Transitional Care

A Promising Path to Person-Centered, High Quality, Affordable Care

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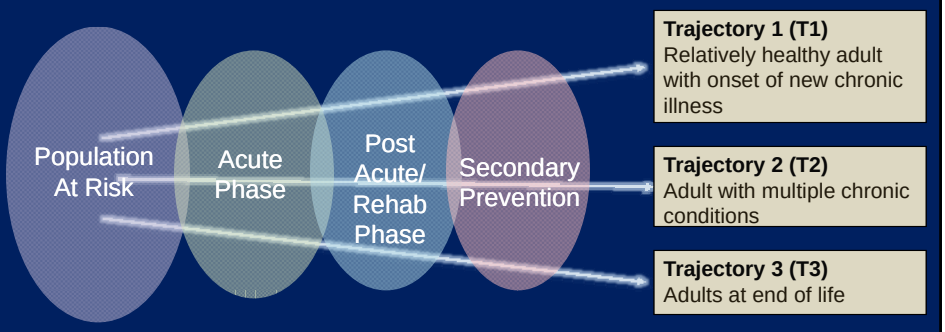
Context: Acute Care Episode



Adapted from the National Quality Forum (NQF) steering committee on Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. The committee's report presents the NQF-endorsed measurement framework for assessing efficiency, and ultimately value, associated with the care over the course of an episode of illness and sets forth a vision to guide ongoing and future efforts.

Published Evidence

- 21 RCTs of diverse "hospital to home" innovations targeting primarily chronically ill older adults
- 9/21, + impact on at least one measure of rehospitalization plus other health outcomes
- Effective interventions
  - Multidimensional and span settings
  - Use inter-professional teams with primarily nurses, as "hubs"

Different Goals of Evidence-Based Interventions

- Address gaps in care and promote effective "hand-offs"
- Address "root causes" of poor outcomes with focus on longer-term value

Transitional Care Model (TCM)

Unique Features

Care is delivered and coordinated

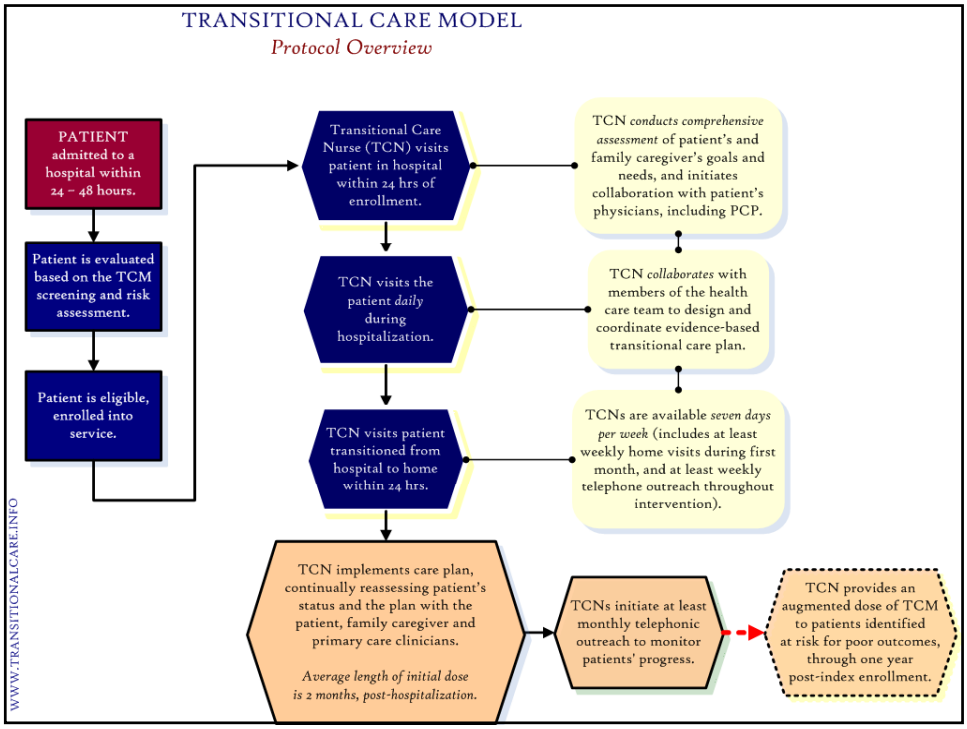
…by same advanced practice nurse

…in hospitals, SNFs, and homes

…seven days per week

…using evidence-based protocol

…with focus on *long term* outcomes



Core Components

- Holistic, person/family centered approach
- Nurse-coordinated, team model
- Protocol guided, streamlined care
- Single "point person" across episode of care (relational/management continuity)
- Information systems that span settings (communication continuity)
- Focus on increasing value over long term

Across RCTs and Translational Research Efforts, TCM has…

- Increased time to first readmission
- Improved physical function and quality of life
- Increased satisfaction/experience with care
- Decreased total all-cause readmissions
- Decreased total health care costs

Potential Measurement Domains – Short Term (Documented)

- Person's/Family Caregiver's Goals
- Assessments – Symptoms, Functional Status, Cognition, Depression, Advanced Care Plans, Home Safety, Need for Help with…
- Selected Processes (e.g., Emergency Contacts, Care Plan, Post-Discharge Follow-Up)
- Medication Management
- Person's/Family Caregiver's Experience with Care
- # All-Cause Admissions, Readmissions, SNF stays and ED visits

Potential Measurement Domains – Longer-Term

- Functional status
- Quality of Life
- Total Health Care Costs

Lessons Learned

- Solving complex problems will require multidimensional solutions
- Evidence is necessary but not sufficient
- Change is needed in structures, care processes, and health professionals' roles and relationships to each other and people they serve
- Overcoming inertia requires substantial force