for Nursing Excellence

(2011-2014)

Does the TCM add Value to the Patient Centered Medical Home?

(Naylor et al., 2013. *J Comparative Effectiveness Research,* 2(5):457-468.)

Study Aims

- In collaboration with Patient Centered Medical Homes and guided by an Advisory Committee, the Penn team is:
  - Comparing outcomes of PCMH+TCM, a new care delivery approach, to those achieved by the PCMH only
  - Using lessons learned and findings to advance larger scale effort

Funding:
Robert Wood Johnson Foundation (2014-2016)

Local Adaptations of the Transitional Care Model

Study Aims

- Describe how sites in health systems and communities across the U.S. are implementing the TCM

- Examine the effects of adaptations to the TCM

Funding:

Patient-Centered Outcomes Research Institute

(2015-2017)

Project ACHIEVE

Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence

Study Aims

- Identify which transitional care services and outcomes matter most to patients and caregivers,
- Compare how evidence-based transitional care services are meeting these needs
- Develop recommendations to spread highly effective, patient-centered care transition programs.

The TCM…

- Focuses on transitions of high-risk cognitively intact and impaired older adults across all settings
- Has been “successfully” translated into practice
- Has been recognized by the Coalition for Evidence-Based Policy as an innovation meeting “top-tier” evidence standards

Key Lessons

- Solving complex problems will require 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 the people they support
- *Carpe Diem*!

Getting Patients Back on Their Feet Faster

Study Says Care Before and After Discharge From the Hospital Saves Money, Spurs Recovery

By JUDY LICHT
Special to The Washington Post

Clifford Lynd Sr. is breathing easier these days. In the heat of the summer, he's feeling strong enough to paint a booster chair he built for his great-granddaughter. "I can always find something to do," said Lynd, a 79-year-old retired meat cutter who lives in Philadelphia. "I have lawn chairs that need new webbing, and I'm refinishing an end table for my grandson."

Lynd would have had trouble tackling these projects a year ago. In July 1998, he was hospitalized with congestive heart failure. He was readmitted in September. "The last time I went in, I had been to church on Sunday morning. I stopped by to see my youngest daughter, who is our family doctor's office manager. When she saw that I could hardly breathe—my lungs were filled up with so much fluid I was panting—she took me right to the hospital."

Congestive heart failure is a chronic debilitating disease. Typically, patients like Lynd are in and out of the hospital. They suffer fatigue, shortness of breath, fluid buildup in their lungs, sleeplessness. The heart muscle is weakened, unable to do its job pumping blood to the lungs and through the rest of the body.

Without proper care, Lynd's condition would have deteriorated. But he was able to take advantage of a research project at the University of Pennsylvania School of Nurs-

BY BARBARA JOHNSTON FOR THE WASHINGTON POST

Clifford Lynd Sr. says the home care he received after hospital treatment for congestive heart failure enabled him to resume tackling projects in his garage workshop.

that patients who received intensive at-home follow-up did significantly better. Compared to a control group that received standard discharge care, the patients receiving intervention by trained professionals had fewer readmissions to the hospital, saving Medicare an average of $3,000 per patient during the six months after their original admission.

The study depended on "advanced practice" nurses with training in geriatrics to assess the patients' physical, emotional and social condition in the hospital and determine what support services would be needed at home.

Collaborating with physicians, family members and other health professionals, the nurses designed individual discharge plans for every patient. They taught patients and the people who would be involved in their care at home about prescribed medications and dietary requirements. They recommended levels of exercise and activity and made follow-up medical appointments. They pointed out potential symptoms and early warning signs of complications that might occur.

Home visits were an integral part of the program. The program's nurses were also available by telephone. All in all, they acted as the go-between for patients and the rest of the medical community. They talked to the patients' doctors when questions or problems arose. They helped patients enroll in supplemental insurance plans and arranged for additional in-home care services. They al-

Question and Answer Session

- Mary D. Naylor, PhD, FAAN, RN
- Marian S. Ware Professor in Gerontology
- Director, NewCourtland Center for Transitions & Health
- University of Pennsylvania School of Nursing

Commission for Case Manager Certification

1120 Route 73, Suite 200, Mount Laurel, NJ 08054

1-856-380-6836 • Email: ccmchq@ccmcertification.org

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Thank you!

- Please fill out the survey after today's session
- Those who signed up for Continuing Education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at www.ccmcertification.org

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