The Transitional Care Program at the University of Pennsylvania Health System

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The Transitional Care Model

The Transitional Care Model (TCM) is a rigorously tested nurse-led, team based model, designed to promote continuity among chronically ill older adults during acute episodes of illness. The TCM has consistently demonstrated improved health outcomes and reduced costs among at risk older adults transitioning from hospital to home.

TCM Core Components

- Care is delivered and coordinated...
- By senior advanced practice nurse (APN) supported by team
- In hospitals, NHs, and homes
- 3x per week
- Using evidence-based protocol
- ...supported by decision support tools

Translating Research Into Practice

- Collaborative real world pilot test of TCM with local Insurer. (Naylor et al., 2011)
- Development of new service line within Penn Home Care and Hospice Services.
- Reimbursed by local payer using case rate with defined performance expectations

Implemented using a learning health system framework that has enabled ongoing improvements.

Modified TCM Protocol

- Patient admitted to a hospital
- Within 24 hours of admission, patient must receive a call from the TCM screening and call center
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- 3x a week, the patient will receive a call from the TCM staff to monitor care transitions
- TCM staff will conduct comprehensive assessment of patient’s needs and outcomes at least once weekly
- TCM staff will provide support to patients and families
- TCM staff will provide education and support to patients and families

Results of Ongoing TCM Program

Length of Intensive TCM (days)

Average: 72.8 days

Eligible diagnoses

- Congestive Heart Failure: 47 (22%)
- Diabetes Mellitus: 34 (16%)
- Anticoagulation: 27 (13%)
- Chronic Obstructive Pulmonary Disease: 15 (7%)
- Coronary Artery Disease/CABG: 21 (10%)
- More than one diagnosis: 17 (33%)

Changes in patient outcomes over time

Patient self-report and APN assessed outcomes

<table>
<thead>
<tr>
<th>Quality of life (increases)</th>
<th>Total number of bothersome symptoms (decrease)</th>
<th>Depressive symptoms (decrease)</th>
<th>Pain (decrease)</th>
<th>Anxiety (decrease)</th>
<th>Fall risk (decrease)</th>
<th>Instrumental activities of daily living (improve)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.001</td>
<td>0.02</td>
<td>0.001</td>
<td>0.001</td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>0.04</td>
</tr>
</tbody>
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Overall rating of experience with transitional care

9.7/10

Discussion

All transitional care nurses participate in a comprehensive orientation and training program including:

- Foundations of Transitional Care On-Line Webinar
- www.transitionalcare.info
- Enhanced palliative care learning experiences
- Shadow opportunities with hospital-based specialists
- Learning with experienced transitional care nurses

Ongoing program evaluation with opportunities for performance improvement is necessary

- Bi-weekly case conferences using root-cause analysis
- Collection and analysis of program fidelity and quality metrics
- Quarterly program evaluation meeting

Support for research continues to extend this service

- Patients with cancer, other diagnoses
- Extension of follow-up phase

Continued evaluation of available funding sources is necessary

- Medicare
- Insurance companies
- Special care delivery models (ACO, IPO)