Penn Homecare & Hospice Services

The Transitional Care Program at the University of Pennsylvania Health System

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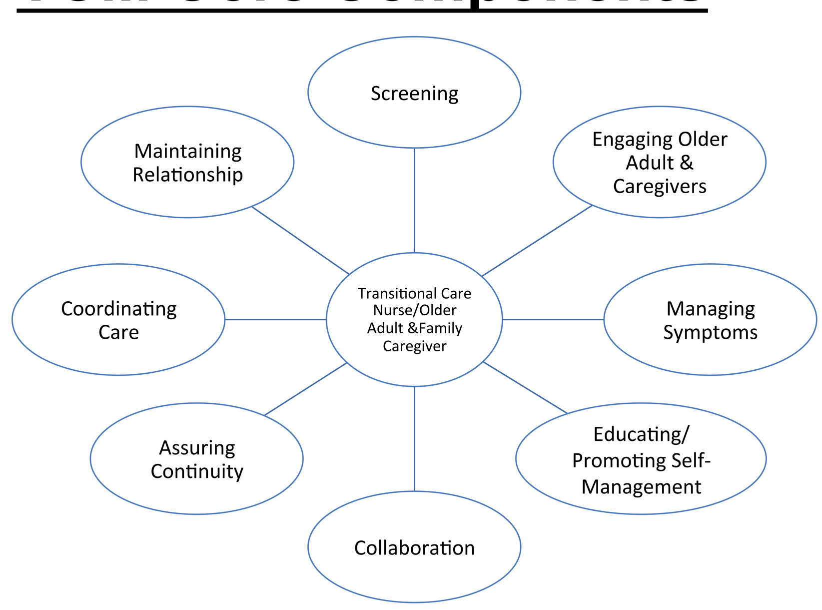
The Transitional Care Model

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.

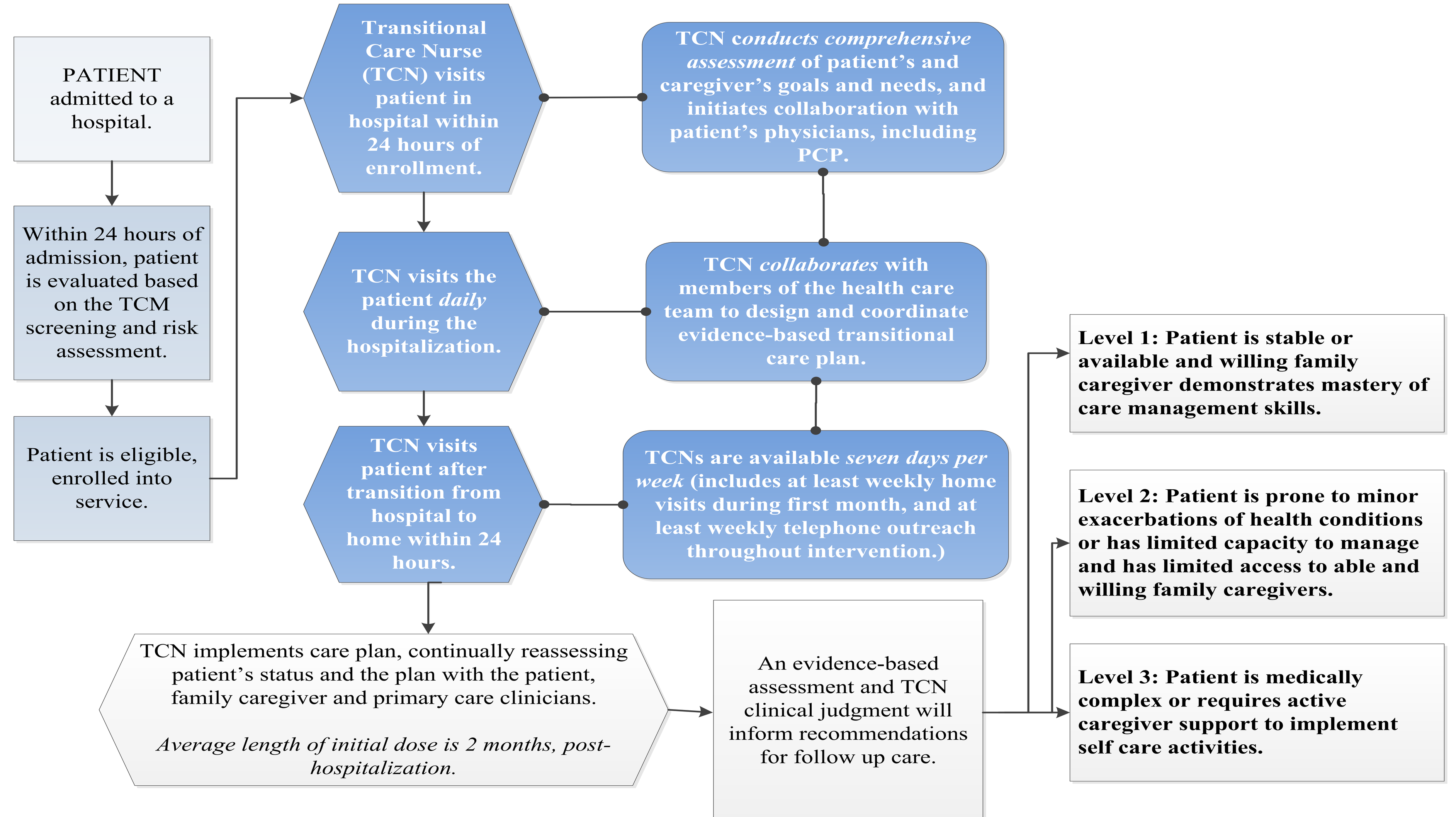
TCM Core Components



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



Results of Ongoing TCM Program

Length of Intensive TCM (days)

Average: 72.8 days

Eligible diagnoses

Diagnosis	n (%)
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

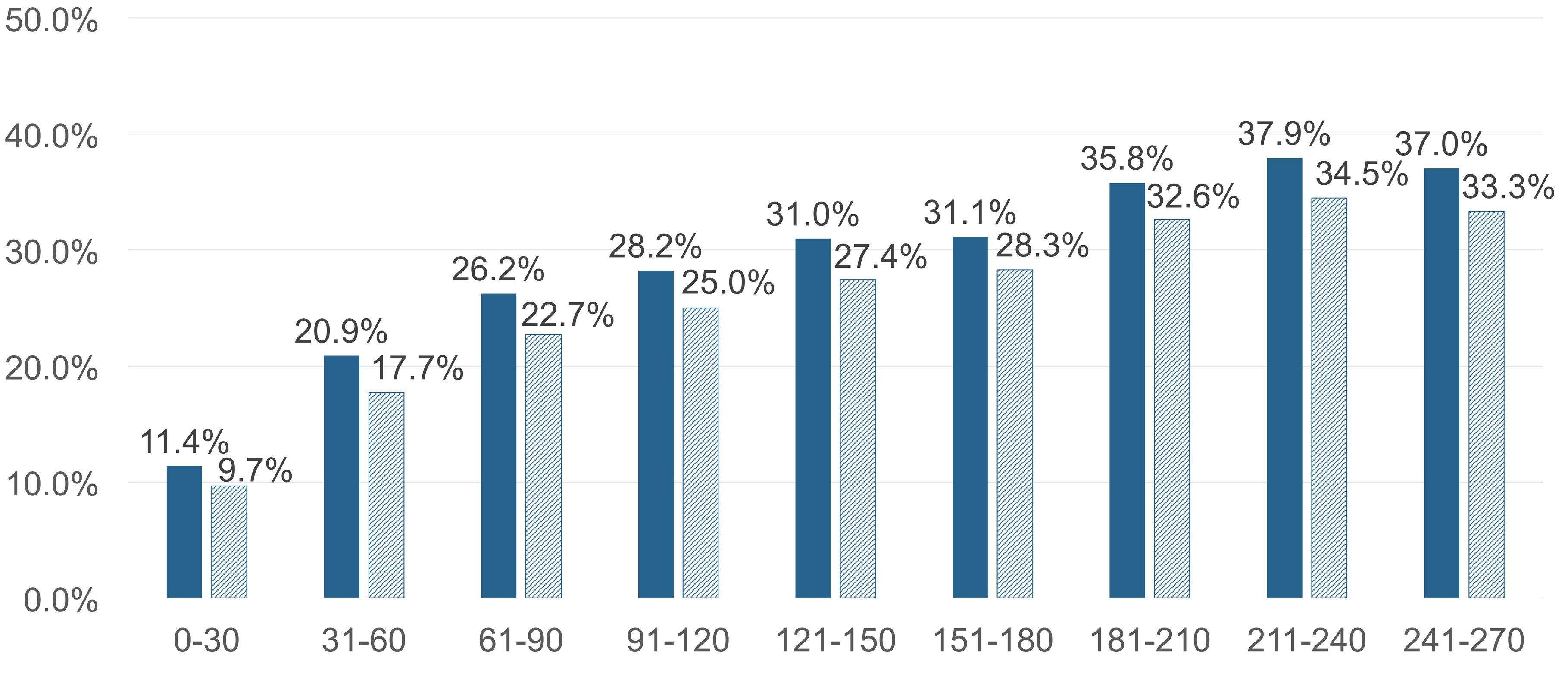
Patient self-report and APN assessed outcomes	p-value*
Quality of life (increases)	0.001
Total number of bothersome symptoms (decrease)	0.02
Depressive symptoms (decrease)	0.001
Pain (decreases)	0.001
Anxiety (decreases)	0.001
Fall risk (decreases)	<0.001
Instrumental activities of daily living (improve)	0.04

Overall rating of experience with transitional care	9.7/10

* Multilevel mixed effects linear regression and generalized estimating equations (GEE) models over multiple time points. Data were collected at enrollment, 30-, 90-, 180-, and 270-days post index hospital discharge.

Enrollment	2/2014 to 11/30/2015
Eligible To Enroll	328
Enrolled	214 (65%)
Declined	113 (34%)
TCM census full	1 (1%)
Attrition	41 (19%)

Number of Patients with at Least One All-Cause Readmission in Post-Index Discharge Time Period



All cause · Unplanned All cause

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)