

**Event ID: 701168**  
**Managing Transitions**

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Disability-Competent Care webinar. At this time, all participants are in a listen-only mode. If you need assistance during the call or if you have a question, press star, then 0. You will hear an acknowledgement tone. If you're using a speakerphone please pick up the handset before pressing the numbers. Once again, if you need assistance or have a question, press star, then 0.

At this time I'd like to turn the conference over to our host, Mr. Chris Duff. Please go ahead.

Chris Duff: Thank you, Retta. On behalf of The Lewin Group, the Institute for Healthcare Improvement and the Disability Practice Institute, I would like to thank you all for attending the webinar on managing transitions, which is part of our series on disability-competent care. As Retta stated, my name is Chris Duff, and I'm the Executive Director of the Disability Practice Institute.

First I'd like to orient you to this webinar platform. If at any time your slides are not advancing, please push F5 on your computer and that should get the slides moving again. There are two icons circled at the bottom of the screen. The one on the right allows you to print out a PDF of the slides. The other circled icon on the left that's red is for questions. So if at any time during the presentation you have a question, please push the icon and type in your question. If it is about the technology, someone behind the scenes will respond to your question in real time. If it is a question for the presenters, we will be compiling them throughout the webinar and will return to them during the Q&A.

This is the sixth in a series of nine webinars being presented throughout the fall. The previous five focused on understanding the perspective of persons with disabilities as they experience the healthcare delivery system and understanding the model of disability-competent care and two of its key components, person-centered care coordination provided by an interdisciplinary team and responsive primary care. Today we are focusing on managing transitions, and next week we will focus on coordinating flexible long-term services and supports. The series will conclude in early December with presentations on building a disability-competent provider network and participant and provider readiness.

Each presentation will reserve 15 minutes for Q&A at the end. All webinars are recorded and will be available, along with a PDF of the slides, at the link on the bottom of each of these slides, [www.resourcesforintegratedcare.com](http://www.resourcesforintegratedcare.com). We hope you can join as many of these as possible and will forward the information to colleagues you think may be interested in the topics. We will also keep you informed on future webinars and products being produced through this initiative.

I would like to step back just a moment to give you the genesis of this series and several other tools for integrating healthcare services for the dual-eligible population. The Lewin Group, along with the Institute for Healthcare Improvement in Cambridge, has a contract with the Medicaid and Medicare Coordination Office, the Centers for Medicare and Medicaid Services, to provide tools and technical assistance to providers that are seeking to integrate care for dual individuals.

As you are probably aware, CMS has been introducing several initiatives over the past couple of years to provide financial incentives for integrating care and to improve and streamline care for the population. Our contract is to provide technical assistance to support these providers. Lewin and IHI have in turn partnered with Disability Practice Institute to provide expertise in serving dual-eligibles with disabilities, the majority of whom are under age 65.

This takes us to the disability-competent care webinar series and the presentation today. We would like this series to address your needs and questions regarding the delivery of disability-competent care, addressing where you and your organization are on the road to this integration and care improvements. So please submit questions in writing and we will additionally open up the phone lines at the end of the presentation for live questions.

We are also asking everyone to please fill out a short survey at the end of this webinar where we will be asking you for feedback to make sure this series and our other efforts are meeting the mark in terms of what you need. Please also send us your ideas for future webinar topics and content either at the end of the survey or to any of those listed at the addresses on the last slide.

Now I'm going to turn this over to Lynne Morishita, who will introduce the presenters and review the webinar outline. Ms. Morishita has presented in the last few webinars and brings 35 years of experience with primary care and care coordination with medically complex populations. She, along with June Isaacson Kailes and myself, coauthored the Disability-Competent Care Assessment Tool that we have referenced throughout these webinars. Lynne?

Lynne Morishita: Yes, thank you, Chris. I'm going to introduce the speakers today and then give you a brief outline of what to expect during this webinar.

Dr. Naylor is nationally and internationally known for her work in transitional care, so we are very pleased to have her with us today. She is Professor of Gerontology and Director of the Center for Transitions & Health at the University of Pennsylvania School of Nursing. For more than two decades Dr. Naylor has led an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations and reduce healthcare costs for vulnerable community-based elders.

Dr. Naylor is also an active member of the Institute of Medicine, RAND Health Board, the National Quality Forum Board of Directors and the MedPAC. She was appointed to the MedPAC in 2010. Today she will share with us the Penn team's work in developing the transitional care model and its impact toward reducing unnecessary acute care.

Elizabeth Chapman Shaid is an Advanced Practice Nurse with the NewCourtland Center for Transitions & Health at Penn School of Nursing. Her work at Penn focuses on the implementation of the transitional care model in the patient-centered medical home. She has been an advanced practice nurse for over 25 years so brings much experience to the project.

Dr. Deborah Streletz earned her medical degree from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. She completed her internship at Tripler Army Medical

Center in Honolulu, Hawaii, and her family medicine residency with Scott & White Memorial Hospital in Temple, Texas. She is a diplomate of the American Board of Family Medicine and works at the Bryn Mawr Family Practice residency program as teaching faculty, with an emphasis on transitional care and geriatrics.

First, Dr. Naylor will present the transitional care model, then the research which has been done mostly on a range of geriatric populations, beginning with older adults with congestive failure and then on to frail older adults. The younger disabled adult population has different expectations which need to be taken into consideration.

Unlike some of our other topics, most of the research has been done in transitional care with older adults over the past 20 years, whereas the research with disabled adults is more limited. Therefore, the presenters are going to present the research done with older adults. Then they will discuss their experience with younger disabled adults at the Inglis Program in Philadelphia. They will also discuss real-world applications of the model at Kaiser and Aetna.

Following Dr. Naylor's presentation, Elizabeth Shaid and Dr. Deborah Streletz will apply the transitional care model in a case study. Then we will follow with a Q&A session.

So now I will hand the program over to Dr. Naylor.

Mary Naylor: Thanks so much, Lynne and Chris. I want to let everyone know how thrilled we are to have this chance to talk with you and hopefully engage you in a conversation about the work that we've been doing for many, many years focused on a high-risk, older adult, chronically ill population whose care is often complicated by some of the same challenges, although unique to this population, that younger adults with disabilities confront. And so we believe there's some application here, but a lot to learn.

I'm going to start by giving you a sense of how we define transitional care, but let me right at the beginning acknowledge that I'm here today to talk on behalf of a terrific team, teams of scholars and health services researchers from nursing, medicine, social policy and practice, healthcare economics. We've enjoyed a journey that has engaged thousands of consumers, family caregivers, clinical partners such as Deb Streletz, amazing advanced practice nurses such as Liz Shaid, have been really amazingly supported by a whole host of funders, clinical partners and sites most recently that are helping us to figure out how to implement what we're learning in the real world. And so we're happy to share a lot of what we've learned in a very short period of time.

So we think about transitional care as this idea that says we can better connect people as they experience changes in health and as they go through the journey of navigating those changes, sometimes confronting our healthcare system, different parts of the healthcare system, that are not always, and matter of fact are often not well connected, and also having to interact with community-based services that are not always connected and aligned with peoples' needs.

So we think about these services as time limited, designed to help people through very stressful times in their lives, get to better care continuity, avoid gaps in services that are avoidable, avoid

unnecessary preventable poor outcomes in health and in use of health resources. As I said, we've targeted at-risk populations as they move across multiple settings such as hospitals to home.

Next slide. What we are always trying to do in thinking about transitional care is to learn from everybody that's engaged in this work. So we had a chance a couple of years ago to look at the whole body of evidence around transitional care, including 21 randomized clinical trials. And what was interesting was to learn how many of them had demonstrated using different strategies, sometimes better preparation of individuals as they're navigating from hospital to home, sometimes better medication management, but different strategies resulted in some positive outcomes, usually reflected in reduction in one measure of rehospitalization as well as something that was important to people -- better function, better symptom status, and so on.

And what we learned is that if you look across those interventions that had some positive effect, they were not always simple. They were usually multidimensional. They usually spanned settings, started in one place and followed patients where they were going, from hospital through postacute skilled nursing facility, home.

They also relied on teams. There was a coordinator. There was someone, a point person, usually in these clinical trials nurses. But they captured and engaged the gifts of everybody that came to the table to help address Mr. Smith or Mrs. Jones' problems.

Next slide. So if you were to bundle the evidence in terms of what it is that we've learned, most of the approaches in transitional care have focused on trying to figure out how to address known gaps in services, where we don't have good information transferring from one site to another, from clinicians or from clinicians to consumers of healthcare, to their families. So they are individual interventions that have tried to say we've got to get better at these handoffs.

Our team started that way. We tried to figure out how to get better from hospital to home by addressing gaps in patient education, in information transfer. But ultimately we learned that those approaches, while they always showed some short-term benefit, never really got to solve the problem, that we would begin to see people reappearing back in the acute-care system because the interventions didn't stick. They didn't have long-term impact. And so our work has begun to figure out how do you get to the root cause of why someone's on this downward trajectory.

Next slide. So, then, let me tell you a little bit about the transitional care model and how it is that we operationalize it today.

The first thing is that we do focus on people that we know who are coming into our healthcare system who are at very high risk for poor outcomes. They might have and often have multiple health problems, oftentimes complicated by depression, maybe lack of family social support. So they represent the complexity of care needs that many individuals living longer with complex problems present.

We do focus, and in this circle we targeted this population of adults with disabilities and their full range of caregivers. As I do it in other presentations, we look at anyone, the population that

we're trying to serve, who's at high risk for poor outcomes, but focus on the whole notion of engagement. We have to figure out how people that we are trying to support are real partners in care. And this has been a very substantial challenge.

We then decided a long time ago that we couldn't go immediately to try to figure out how to get them to be able to become engaged without better figuring out how to help address the problems that they're confronting. So, for example, many older adults present with polypharmacy. They're on 20 prescribed medications. And we are wondering why is it that they're not adhering two months or three months or six months or a year after a hospital discharge. So we had to figure out how to get to help people to better manage their symptoms by getting to a more simplified plan of care. Then we can begin to work with individuals and their families to really help position them to be able to take on as much as they can in terms of their care needs.

The rest of the model is based on everything that any of us in this audience have learned in our respective disciplines first class. This is about teamwork. Continuity of care matters very much to people, to the consumers of our services. Care coordination is central. And this is not just connecting the dots. This is not just making sure people have the next appointment, but rather that we get to the simplified, integrated plan that represents the holistic care needs of individuals.

And relationships matter a great deal. We learned very painfully that many times the people that we would be encountering for the first time did not have the level of trust in us and in our work, in the care system. So often we were working first and foremost to rebuild trust in order to get to better outcomes.

Next slide. In our care model the care is delivered and coordinated by the same advanced practice nurse. Liz Shaid, who's going to talk with you, will begin to work with patient identified at high risk and follow them until they're no longer at high risk for poor outcomes. I don't mean that their risks have been eliminated, but rather we've really helped them work through how to position themselves so that they don't end up back in an emergency room or hospital.

The same nurse is working with the patients and family caregivers throughout the experience as they define it. This is not door to door. It's an effort that says we've got to figure out peoples' needs over time across settings, seven days per week, using everything that we know in terms of knowledge about how to address peoples' needs.

We know, for example, among people that are hospitalized, seven to 10 days post hospitalization they're at a low ebb functionally, physically, emotionally. So that becomes a very important time for outreach. And we've built a set of decision support tools in order to help clinicians and patients and family caregivers get to better care and outcomes.

Next slide. So the core component of our work, and I think in this way very transferrable to the work that all of you are engaged in, is that it's holistic. It is about people. It's about the context in which they operate, families broadly defined, blood relatives, neighbors, friends. It's a team model that has a quarterback, in this case an advanced practice nurse. It's guided by everything we know, but it relies very much also on the clinical judgment of clinicians working in partnerships with consumers of care to get it better.

It focuses a great deal on trying to make a very complex plan of care in a complex system much more simple for individuals. This single point person is very important over time, and, again, supported by information, decision support systems, with a goal that this is not just about preventing 30-day readmissions. This is about helping Mrs. Smith, Mr. Jones, get to, for as long as possible, a higher quality of life, better function, and avoiding unnecessary encounters with a costly healthcare system.

Next slide. So we had multiple clinical trials that consistently demonstrated we can do it better. We can, against standard care in these randomized trials, get to better health outcomes, get to better care experiences. And in the next slide we can do that in a way that helps to reduce avoidable hospitalization.

So in the next slide we show how over time we've gotten to better ability to reduce avoidable hospitalization in our early work just at six weeks. By the time we finish this stage of our work we are avoiding hospitalization for as many people as we can, significant reductions through 12 months.

Next slide. Well, what that helps us to understand is that when you do that, when you are able to get to better experiences with care and health outcomes and reduce avoidable hospitalization, you can do that in a way that reduces cost of care overall, because hospitalizations, ED visits are the most costly of, in this population, consumed resources.

Next slide. So we had these papers on these multiple clinical trials published in all the right places, received a lot of public attention. And we are just waiting for systems to adopt it. And we waited and waited and began to realize as a team that this was not going to happen in the current context of care, that there were organizational barriers, there were regulatory barriers, that we didn't have the aligned financial and quality incentives to create a real intent to do something different.

And fundamentally we did not have a culture of caring that said our systems have to be aligned with the changing needs of people. We had moved in the older generation from an acutely ill population to a chronically ill population, but the care system had not been redesigned to match their needs.

Next slide. So we entered what I describe, and I don't know how many of you may respond, but I call it the Erma Bombeck phase of our work. Instead of continuing to produce clinical trials, we said, wait a minute. We want to have some impact here. How can we partner with the real users of resources, with the people who are paying for these resources and show that they work in the real world?

And so our team entered a partnership with Aetna, a major insurer, with Kaiser Health -- Kaiser Permanente Health System, a major deliverer of health services, to think about ways in which we could make evidence work in the real world. The question fundamentally was could what we had learned in the clinical trials happen in living, breathing, organic systems. And we were very fortunate to have multiple foundations support this effort.

Next slide. We had, however, little appreciation of what it was going to take to take a model of care developed on the East Coast and have it operationalize and work on the West Coast. We had not built the tools of translation. And so we needed to step back and build them.

We had to build screening tools to say who should receive these services. We had to build orientation modules, web-based orientation modules, to prepare nurses in other systems and indeed, teams in other systems, to be able to deliver this evidence-based approach. We had to build documentation and quality monitoring systems, a performance improvement system that was standardized. And ultimately, obviously, we had to apply what we did know, which was how to rigorously evaluate now an effort to translate evidence into practice.

Next slide. So I'm going to tell you a little bit about what we learned in our efforts, specifically with Aetna. And on the next slide we'll -- you'll be able to see what were the goals here. We were first to test the transitional care model in a market that Aetna had defined. In this case it was the Mid-Atlantic market. We had to work with independent organizational consultants who helped us to understand the challenges in both startup and rollout of evidence-based approaches.

We had to present our findings, win, lose or draw, to Aetna and all the decisionmakers who were engaged in this work. And then of course you don't get funding for anything unless you agree to widely disseminate your findings.

So in the next slide I'll show you what we -- fortunately, despite many challenges, legal and regulatory and everything else, we were able to demonstrate in the Mid-Atlantic market, compared to a similar population, high risk, in another Aetna market, that we could get to better care, improvements in quality, improvements in member and physician satisfaction, reduction in all-cause rehospitalizations, and, importantly for this insurer, reduction or cost savings that extended for at least a year.

Next slide. So then we think, okay, we've got it. Now you all, everyone will pick this up. We'll go back to building the science. Up to this point in time all of our work had been with high-risk, chronically ill people who were cognitively intact. We receive a call from the Alzheimer's Association, the head of policy at the time, who said, "Really? Mary, you and your team have not tackled the really high-risk population. The high-risk population are those that are entering our healthcare system with all of the problems you describe but who also have cognitive impairment as a coexisting health problem." And so with the support of the National Institute of Aging and the Marian S. Ware Alzheimer Program, we entered a new phase in our work.

Next slide. What we did here was we said could we get to better care and outcomes in comparing the transitional care model to other evidence-based approaches to care? So now this is no longer against standard care, but other solutions that had some evidence base.

In one case we tested just sharing with everybody information about the cognitive findings of the population, and sharing it with the nurses and physicians and social workers and discharge planners, everyone that was going to be involved in care, letting them know, Mrs. Smith has a diagnosis of dementia, or Mrs. Smith has problems with orientation and recall, or has delirium,

so letting them know that very deliberately to see how it would affect their care. And that was shown in one case to work.

In another case, a situation in another system, we prepared nurses to be able to work directly with patients with cognitive impairment or to coach their team members. And then we, in a third system, we implemented the transitional care model. And here is what we learned, that we were able to reduce time to first readmission using the transitional care model compared to the other two approaches.

Next slide. But we also looked at what were we learning about the timing of our reduction. And so, while we were able to reduce all-cause readmissions through six months, we saw that the major impact of our intervention was in the first 90 days post index hospital discharge. And we are now looking at our data and the very deliberate case studies that our nurses collected to understand why did we have such a big impact early on and why did it dissipate over time.

Next slide. We also are continuing our work to think about how it is that we can appreciate and understand the effects of transitions among frail older adults. So these are individuals who've begun to receive social support services, long-term services and supports, in their homes, in assisted living facilities, or they may be in nursing homes.

This is a group, honestly, that we know very little about. Most of the work up until ours has been to try to take a snapshot of what this group needs and their experiences with our care system, with our community-based systems. But we are following a group of 500 English- and Spanish-speaking individuals for a couple of years just tracking their transitions in health, in quality of life and in their use of services so we can try to get it better.

Next slide. So this tells you a little bit about what we're learning. We're learning, for example, that as people begin to receive long-term services and supports, and, again, an older adult population, that they're coming into this new world with lots of problems. These represent the percentages of people who report that they are highly bothered by pain, by shortness of breath, by aching.

Next slide. This gives you a sense of what we're able to show over time. So here at baseline are the number of people, for example, who had severe depression at the time they began to receive long-term services and support, 11 percent. By one year we see that that group of those with severe depression has been reduced, but honestly we haven't dramatically reduced, even now that they have these services, the numbers of people who have moderate and severe depression combined.

Next slide. In the next iteration of our work we're trying to figure out how it is that we can start earlier. So in the next slide we are able to now tell you about a very important study, how we can begin to work with people in the community and pick those individuals up and try to help prevent them from entering our acute-care system.

So here is where we are, in the next slide, focusing on patients in the community who are part of patient-centered medical homes. We have for all of our projects now advisory committees of

people that we're trying to influence with our work. And we're comparing the outcomes of the patient-centered medical home when combined with the transitional care model. That is now a new delivery approach to those achieved by the patient-centered medical home alone.

And what does that mean? Patient-centered medical homes are these emerging care systems that have decision support, care coordination, a whole host of resources available to them but have had limited capacity to follow patients, especially their high-risk patients, in a way that enables us as a system to prevent risk from resulting in emergency department or hospitalization, or if that does occur, to follow these patients throughout that experience as part of the patient-centered medical home model and to bring them quickly back home.

So in the next slide what we are doing is we are collaborating with a set of patient-centered medical homes who volunteered to say we're doing something great. We want to get it better. We're focusing our entire intervention on what people define as their goals, not what the healthcare system does. And in this we could learn a great deal from your work. Our emphasis here is on prevention of acute-care resources, or if Mr. Smith is hospitalized, having Liz follow him from the home into the hospital and bringing back home, providing the continuity of care essential.

Next slide. So, in essence, what our work has been doing is saying, look it, we've got high-risk populations in our society that need a reenvisioned care system. We have tried, and I put in quotes, "successfully" translated this into practice, and we've been recognized by many, including this Coalition for Evidence-Based Policy, as a top-tiered evidence-based approach.

Next slide. We've been working diligently to try to make this happen in real world. We're working directly with Aetna to try to expand the use of the transitional care model in their Medicare market. Our own health system has adopted this evidence-based approach, and we have local insurers paying for it. We are working with many healthcare systems and communities throughout the country to move toward adoption, and in many ways we're informing implementation of provisions in the Affordable Care Act related to care transitions.

Now, how does this apply? Next slide, and, honestly, over the next couple of slides, maybe four slides, quickly kind of put them up there, but you'll be able to go back and read them.

We have been really sensitive to the challenges and issues that you are confronting in each of your respective organizations with consumers with disabilities. We know, for example, that there's common ground here, that many of these consumers have multiple unmet needs, emotional, housing, physical, social over time.

Many have support issues in terms of access to reliable services such as attendant care. Many don't have access to the community-based services such as transportation that they need to get to optimal health and quality-of-life outcomes. And then when they confront our healthcare system, when the people that you're serving confront our healthcare system, they also confront multiple clinicians, often who do not have unique knowledge about their very distinct set of challenges.

And so a few years ago we entered and embarked with Inglis House on a very small project that wanted -- and this was Inglis House leadership with Pew funding, to say could the transitional care model work for young adults with severe disabilities? We had very few in this study. It was a pre-/post-test of our approach to care advanced practice nurses based on the TCM. And even with 50 people we were able to show we can get it better. And this was remarkable, because 50 people, you need big effects to be able to show. So we were able to demonstrate improved function and a trend toward decreased hospitalizations and ED visits.

So, we've only stepped our toe in this population. Let me quickly go to your case study, Liz and Debbie, so we can then wrap this up and talk with this great audience.

Deborah Streletz: Thanks very much, Mary. I appreciate it.

I'm going to introduce our case study of Mrs. Smith. I'm Dr. Debbie Streletz, and I want to say thanks to Mary and the whole transitional care team at Penn for bringing this pragmatic, real transitional care to our office.

I just want to say we could enroll 10 patients in the transitional care study, and Mrs. Smith here was our number one choice. Her trigger event to enter the study was recurrence of UTI. She had more than three office visits in the three months prior to the onset of enrollment. And, as a background, she also presented to our office with very vague complaints -- stomach pain, headache. So that's her background.

She's a 75-year-old female, dual eligible, Medicare and Medicaid, with moderate functional impairment. She's retired from domestic work. She lives alone in Section 8 housing in a two-story home alone. She had family support in the home, but that was no longer present. She had one son and three daughters in the local community, but they were not consistently supportive and identifiable to us as a support for her. She did have social support from her church, who visited her weekly.

She already had a documented history of nonadherence to her regimen through our primary care office. Her primary care provider was aware that she was nonadherent to general recommendations but really didn't have any idea about her nonadherence to her prescribed medications.

She does have a history of depression. She has 20 chronic medical conditions. Some of these are listed. And she had 18 prescribed medications. And this is not an unusual case to present. And, as I said at the beginning, her PCP was aware that she was nonadherent to recommendations but had no idea about her nonadherence to these 18 medications.

And I'm going to turn it over to Liz to give more details about the case.

Elizabeth Shaid: Thanks, Dr. Streletz.

I worked directly with this patient, and after being oriented about her case I scheduled a home visit and went in to see her and as part of the initial visit helped to identify what her particular

individual goals were for our time together in addition to trying to identify some underlying reasons for her recurrent UTIs. But really her main goal all focused around the use of her motorized chair and wanting to be able to use that and get it in and out of her house.

So what was important to me in working with her was to also help her to understand that in order to make that goal for her come to fruition we also had to understand how all of her medical needs impacted her social needs and how it all impacted and would work toward her being able to use that motorized chair. So I identified other health concerns that I had with her and that her physicians had with her to try to streamline her care and to help her to be better managed in order to be able to reach her goal.

Next slide, please. So for this patient we -- the work that I did with her, she was in the Medicare, in the waiver program. So she had a home health aide assigned to her for four hours a day. So I engaged the home health aide to work with me and the patient, and the three of us always met together for her medical evaluation in her home as well as all of her social needs. We worked to identify how to get the motorized chair fixed and how to get that portion of her plan working.

But in addition we also looked at a lot of her medical needs, so that what I had explained to her was that if she wasn't feeling well having her motorized chair working wasn't going to be much of assistance to her if she didn't feel up to using it. So it was important for her to understand the interrelatedness of everything involved in this case.

Once I was able to gain her trust she did let me in on some of the ways that she was noncompliant, especially with regards to her medications. So we worked with her primary care provider to streamline her prescription medications and go from 18 prescribed medications to 12. We did a lot of medical education in her home regarding diabetes and bowel and bladder training programs to try to get her diabetes under better control and to also avoid urinary tract infections through a good bowel and bladder program.

In addition, she had had a lot of difficulty managing all of her medical providers and her follow visits, and that had really fallen by the wayside. So the three of us worked together to come up with a master list of all of her providers, their phone numbers, and all of her appointments. And then, finally, because she was at such high risk for falls, I did a lot of fall prevention work with her and her home health aide to reduce that risk.

And I'm going to turn this back over to Dr. Streletz at this time.

Deborah Streletz: Thank you, Liz.

And issues we all identified to consider after transition, when we had taken back our patient into the patient-centered medical home to follow, these patients were as stable as they could be, but in listening to the case, her stability was only a matter of time before one of her disease processes became exacerbated. So what we identified was really ideal would be to be able to activate a transitional advanced practice nurse or a team early in the disease exacerbation when we identified them in the office and restart with this intervention to keep the person as medically stable in the outpatient setting as possible.

The next bullet is continuing to assess the appropriate housing for patients with cognitive impairment, disability, really anything that would drive a change in their housing setting; continuing to identify if social and family support exists or does not exist and how we can help bulk that up; continuing to identify emotional challenges to chronic disease management, most importantly depression -- as we all know, it impairs the ability to manage any chronic disease, and as PCPs we need to continue to make this a priority in our office visits; and identifying -- continuing to identify and assess the patient's goals and symptoms, not just the disease process driving the interaction.

And I'll hand it back over to you, Mary. Thanks very much.

Mary Naylor: So let us end with just some key lessons about what we've learned, thank you, over these 20-some years, that these are very, as you know, very complex problems, and that they're going to require multiple and multidimensional solutions.

I think one of the biggest issues that we've learned is how critically important connection with community-based services is in achieving any of the outcomes that people have needed, that evidence that we thought was going to be all that was needed was necessary but not sufficient, that we are working directly with our partners in helping them, and I mean healthcare systems, we have a community that has said they want to implement the transitional care model, and working directly with the community to serve people in rural areas to help them along their journey, that change is going to be needed in our structures, in our processes, but, most importantly, as you have already have taught us through your work, in our relationships with the people we serve. So we've been honestly just blessed to have had so many thousands of patients and family caregivers willing to help us learn so much, along with all of the clinicians.

So now let's open it up to you to talk a little bit about what you're learning and also to hear some of the questions that you might have about our work.

Chris Duff: Thank you, Mary, Deborah and Lynne, for your presentation. It was very interesting, and you've certainly traveled down a long road. We have a lot to learn from you.

Retta, would you now open the lines for questions and give instructions?

Operator: Ladies and gentlemen, if you'd like to ask a question, please press star, then 0 on your touchtone phone. You'll hear an acknowledgement tone. An operator will then take your name and further instruct you. If you're using a speakerphone, please pick up the handset before pressing the numbers. Once again, if you have a question, please press star 0 at this time. And you have -- once again, if you have a question, please press star, then 0. If you've already given your name to an operator, please press star, then 1.

One moment, we have a question.

Chris Duff: I think while we're --

Mary Naylor: Hello?

Chris Duff: Oh, go ahead.

Mary Naylor: I was going to say, I'm watching some of the questions that are emerging. This is Mary. And a number of you have been asking about the actual role of the advanced practice nurses, of people like Liz, working with Debbie Streletz.

So, first of all, it is a real partnership with patients, families and communities. In the hospital-to-home model, the advanced practice nurses begin to work with patients, for example, as soon as they are admitted. They work with the care team to do everything imaginable to prevent poor outcomes, even on a three- or four-day hospitalization. Functional decline in just a very short period of time is common ground for people -- this population of older adults.

They begin to help figure out how to work with other team members, with the pharmacist, to say here is what the -- as you just saw, someone's on 20 medications, how do we get this down to a reasonable number so that we can promote adherence? So they'll work with the team members in the hospital.

That same nurse is in the patient's home within 24 hours after transition, knowing the challenges that people experience as they go from 24/7 care to often care by a very frail spouse. And that -- the role of the nurse at that point in time is both direct deliverer of services, of care. They are substituting for traditional -- what might be traditional skilled care, and they are also the coordinator.

They are going to the first visit back to Debbie Streletz for follow-up, positioning the patients and families to be able to optimize on that visit. They're doing all of the work of connecting health and community-based services aligned with this patient. Sometimes they're helping people to decide maybe this journey isn't the right one. How is it that your preferences could be better aligned with existing services, perhaps palliative or hospice care? So their efforts are all about trying to figure out through both direct services and care coordination how is it that we can realign a plan of care with Mr. Smith's goals, with Mrs. Jones' aspirations.

Okay, so -- go ahead.

Chris Duff: Dr. Naylor, I just -- you really addressed the issue that seems to be coming from a lot of people as we all review these questions that we're receiving online. Before I turn to the phone line in just a minute, it really boils down to how you do the handoff between -- you've got the acute episode and then you have that transition. But then how do you do the handoff from the transition to the long-term support, and how (multiple speakers) scale back?

Mary Naylor: So, first of all, you're part -- yes, and, as I said, I think handoffs are important. But I think what we have learned is that it is insufficient. So, first of all, these nurses are the handoff. They are part and parcel of the journey with these patients during very high-risk times.

So if someone -- this nurse who begins to work with a patient in the community is the one who will follow the patient into the hospital, through the postacute skilled facility, if referred, and back home, always there trying to advocate for what -- and doing this in strong collaboration with the primary care providers, with the acute care providers, in fact, being the connecting arm here throughout an entire acute episode of illness as defined by the patient.

They are also there to position these patients and family caregivers with the knowledge, with the skills, with the resources, with access to services, primary care, community-based services, whatever is needed to prevent long-term -- I mean, or to assure, I should say, long-term positive outcomes.

And so it's not just about gaps. It's about interrupting, for many of these people, a chronic illness trajectory that has resulted in this downward movement when, for some, not all, it could be interrupted. And for those for whom it can't, it's about saying how might we work with you in a trusting relationship to think about other opportunities, and that's where we really spend a lot of time on palliative and hospice services.

Chris Duff: Thank you, Dr. Naylor. What you're talking about is totally consistent with the disability-competent care model that we've been presenting over the last many months is that it boils down to the relationship that is developed and maintained with the consumer, the participant, and it's more than just the handoff. So thank you very much for that answer.

Let's open it up to the phone line. I believe we have someone on the phone line.

Operator: If you'd like to ask a question, please press star, then 0 on your touchtone phone.

Chris Duff: Retta, do we have someone?

Operator: Not at this time, Mr. Duff.

Chris Duff: Okay. So I'll revert back to the questions we were getting online. And there's a whole bunch of them. May I show everyone here --

Mary Naylor: So, I was going to say a number of these questions seem to be about the issue of scalability and implementation. And I did, of course, briefly mention some of the barriers that we confronted.

So, for example, when we went to roll out the transitional care model in California there were regulatory barriers that said only home-care nurses can touch patients. So you could have a model where people had a coordination of care but not directly able to intervene, deliver services, do all the things that Liz was describing in terms of direct service delivery. So we had to work in that case with some of the state regulators to be able to try to figure out how to work through those challenges. So we -- organizational barriers, we've had -- we even had our legal system challenge us in the beginning to say whether or not we were taking on too much of a risk in trying to implement this in real world.

So the barriers, though, I think in terms of quality and finances, are changing, I mean, meaning there is much more alignment now for older adult populations with both accountable care organizations, so redesigned delivery innovations, as well as payment models, such as bundled payments, that are really moving us toward a care system, the Community-Based Care Transitions Act, which said hospitals need to figure out how to better interact and work with and partner with community-based organizations on behalf of populations. So there's much more alignment now than ever with the payment innovations and system redesign innovations that are being tested. So we see bright light there.

Chris Duff: Thanks, Dr. Naylor. That is consistent with a lot of the questions being asked. And some of the other questions are focusing on how do you build relationships and supports with community-based organizations. And that's really going to be the focus of our whole presentation next week, so I encourage the participants to join us in that.

Ellen Robin from FCIU talked about quality partnerships between home and acute care. Jennifer Crossley-Hale from the Department of Public Health talked about advanced practice nurses.

Mary Naylor: So let me just -- first of all, a resource that I would -- those of you that are interested in learning more than we could do, obviously, in one hour, one of the slides does have a website that will provide you, because some of you are interested in learning about details of studies, how many patients were enrolled, so we have a website, [www.transitionalcareinfo](http://www.transitionalcareinfo), that will provide you with access to all of our studies and some of the key learnings from that.

We do have -- for example, we run orientation seminars to allow nurses and other team members to understand much more deliberately how do we build these partnerships between home and acute care where they have not existed. And this is the real challenge here, that we have built, even if we have exquisite care in one site, and we, because we haven't deliberately connected it with the next site of care for these patients, we've created these gaps.

So our interest, of course, is to try to figure out how to address those gaps. So we will -- we've built partnerships, let me tell you, largely by bringing onto our teams everyone that we're trying to influence. We bring in, when we're working with hospitals, bring in home care representatives and leaders to be part of a project team to be able to advise us on how we're going to connect it.

In our case we are able to get people like Liz credentialed to work in hospitals, in home care agencies. When she went to partner with Debbie and the primary care practice at Bryn Mawr, she had to become credentialed to work within that primary care practice, within the local hospitals that are served by that practice. She had to learn how to use the electronic health records so she could be a team member. And so we've set up systems that allow for these actual bridges.

The model at Penn is a special service line within Penn Home Care and Hospice. When people are identified as needing the service they are deployed from that agency, advanced practice nurses are, to follow the patients from hospital through skilled nursing home. So they're able to do that because of the way that we've structured the practice. And now, we, of course, have payers paying for it.

Chris Duff: And may I say that that, looping back through all these webinars, that is the main incentive and reason they're doing all these dual initiatives across the country, these demonstrations, is to start peeling away the barriers to what we all who do hands-on care know are preventing us from meeting Sally and Beth's needs.

A lot of it will be done through the integration of funding and resources that's happening through the dual demos. Some of it, it needs to be done at the state level by nurses' practices acts. I know in Massachusetts they need to do some work around what homemakers or personal care attendants were allowed to do. And it really takes a team, as Mary stated, being creative and flexible and identifying the barriers and then figuring out who do you need to get at the table to remove the barriers.

Mary Naylor: One last thing that I'll mention, because I see the time's elapsing, we had a session a couple of months ago, Deb was there, patients, family caregivers, insurers, people who were measuring care, advocacy groups, all there. And Deb, if I might, your comment, so she said, "I don't want to do it the way that we've been doing it in the past." The opportunity for partnerships between clinicians that allow people to get into people's homes and support the work of our healthcare team directly but all aligned with what people want, with what the recipients of care define as their goals, is extraordinarily challenging but unbelievably rewarding. And patients and family caregivers and clinicians alike said this is what we have to work toward.

So we're honestly delighted to have the chance to talk with you. Actually you had a chance to listen to us. But we would love to hear -- if you have any ideas about how we can get it better, we would love to hear from you.

Chris Duff: Thank you very much, Dr. Naylor and your team.

I need to wrap this up at this point. We have received a lot of questions, and we will certainly be following up with them as much as possible. Many of them actually are subjects that we'll be covering over the next several weeks. Some were talking about how do you prepare providers and participants to function and operate in this new world that we're trying to put together. So we will address some of them -- we'll respond to all the questions in very short order, and I encourage you to listen in to the other webinars we have planned, because some of these questions will be addressed at that point also.

I'd like to remind you that this webinar and all the previous ones are available online. We have links to all of us on the latter few slides. So if you have follow-up questions you wish to ask, feel free to do so.

And the website given at the bottom of each of these slides, we're compiling over time here a really comprehensive list of resources. So all the studies that Dr. Naylor referenced will be linked there. They have a phenomenal website -- spend some time at it -- UPenn. And I think that would be a great resource. As you've -- as we've learned today, it doesn't take that much to translate care for older Americans to a younger population that may have similar chronic health issues and barriers.

So, thank you for participating. I appreciate it very much.

Please take a few minutes, or a minute or two, it's a very short survey. We'd appreciate your feedback so that we can tailor our presentations and other material going forward.

At this point we'll end the webinar. Thank you very much.

Operator: Okay, that does conclude our conference for today. Thank you for your participation and for using the AT&T Executive Teleconference Service. You may now disconnect. Speakers, please hold for transfer.