TRANSLATING RESEARCH INTO PRACTICE

Despite the evidence establishing the linkage between TCM and enhanced value, a number of organizational, regulatory, financial and cultural barriers have prevented the model's adoption.

In response to these challenges and with the support of a number of foundations,[4] the Penn team formed partnerships with leaders of the Aetna Corporation (Aetna) and Kaiser Permanente Health Plan (KP) to translate and integrate the TCM for use in everyday practice and promote widespread adoption of the model by demonstrating its effectiveness among at risk, chronically ill older adults. The findings of this translational research effort have resulted in TCM being identified as a "high value" proposition by Aetna leaders. The project with KP is ongoing. Based on the improvements in health outcomes, member and physician satisfaction and the reductions in rehospitalizations and total health care costs observed in the Aetna project, the University of Pennsylvania Health System (UPHS) has adopted TCM as a service and local insurers are expected to reimburse UPHS for delivery of TCM to their members in 2009.

CONTINUING TO ADVANCE THE SCIENCE

The Penn team is currently testing the effects of TCM among hospitalized cognitively impaired older adults in the *Enhancing Care Coordination* project.[5] Medicare costs for cognitively impaired patients are three times higher than for other older adults. Another ongoing study, *Health Related Quality of Life (HRQoL): Elders in Long Term Care,*[6] is helping to making the case to expand the application of TCM among elders receiving long-term care. Frail older adults receiving both acute and long-term care services are arguably the most vulnerable of patient groups.

1. Naylor MD, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, & Pauly M. Comprehensive discharge planning for the hospitalized elderly. *Ann Intern Med*. 1994;120:999-1006.
2. 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.
3. 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.
4. The Commonwealth Fund; Jacob & Valeria Langeloth Foundation; The John A. Hartford Foundation, Inc.; Gordon and Betty Moore Foundation; California HealthCare Foundation.
5. PI: Naylor, MD. Hospital to Home: Cognitively Impaired Elders and Their Caregivers. Sponsored by: *National Institute on Aging*, R01-AG023116-04, and the *Marian S. Ware Alzheimer's Program* (2005-1010).
6. PI: Naylor, MD. Health Related Quality of Life: Elders in Long-Term Care. Sponsored by: *National Institute on Aging*, the *National Institute of Nursing Research*, R01-AG025524-03, and the *Marian S. Ware Alzheimer's Program*, 2006-2011.

TRANSITIONAL CARE MODEL

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Overview of the Transitional Care Model (TCM)

Given the expected growth of older adults coping with complex chronic conditions, rapidly rising health care costs and a projected shortfall in the Medicare Trust Fund, there is an urgent need to promote older adults' access to high quality, cost-effective and efficient services such as those provided via the TCM.

For the millions of older Americans who suffer from multiple chronic conditions, the TCM emphasizes identification of patients' health goals, coordination and continuity of care throughout acute episodes of illness, development of a rationale, streamlined plan of care to prevent future hospitalizations, and preparation of the patient and family caregivers to implement this care plan—all accomplished with the active engagement of patients and their family caregivers and in collaboration with the patient's physicians and other health team members.

10 Essential Elements of TCM

TCM targets older adults with two or more risk factors, including a history of recent hospitalizations, multiple chronic conditions and poor self-health ratings.

1. The transitional care nurse (TCN), a master's prepared nurse with advanced knowledge and skills in the care of this population, as the primary coordinator of care to assure continuity throughout acute episodes of care;
2. In-hospital assessment, collaboration with team members to reduce adverse events and prevent functional decline, and preparation and development of a streamlined, evidenced-based plan of care;
3. Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge;
4. Continuity of medical care between hospital and primary care providers facilitated by the TCN accompanying patients to first follow-up visit(s);
5. Comprehensive, holistic focus on each patient's goals and needs including the reason for the primary hospitalization as well as other complicating or coexisting health problems and risks;
6. Active engagement of patients and family caregivers with focus on meeting their goals;
7. Emphasis on patients' early identification and response to health care risks and symptoms to achieve *longer term* positive outcomes and avoid adverse and untoward events that lead to readmissions;
8. Multidisciplinary approach that includes the patient, family caregivers and health care providers as members of a team;
9. Physician-nurse collaboration across episodes of acute care; and
10. Communication to, between, and among the patient, family caregivers, and health care providers.

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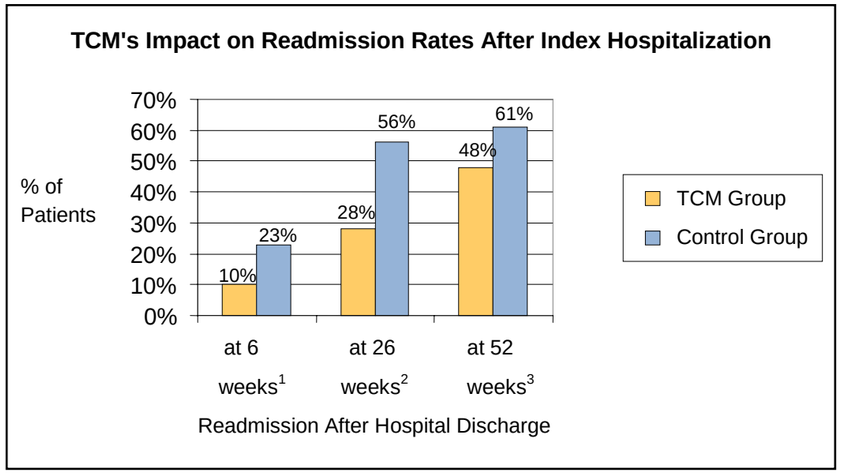
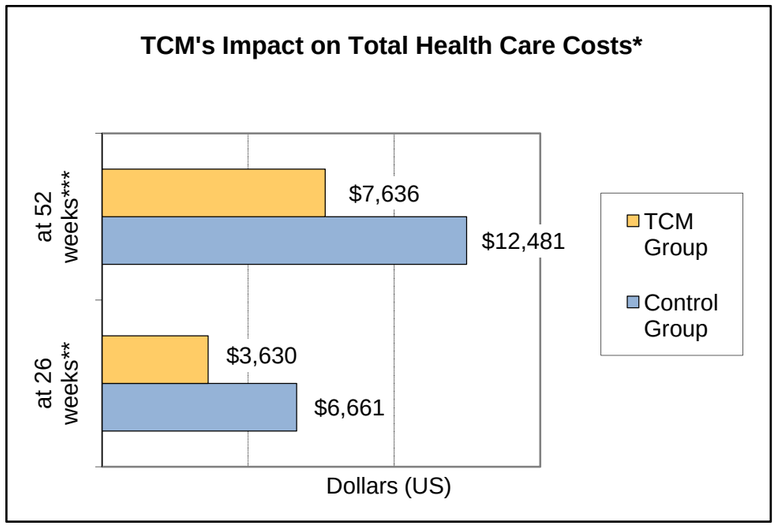
Effects on Quality, Cost, and Value

The TCM has been tested and refined for more than 20 years by a multidisciplinary team of clinical scholars and health service researchers from the University of Pennsylvania. Across three National Institute of Nursing Research (NINR)-funded RCTs completed to date,[1-3] TCM has demonstrated improved quality and cost outcomes for high risk, cognitively intact older adults when compared to standard care:

- ✓ **Reductions in preventable hospital readmissions for both primary and co-existing health conditions.** Additionally, among those patients who are rehospitalized, the time between their index hospital discharge and readmission was increased and the number of inpatient days decreased.



- ✓ **Improvements in health outcomes.** In the most recently reported RCT,[3] short term improvements in physical health, functional status, and quality of life were reported by patients who received TCM.
- ✓ **Enhancement in patient satisfaction.** Overall patient satisfaction has increased among patients receiving TCM.
- ✓ **Reductions in total health care costs.** Both total and average reimbursements per patient have been reduced in TCM focused RCTs.[2-3]



** 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 et al., JAMA, 1999;*
**** Naylor et al., JAGS, 2004*