The Transitional Care Model for Older Adults

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Transitional Care

*Transitional care* – range of *time limited* services that *complement primary care* and are designed to ensure health care continuity and avoid preventable poor outcomes among *at risk* patient groups as they move from one level of care to another, among multiple providers and across settings.
Context for Transitional Care: Acute Care Episode

Adapted from the National Quality Forum committee on Measurement Framework: Evaluating Efficiency across Episodes of Care

Trajectory 1 (T1)
Relatively healthy adult with onset of new chronic illness

Trajectory 2 (T2)
Adults with multiple chronic conditions

Trajectory 3 (T3)
Adults at end of life
Quality Cost
Transitional Care Model (TCM)

Screening

- Maintaining Relationship
- Coordinating Care
- Assuring Continuity

Collaborating

- Engaging Elder/Caregiver
- Managing Symptoms
- Educating/Promoting Self-Management
Unique Features

Care is delivered and coordinated

...by same TC nurse

...in hospitals, SNFs, and homes

...7 days per week/mean of 2 months

...using evidence-based protocol

...with focus on long term outcomes
Core Components

- Holistic, person/family centered approach
- Protocol guided, streamlined care
- Team model; shared accountability
- Single “point person” across episode of care
- Information/communication systems that span settings
Findings from Randomized Clinical Trials To Date

Funding: National Institutes of Health, National Institute of Nursing Research, National Institute on Aging (1990-2010)
Across all RCTs, TCM has...

- Increased time to first readmission or death
- Improved physical function and quality of life*
- Increased patient satisfaction
- Decreased total all-cause readmissions
- Decreased total health care costs

*Most recently completed RCT only


** 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.


Translating TCM into Practice

Penn research team formed partnerships with Aetna Corporation and Kaiser Permanente to test “real world” applications of research-based model of care for high risk elders.

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National Advisory Committee
Tools of Translation

- Patient screening and recruitment
- Web-based modules to orient nurses
- Documentation and quality monitoring via clinical information system (CIS)
- Quality improvement (case conferences and CIS)
- Evaluation
Environment: Ongoing chronic care management programs.

Question: Does the Transitional Care Model offer greater value in this environment?
Progress to Date

- **Aetna** – identified as “high value” proposition; expansion proposed as part of Aetna’s 2009 Strategic Plan
- **Kaiser** – data collection/analyses ongoing
- **University of Pennsylvania Health System** – adopted TCM (Blue Cross reimbursing)
- **QIOs** – working w/States to implement TCM
Barriers to Wide Scale Adoption

- Organization of current care system
- Regulatory issues
- Lack of quality and financial incentives
- Challenges current “practice culture”
FROM HERE TO INFIRMITY
"You're looking for the Holy Grail? Have you tried Ebay?"
Acknowledgements

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www.transitionalcare.info
Thank You!