National Advisory Council on Nurse Education and Practice
Health Resources and Services Administration

# Transitions of Care

**Mary D. Naylor, PhD, RN**

Marian S. Ware Professor in Gerontology

Director, NewCourtland Center for Transitions and Health

University of Pennsylvania School of Nursing

May 21, 2019











# Penn Team

**Mary D. Naylor**
Lead Architect

Marian S. Ware Professor in Gerontology and Director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania School of Nursing

**Mark V. Pauly**
Lead Economist

Bendheim Professor in Health Care Management, Economics, and Public Policy at the University of Pennsylvania, Wharton School of Business

**Kathy McCauley**
Lead Clinician

Professor of Cardiovascular Nursing and former Associate Dean at the University of Pennsylvania School of Nursing

**Karen Hirschman**
Lead Implementer

Research Associate Professor and NewCourtland Term Chair in Health Transitions Research at the University of Pennsylvania School of Nursing

**Alex Hanlon**
Lead Biostatistician

Professor of Practice
Department of Statistics
Virginia Tech

20+ dedicated TCM team members and affiliates covering nursing, healthcare economics, social work, biostatistics and medicine

Transitional Care

Population Health

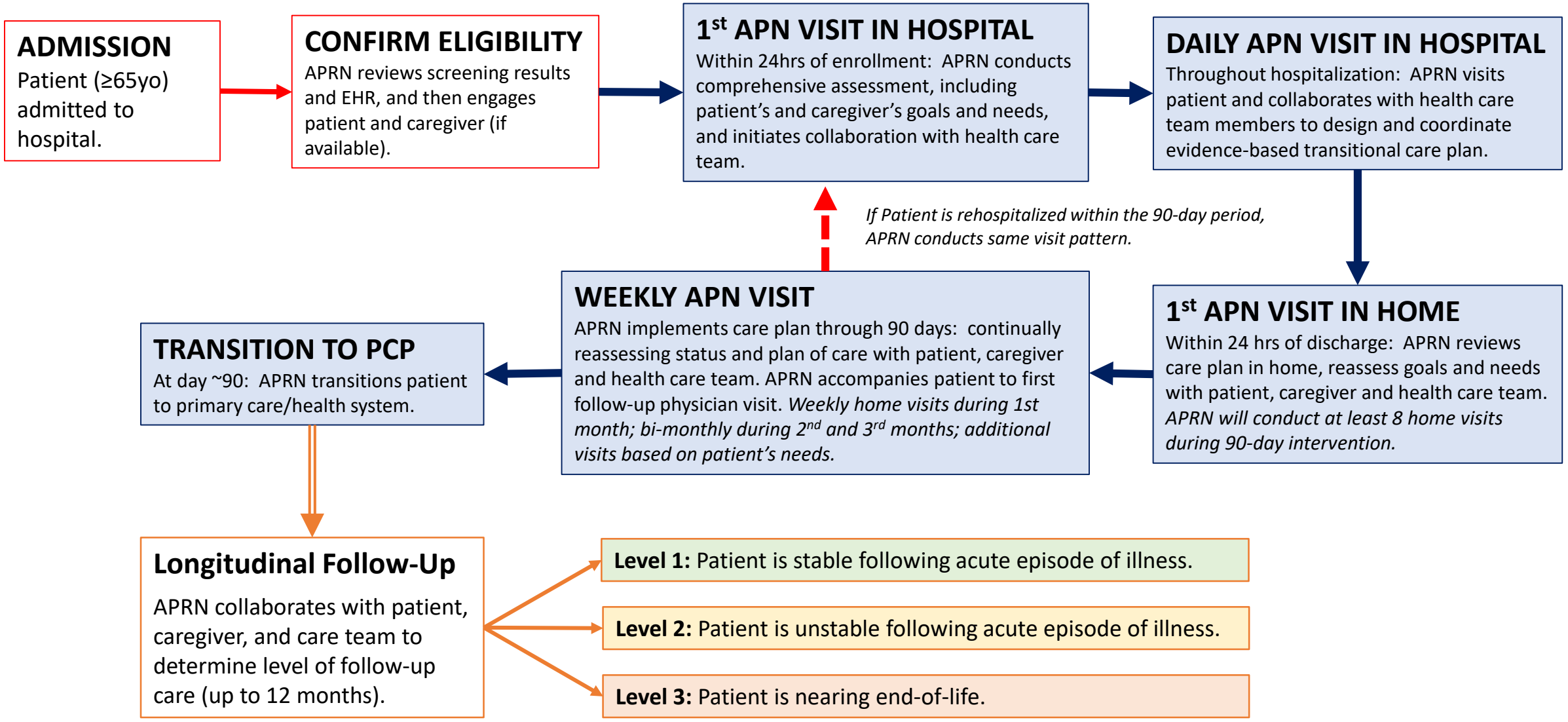
# TCM's Core Components

| | |
|---|---|
| Screening | • Targets older adults in the community or hospital who are at risk for poor outcomes. |
| Staffing | • Uses APRNs to assume primary responsibility for care management throughout episodes of acute illness and oversee/support longitudinal follow-up. |
| Maintaining Relationships | • Establishes and maintains trusting relationships with older adults and family caregivers. |
| Engaging Patients and Caregivers | • Engages older adults and family caregivers in design and implementation of plans of care aligned with individuals' preferences, values and goals. |

# TCM's Core Components

| | |
|---|---|
| Educating/Promoting Self-Management | • Prepares older adults and family caregivers to prevent or identify and respond quickly respond to worsening health and social needs. |
| Collaborating | • Promotes consensus on plans of care between older adults and members of the care team. |
| Promoting Continuity | • Prevents breakdowns in care by having same APRN help older adult and family caregivers navigate multiple clinicians, health and community sectors. |
| Fostering Coordination | • Promotes communication and connections between healthcare and community-based care staff. |

# Sample TCM Protocol: Intensive Phase (Hospital to Home)



# Sample TCM Protocol: Longitudinal Follow-up

## Level 1

STABLE FOLLOWING ACUTE EPISODE OF ILLNESS

APRN continues to collaborate with PCP and community-based staff.

## Level 2

UNSTABLE FOLLOWING ACUTE EPISODE OF ILLNESS

APRN engages registered nurses or community health workers

## Level 3

NEARING END OF LIFE

APRN continues to conduct home visits and other forms of outreach with emphasis on meeting palliative care needs.

# TCM Design and Testing with At Risk Older Adults and Their Caregivers



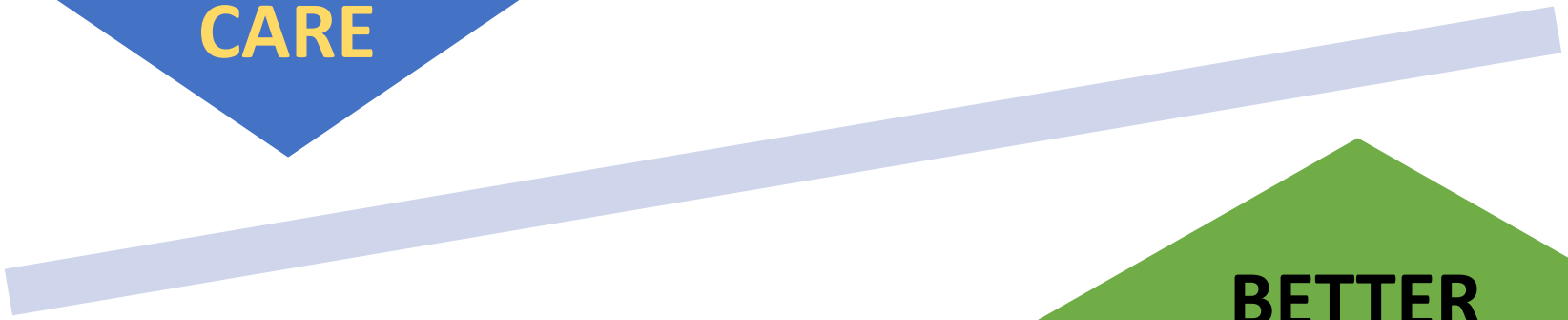

RCT/CER

CER

Observational

# Older Adults'/Caregivers' Outcomes


Decreased symptoms, Improved function, Enhanced quality of life, Reduced caregiver burden§



Improved access, Reduced errors, Increased time to first rehospitalization or death, Enhanced care experiences


(Based on 4 NIH funded RCTs and CER: *Ann Intern Med*, 1994, 120:999-1006; *JAMA,* 1999, 281:613-620; *J Am Geriatr Soc*, 2004, 52:675-684; *J Comp Eff Res, 2014,*3:245-257, § specific to CER trial. *J Comp Eff Res, 2013*, 2(5):457-468.)

# Health Resource Use and Cost Outcomes


(4 NIH funded RCTs and CER: **Ann Intern Med*, 1994, 120:999-1006; ***JAMA,* 1999, 281:613-620; ****J Am Geriatr Soc*, 2004, 52:675-684; *J Comp Eff Res,* 2014, 3(3):245-257; *J Comp Eff Res,* 2018, 7(9):913-922. § Estimated total savings per older adult after accounting for TCM costs.

# Examples of TCM Implementation with Partnering Health Systems/Communities

BLUEGRASS care navigators
Expert. Connected. Care.


Trinitas Regional Medical Center


Yale NewHaven Health


CEDARS-SINAI

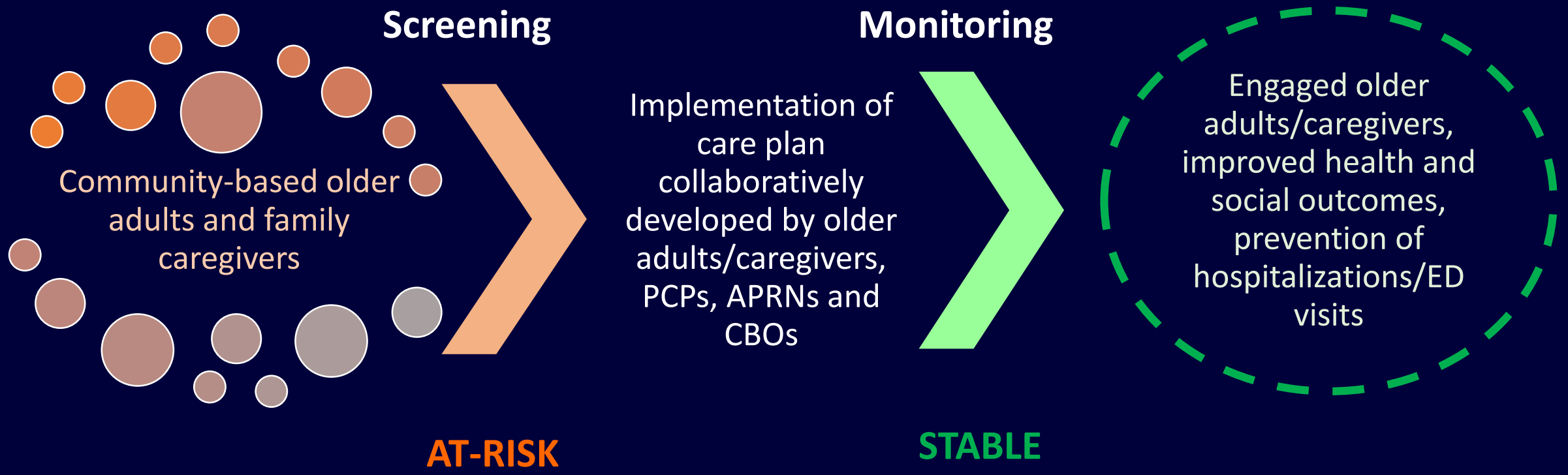
# Overarching Recommendations

- Accelerate widespread use of the TCM to maximize on the contributions of nurses in addressing the challenges of the rapidly growing population of older adults with complex health and social needs.
- Expand testing of the TCM to older adults living in rural/underserved communities (e.g., non-English speaking) who have not been a focus of prior efforts.
- Test technological innovations designed to broaden access of the TCM to a much wider population of older adults with complex care needs.

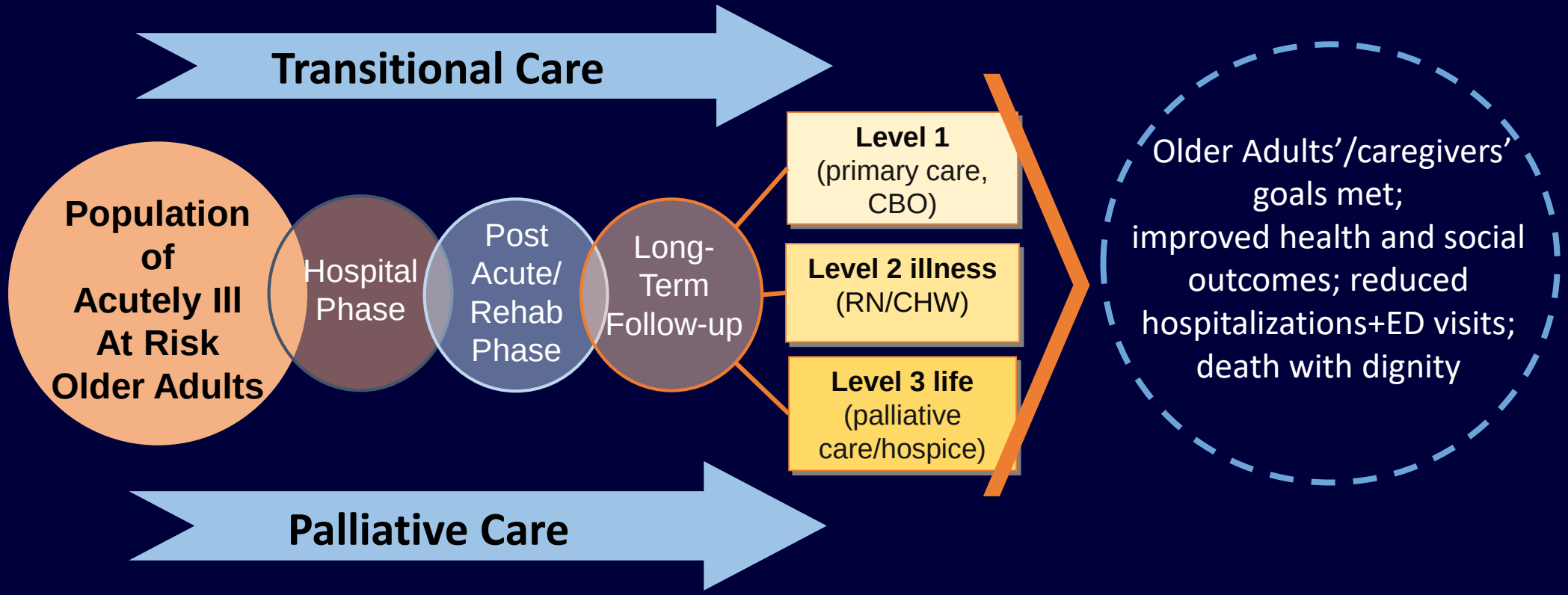
# Overarching Recommendations (cont.)

- Position the existing and emerging nursing workforce with the competencies, tools and resources essential for high quality implementation of evidence-based transitional care and population health.
- Test the older adult, family caregiver and cost outcomes achieved by implementing the TCM using BSN prepared nurses compared to MSN/DNP prepared nurses.

# Upstream: Primary Care + TCM Strategy for "At Risk" Older Adults



# Downstream: Intensive and Longitudinal Phases for Acutely Ill Older Adults



# Thank You!